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State/Territory Name: Oregon

State Plan Amendment (SPA) #: 15-0007

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Seattle Regional Office
701 Fifth Avenue, Suite 1600, MS/RX-200
Seattle, WA 98104

Division of Medicaid & Children's Health Operations

February 1, 2016

Lynne Saxton, Director
Oregon Health Authority
500 Summer Street Northeast, E-15
Salem, OR 97301-1079

RE: Oregon State Plan Amendment (SPA) Transmittal Number 15-0007

Dear Ms. Saxton:

The Centers for Medicare & Medicaid Services (CMS) Seattle Regional Office has completed its review of State Plan Amendment (SPA) Transmittal Number 15-0007. This SPA changes the retroactive effective date of eligibility for all eligibility groups except Qualified Medicare Beneficiaries from the date of eligibility/application to the first day of the month of eligibility/application under the Medicaid State plan.

This SPA is approved effective December 1, 2015.

If there are any questions concerning this approval, please contact me or your staff may contact Janice Adams at janice.adams@cms.hhs.gov or (206) 615-2541.

Sincerely,

[redacted]
Digitally signed by David L. Meacham -S
DN: c=US, o=U.S. Government, ou=HHS, ou=CMS, ou=People, 0.9.2342.19200300.100.1.1=2000041858, cn=David L. Meacham -S
Date: 2016.02.02 12:49:35 -08'00'

David L. Meacham
Associate Regional Administrator

Enclosure

cc:
Lori Coyner, Oregon Health Authority
Jesse Anderson, Oregon Health Authority

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **15-0007**

2. STATE: Oregon

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) Medical Assistance

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
12/1/15

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 435.915

7. FEDERAL BUDGET IMPACT:
a. FFY 2015 $ 0
b. FFY 2016 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 2.6-A, page 24

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 2.6-A, page 24

10. SUBJECT OF AMENDMENT: This transmittal is being submitted change the retroactive effective date in order to coordinate the streamlined application and new ONE eligibility system.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: The Governor does not wish to review any plan materials.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME Lori Coyner

14. TITLE: Medicaid Director, OHA

15. DATE SUBMITTED: 12/28/15

16. RETURN TO:
Oregon Health Authority
Medical Assistance Programs
500 Summer Street NE E-35
Salem, OR 97301

ATTN: Jesse Anderson, State Plan Manager

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12/28/15

18. DATE APPROVED: 02/01/16

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 12/01/15

20. SIGNATURE OF [redacted]

Digitally signed by David L. Meacham -S
DN: c=US, o=U.S. Government, ou=HHS, ou=CMS, ou=People, 0.9.2342.19200300.100.1.1=2000041858, cn=David L. Meacham -S
Date: 2016.02.02 12:50:22 -08'00'

21. TYPED NAME: David L. Meacham

22. TITLE: Associate Regional Administrator

23. REMARKS:

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)		Condition or Requirement
42 CFR 435.915	11.	Effective Date of Eligibility

a. Groups Other Than Qualified Medicare beneficiaries

(1) For the prospective period.
Coverage is available for the full month if the following individuals are eligible at any time during the month.

X Aged, blind, disabled.
X AFDC-related.
X MAGI.

Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements.

___ Aged, blind, disabled.
___ AFDC-related.
___ MAGI.

(2) For the retroactive period.

Coverage is available for three months before the date of application if the following individuals would have been eligible had they applied:

___ Aged, blind, disabled.
___ AFDC-related.
___ MAGI.

Coverage is available beginning the first day of the third month before the date of application if the following individuals would have been eligible at any time during that month, had they applied.

X Aged, blind, disabled.
X AFDC-related.
X MAGI.