Table of Contents

State/Territory Name: OR

State Plan Amendment (SPA) #:18-0008

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

Margie C. Stanton, Interim State Medicaid Director
Oregon Health Authority
500 Summer Street Northeast, E-49
Salem, Oregon 97301-1079

JAN 10 2019

RE: OR State Plan Amendment (SPA) Transmittal Number #18-0008 – Approval

Dear Ms. Stanton:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 18-0008. This SPA revises the nursing home facility reimbursement rate to include ventilator-assisted units as part of the prospective payment rate methodology.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment 18-0008 is approved effective as of February 1, 2019. For your files, we are enclosing the HCFA-179 transmittal form and the amended plan pages.

If you have any questions concerning this state plan amendment, please contact Tom Couch, CMS' RO NIRT Representative at 208-861-9838 or Thomas.Couch@cms.hhs.gov .

Sincerely,

[redacted]

Kristin Fan
Director

Enclosures

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: **18-0008**

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
2/1/19

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 447 Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY 2019 $ 668,376
b. FFY 2020 $ 1,002,564

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D, Part 1, page 1-13.b

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D, Part 1, page 1-13.a

10. SUBJECT OF AMENDMENT: This transmittal is being submitted to revise the nursing facility rate to include new designated Ventilator Assisted units within a facility.

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:
[redacted]

13. TYPED NAME David Simnitt

14. TITLE: Interim State Medicaid Director, OHA

15. DATE SUBMITTED: 10/23/18

16. RETURN TO:
Oregon Health Authority
Medical Assistance Programs
500 Summer Street NE E-65
Salem, OR 97301

ATTN: Jesse Anderson, State Plan Manager

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 10/23/18

18. DATE APPROVED: JAN 10 2019

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: FEB 01 2019

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMG

23. REMARKS:

FORM HCFA-179 (07-92)

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

NURSING FACILITIES

Reimbursement for services provided by Nursing Facilities is made by means of rates determined in accordance with the following principles, methods, and standards which comply with 42 CFR Part 447, Subpart C.

I. Reimbursement Principles.

The payment methodology is based on the following:

A. Reimbursement by the Senior and People with Disabilities Division of the Department of Human Services is based on a prospective, all-inclusive rate system which constitutes payment in full for services which are not reimbursed through another Medicaid payment source. The rates established for these long-term care services include reimbursement for services, supplies, and facility equipment required for care by state and federal standards. Costs which are or can be reimbursed by Medicare Part B or a third party payer are not allowed;

B. A standard, statewide flat rate which bears a fixed relationship to reported allowable costs;

C. A complex medical needs add-on rate which bears a fixed relationship to the standard flat rate;

D. A ventilator assisted program rate which bears a fixed relationship to the standard flat rate;

E. A pediatric rate for Medicaid residents under the age of 21 who are served in a pediatric facility or a self-contained pediatric unit; and

F. Annual review and analysis of allowable costs for all participating nursing facilities. Allowable costs are the necessary costs incurred for the customary and normal operation of a facility, to the extent that they are reasonable and related to resident care.

G. All Nursing Facility Financial Statements are subject to desk review and analysis to determine that the provider has included its costs in accordance with Generally Accepted Accounting Principles and the provisions of the Oregon Administrative Rules.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

II. Nursing Facility Rates.

A. The Basic Rate.

1. The Division shall pay the basic rate to a provider as prospective payment in full for a Medicaid resident in a nursing facility.

2. "Basic rate" means the standard, statewide payment for all long term care services provided to a resident of a nursing facility except for services reimbursed through another Medicaid payment source.

3. The basic rate is an all-inclusive rate constituting payment in full, unless the resident qualifies for the complex medical needs add-on rate (in addition to the basic rate) or the all-inclusive pediatric rate (instead of the basic rate). The methodology for calculating the basic rate is described in Section III.

B. The Complex Medical Needs Add-on Rate.

1. If a Medicaid resident of a nursing facility qualifies for payment at the basic rate and if the client's condition or care needs are determined to meet one or more of the medication procedures, treatment procedures or rehabilitation services described in paragraph 2 of this subsection, the Division will pay the basic rate plus the complex medical add-on rate for the additional licensed nursing services needed to meet the client's increased need to a provider as prospective payment in full.

2. "Complex Medical Needs Add-on Rate" means the standard, statewide supplemental payment for a Medicaid client of a nursing facility whose care is reimbursed at the basic rate if the client needs one or more of the following medication procedures, treatment procedures or rehabilitation services for the additional licensed nursing services needed to meet the client's increased needs.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

a. Medication Procedures

(1) Administration of medication(s) at least daily requiring skilled observation and judgment for necessity, dosage and effect for example new anticoagulants, etc. (This category does not include routine medications, any oral medications or the infrequent adjustments of current medications);

(2) Intravenous injections/infusions, heparin locks used daily or continuously for hydration or medication;

(3) Intramuscular medications for unstable condition used at least daily;

(4) External infusion pumps used at least daily. This does not include external infusion pumps when the client is able to self-bolus;

(5) Hypodermoclysis daily or continuous use;

(6) Peritoneal dialysis, daily. This does not include clients who can do their own exchanges;

b. Treatment Procedures

(1) Nasogastric, Gastrostomy or Jejunostomy tubes used daily for feedings;

(2) Nasopharyngeal suctioning twice a day or more. Tracheal suctioning as required for a client who is dependent on nursing staff to maintain airway;

(3) Percussion, postural drainage, and aerosol treatment when all three are performed twice per day or more often;

(4) Care and services for a ventilator dependent client who is dependent on nursing staff for initiation, monitoring, and

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

(5) Is limited to Stage III or IV pressure ulcers which require aggressive treatment and are expected to resolve. The Pressure Ulcer is eligible for add-on until the last day the ulcer is visibly a Stage III pressure ulcer;

(6) Open wound(s) as defined by dehisced surgical wounds or surgical wounds not closed primarily, which require aggressive treatment and are expected to resolve;

(7) Deep or infected stasis ulcers with tissue destruction equivalent to at least a Stage III. Eligible for add-on until the last day the ulcer is equivalent to a Stage III. If the stasis ulcer is chronic, it is eligible for add-on only until it returns to previous chronic status.

(8) Unstable Insulin Dependent Diabetes Mellitus (IDDM) in a client who requires sliding scale insulin; and

(i) Exhibits signs/symptoms of hypoglycemia and/or hyperglycemia; and

(ii) Requires nursing or medical interventions such as extra feeding, glucagon or additional insulin, transfer to emergency room; and

(iii) Is having insulin dosage adjustments.

While all three criteria do not need to be present on a daily basis, the client must be considered unstable. A Client with erratic blood sugars, without a need for further interventions, does not meet this criteria.

(9) Professional teaching. Short term, daily teaching pursuant to discharge or self-care plan;

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

(10) Emergent medical/surgical problems requiring short term licensed nursing observation and~~/or~~ assessment. This criteria requires pre-authorization from the Division's Complex Medical Add-On Coordinator. Eligibility for add-on will be until the client no longer requires additional licensed nursing observation and assessment for this medical/surgical problem); or

(11) Emergent behavior problems which involve a sudden, generally unexpected change or escalation in behavior of a client that poses a serious threat to the safety of self or others and requires immediate intervention, consultation and care planning. This criteria requires pre-authorization from the Division's Complex Medical Add-On Coordinator. Eligibility for add-on will be until the client no longer requires additional licensed nursing observation and assessment for this medical problem);

c. Rehabilitation Services. Utilization of rehabilitation services in the frequencies specified below are used only to determine qualification for payment of the "complex Medical Needs Add-On Rate". No separate reimbursement will be made for these services outside the approved State Plan.

(1) Physical therapy performed at least 5 days every week;

(2) Speech therapy performed at least 5 days every week;

(3) Occupational therapy performed at least 5 days every week;

(4) Any combination of physical therapy, occupational therapy and speech therapy performed at least 5 days every week; or

(5) Respiratory Therapy at least 5 days every week by a respiratory therapist. These services must be authorized by Medicare, Medicaid Oregon Health Plan or a third party payer.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

3. The basic rate plus the complex medical needs add-on rate is the all-inclusive rate constituting payment in full for a Medicaid resident of a nursing facility who qualifies for a supplemental payment for complex medical care in addition to the basic rate. The methodology for calculating the basic rate is described in Section III.

C. Ventilator Assisted Program Rate.

1. If a Medicaid resident of a nursing facility qualifies for payment at the ventilator assisted program rate and meets the requirements described in paragraph 2 of the subsection, the Division will pay the ventilator assisted program rate stated in Section III.B.1.c.

2. Ventilator Assisted Program Rate means the statewide payment for all long term care services provided to a Medicaid resident of a Ventilator Assisted Program Unit who meets the requirements below, except for services reimbursed through another Title XIX payment source.

(a) Is chronically dependent on an invasive mechanical ventilator to sustain life;
(b) Requires the ongoing use of a CPAP or Bi-Pap to sustain life; or
(c) Is receiving necessary support and services during the transition from mechanical ventilation to a lower level of service.

3. The Ventilator Assisted Program Rate is the all-inclusive rate constituting payment in full for a Medicaid resident of a nursing facility who qualifies for the services necessary to accommodate the needs of a person in a Ventilator Assisted Program. The methodology for calculating the Ventilator Assisted Program Rate is described in Section III.

D. Pediatric Rate.

1. Notwithstanding subsections A and B, if a Medicaid resident under the age of 21 is served in a "pediatric nursing facility" or a "self-contained pediatric unit", as those terms are defined in Section III.C. The Division shall pay the pediatric rate stated in Section III.C.2. as prospective payment in full.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

2. "Pediatric rate" means the standard, statewide payment for all long term care services provided to a Medicaid resident under the age 21 who is a resident of a pediatric nursing facility or a self-contained pediatric unit except for services reimbursed through another Title XIX payment source.

3. The pediatric rate is the all-inclusive rate constituting payment in full for a Medicaid resident under the age of 21 who is a resident of a pediatric nursing facility or a self-contained pediatric unit. The methodology for calculating the pediatric rate is described in Section III.

E. Other Payments.

1. Medicare. The Division shall pay the coinsurance rate established under Medicare, Part A, Hospital Care for care rendered to an eligible client from the 21st through the 100th day of care in a Medicare certified nursing facility.

2. Swing Bed Eligibility. To be eligible to receive a Medicaid payment under this rule, a hospital must:

(a) Have approval from the Centers for Medicare and Medicaid Services (CMS) to furnish skilled nursing facility services as a Medicare swing-bed hospital;

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

(b) Have a Medicare provider agreement for acute care; and

(c) Have a current signed provider agreement with the Seniors and People with Disabilities Division to receive Medicaid payment for swing-bed services.

(1) NUMBER OF BEDS:

(a) A Critical Access Hospital (CAH) that is not located within a 30 mile geographic radius of a licensed nursing facility as of March 13, 2007 may provide swing bed services to up to 20 Medicaid residents at one time. The CAH must maintain at least five beds or twice the average acute care daily census, whichever is greater, for exclusive acute care use;

(b) Other hospitals providing swing bed services under this rule may not receive provide such services to more than five Medicaid residents at one time. In addition, the residents must have a documented need for and receive services that meet the complex medical add-on requirements outlined in OAR 411-070 as of July 1, 2009, This OAR contains relevant details of the State's NF reimbursement methodology and as such is adhered to by the State;

(c) If circumstances change so that a CAH receiving payment for Medicaid services pursuant to section (2)(b) of this rule meets the criteria set out in section (2)(a) of this rule after March 13, 2007, the CAH may petition the Division for authorization to receive such payment pursuant to section (2)(a) of this rule. The Division will evaluate all available long-term care resources within a 30 mile geographic radius of the CAH and the amount of unmet long-term care need in the same area and determine if the CAH will be authorized to receive payment pursuant to section (2)(a) of this rule.

(2) PAYMENT:

(a) Daily Rate. Medicaid payment for swing-beds will be equal to the rate paid to Oregon's Medicaid certified nursing facilities.

(b) Medicare Co-payment. Medicaid payment for Medicare co-insurance for Division clients will be made at a rate which is the difference, if any, between the Medicare partial payment and the facility Medicaid rate.

(3) ADMISSION OF CLIENTS. Prior to determination of Medicaid payment eligibility in the swing bed, the case manager must determine there is no nursing facility bed available to the client within a 30 mile geographic radius of the hospital. For the purpose of this rule, "available bed" means a bed in a nursing facility that is available to the client at the time the placement decision is made.

3. Out-of-State Rate. When an Oregon Medicaid resident is cared for temporarily in a nursing facility in a state contiguous to Oregon while an appropriate in-state care setting is being located. In order to approve a temporary out-of-state rate, the Division must be furnished a written statement from the resident's physician that specifies an anticipated date of discharge or length of stay. Once approved, the Division shall pay the lesser of:

   a. The Medicaid rate for the resident's level of care established by the state in which the nursing facility is located; or

   b. The rate for which the resident would qualify in Oregon which is either the Basic Rate with a possible Complex Medical Needs Add-on payment, Ventilator Assisted Program rate, an Extreme Outlier Client Add-on payment, or the pediatric rate.

4. Outlier Client Add-On

   a. The Division may make an outlier client add-on payment when a client has a combination of extraordinary medical, behavioral and/or social needs and no satisfactory placement can be made within the established payment categories.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

b. The add-on will be specific to the client's care needs, based on an outlier care plan approved by the Division at the beginning of outlier care and at six month intervals thereafter, and the facility-specific direct care costs related to the client's outlier care plan.

c. The outlier add-on will be calculated using the latest audited facility-specific unit price of the direct care component(s) whose costs are increased due to the outlier care plan.

5. Nurse Aide Training and Competency Evaluation.

The administrative expenses incurred by nursing facilities for nurse aide training and competency evaluation will be reported on a quarterly basis, and the facility will be reimbursed the eligible portion of these costs. Payments made under this provision will be on a pass-through basis outside the approved reimbursement system.

6. Trustee.

When a trustee is appointed temporarily by the court to manage a facility for protection of the health and welfare of residents, costs related to the operation of the facility which are not covered by the facility's revenue sources, including regular Medicaid rates and the State's trust fund, will be reimbursed as administrative costs under Section 6.2 of the approved State Plan.

7. Certified Nursing Assistant (CNA) Staffing Standard.

a. The Division shall add to the basic rate and the pediatric rate a Certified Nursing Assistant staffing standard payment to work toward implementation of a new minimum CNA staffing standard of 2.46 hours per resident day (HPRD).

(1) Raise HPRD to 2.07 on March 1, 2008
(2) Raise HPRD to 2.31 on April 1, 2009
(3) Raise HPRD to 2.46 on July 1, 2009

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

b. The Division shall collect quarterly staffing updates from nursing facilities and monitor staffing compliance.

III. Financial Reporting, Facility Auditing, and the Calculation of the Standard Statewide Basic Rate, Complex Medical Needs Add-on Rate and Ventilator Assisted Program Rate.

A. Financial Reporting and Facility Auditing.

1. Effective July 1, 1997, each facility files annually and for the period ending June 30 a Nursing Facility Financial Statement (Statement) reporting actual costs incurred during the facility's most recent fiscal reporting period. The Statement can be filed for a reporting period other than one year only when necessitated by a change of ownership or when directed by the Division.
2. Each Statement is subject to desk audit within six months after it has been properly completed and filed with the Division. The Division may conduct a field audit which, if performed, will normally be completed within one year of being properly completed and filed with the Division.

B. Calculation of the Standard Statewide Basic Rate, Complex Medical Needs Add-on Rate and Ventilator Assisted Program Rate.

1. Basic Rate, Complex Medical Needs Add-on Rate, and Ventilator Assisted Program Rate.

a. Basic Rate. The rate is determined annually. The Basic Rate is based on the Statements received by the Division by October 31 for the fiscal reporting period ending on June 30 of the previous year. Statements for pediatric nursing facilities and ventilator assisted Program are not used to determine the Basic Rate. The Division desk reviews or field audits these Statements and determines for each nursing facility, its allowable costs less the costs of its self-contained pediatric unit and Ventilator Assisted Program unit, if any.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

For each facility, its allowable costs, less the costs of its self-contained pediatric unit or ventilator assisted Program (if any) is inflated from the mid-point of its fiscal reporting period to the mid-point of the following fiscal year, by projected changes in the DRI* Index.

For each facility, its Allowable Costs Per Medicaid Day is determined using the allowable costs as inflated and resident days excluding days in a self-contained pediatric unit or ventilator assisted program unit as reported in the Statement.

b. Complex Medical Needs Add-on Rate. The Complex Medical Needs Add-on Rate is 40 percent of the Basic Rate.
c. Ventilator Assisted Program rate is 200% of the basic rate.

2. For the period beginning July 1, 2007 through June 30, 2016, the Rate is set at the 63rd percentile of allowable costs (both direct and indirect).

3. Nursing facility bed capacity in Oregon shall be reduced by 1,500 beds by December 31, 2015, except for bed capacity in nursing facilities operated by the Department of Veteran's Affairs and facilities that either applied to the Oregon Health Authority for a certificate of need between August 1, 2011 and December 1, 2012, or submitted a letter of intent under ORS 442.315(7) between January 15, 2013 and January 31, 2013. An official bed count measurement shall be determined and issued by the Department prior to July 1, 2016 and each quarter thereafter if the goal of reducing the nursing facility bed capacity in Oregon by 1,500 beds is not achieved.

a. (a) For the period beginning July 1, 2013 and ending June 30, 2016, the Department shall reimburse costs as set forth in section (1) of this rule at the 63rd percentile.

b. For each three-month period beginning on or after July 1, 2016 and ending June 30, 2018, in which the reduction in bed capacity in licensed facilities is less than the goal described in this section, the Department shall reimburse costs at a rate not lower than the percentile of allowable costs according to the following schedule:

(A) 63rd percentile for a reduction of 1,500 or more beds.

* DRI compiled from *the IHA Economics, Healthcare Cost Review* Report, Table 6.7 titled "CMS Nursing Home without Capital Market Basket

(B) 62nd percentile for a reduction of 1,350 or more beds but less than 1,500 beds.

(C) 61st percentile for a reduction of 1,200 or more beds but less than 1,350 beds.

(D) 60th percentile for a reduction of 1,050 or more beds but less than 1,200 beds.

(E) 59th percentile for a reduction of 900 or more beds but less than 1,050 beds.

(F) 58th percentile for a reduction of 750 or more beds but less than 900 beds.

(G) 57th percentile for a reduction of 600 or more beds but less than 750 beds.

(H) 56th percentile for a reduction of 450 or more beds but less than 600 beds.

(I) 55th percentile for a reduction of 300 or more beds but less than 450 beds.

(J) 54th percentile for a reduction of 150 or more beds but less than 300 beds.

(K) 53rd percentile for a reduction of 1 to 149 beds.

4. For the period beginning July 1, 2018 through June 30, 2026, the rate is set at the 62nd percentile of allowable costs (both direct and indirect).

C. Quality and Efficiency Incentive Program.

The Quality and Efficiency Incentive Program is designed to reimburse quality nursing facilities that voluntarily reduce bed capacity. This design increases statewide occupancy levels and enhances efficiency with the goal of slowing the growth of system-wide costs. As a result of the increased occupancy rates, nursing facilities that participate are likely to increase staffing levels and consolidate resources to improve the quality of care.

Only nursing facilities that meet strict quality criteria are eligible. A quality/qualifying nursing facility must have evidence of compliance with nursing facility regulations such that the health, safety or welfare of residents is or was not jeopardized. A quality nursing facility is determined eligible by multiple components including being a licensed facility by the Department, being in substantial compliance with annual licensing and recertification surveys and having no substantiated facility abuse within the preceding six months.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

The Department may provide additional compensation to nursing facilities who qualify for the legislatively approved Quality and Efficiency Incentive Program. Such compensation may not exceed $9.75 per Medicaid resident day and may not exceed four years from the facility's date of eligibility. Eligibility to participate in this Program sunsets on June 30, 2016.

D. Pediatric Nursing Facilities.

1. Pediatric nursing facility means a licensed nursing facility, 50% of whose residents entered the facility before the age of 14 and all of whose residents are under the age of 21.

2. Pediatric nursing facilities will be paid a per diem rate which rate will:

   a. Be prospective;
   b. Not be subject to settlement; and
   c. The per diem rate will be calculated as follows:

      The per resident day total cost from the desk reviewed or the field audited cost report for all pediatric nursing facilities are summed and divided by the total pediatric resident days.

      Once the weighted average cost is determined, the rebase relationship percentage (93%), is applied to set the new rate. Before computing the weighted average cost, the facility-specific total costs are inflated by a change in the DRI Index to bring the cost to the rebase year.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

3. For the services rendered between October 1, 2013 and June 30, 2020, the Department shall set the relationship percentage to 93% and rebase annually.

4. Pediatric nursing facilities must comply with all requirements relating to timely submission of Nursing Facility Financial Statements.

E. Licensed Nursing Facility With a Self-Contained Pediatric Unit.

1. A nursing facility with a self-contained pediatric unit means a licensed nursing facility that cares for pediatric residents (residents under the age of 21) in a separate and distinct unit within or attached to the facility.

2. Nursing facilities with a self-contained pediatric unit will be paid in accordance with subsection C.2. of this section for pediatric residents cared for in the pediatric unit.

3. Nursing facilities with a self-contained pediatric unit must comply with all requirements related to timely submission of Nursing Facility Financial Statements and must file a separate attachment, on forms prescribed by the Division, related to the costs of the self-contained pediatric unit.

IV. Public Process

The State has in place a public process which complies with the requirement of Section 1902(a)(13)(A) of the Social Security Act.