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State/Territory Name: Oregon

State Plan Amendment (SPA) #: 15-0007

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Pages

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,

A black rectangular box redacting the signature of David L. Meacham.

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

| | | |
|---|--|---------------------------|
| TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL | 1. TRANSMITTAL NUMBER: 15-0007 | 2. STATE Oregon |
| | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) Medical Assistance | |
| FOR: HEALTH CARE FINANCING ADMINISTRATION | 4. PROPOSED EFFECTIVE DATE 12/1/15 | |
| TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES | | |

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 |

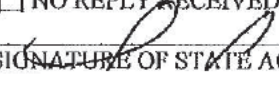
10. SUBJECT OF AMENDMENT: This transmittal is being submitted change the retroactive effective date in order to coordinate the streamlined application and new ONE eligibility system.


11. GOVERNOR'S REVIEW (Check One):

GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED: The Governor does not wish to review any plan materials.

COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

| | |
|--|--|
| 12. SIGNATURE OF STATE AGENCY OFFICIAL:  | 16. RETURN TO: Oregon Health Authority Medical Assistance Programs 500 Summer Street NE E-35 Salem, OR 97301 ATTN: Jesse Anderson, State Plan Manager |
| 13. TYPED NAME: Lori Cofner | |
| 14. TITLE: Medicaid Director, OHA | |
| 15. DATE SUBMITTED: 12/28/15 | |

| 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:  |
| 21. TYPED NAME: David L. Meacham | 22. TITLE: Associate Regional Administrator |
| 23. REMARKS: | |

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

Transmittal #15-0007
ATTACHMENT 2.6-A
Page 24
OMB No.: 0938-

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 | <p>11. Effective Date of Eligibility</p> <p>a. Groups Other Than Qualified Medicare beneficiaries</p> <p>(1) For the prospective period. Coverage is available for the full month if the following individuals are eligible at any time during the month.</p> <p><input checked="" type="checkbox"/> Aged, blind, disabled. <input checked="" type="checkbox"/> AFDC-related. <input checked="" type="checkbox"/> MAGI.</p> <p>Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements.</p> <p><input type="checkbox"/> Aged, blind, disabled. <input type="checkbox"/> AFDC-related. <input type="checkbox"/> MAGI.</p> <p>(2) For the retroactive period.</p> <p>Coverage is available for three months before the date of application if the following individuals would have been eligible had they applied:</p> <p><input type="checkbox"/> Aged, blind, disabled. <input type="checkbox"/> AFDC-related. <input type="checkbox"/> MAGI.</p> <p>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.</p> <p><input checked="" type="checkbox"/> Aged, blind, disabled. <input checked="" type="checkbox"/> AFDC-related. <input checked="" type="checkbox"/> MAGI.</p> |