State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO
THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.
Provided: / / No limitations /X/ With limitations*

2.a. Outpatient hospital services.
Provided: / / No limitations /X/ With limitations*

b. Rural health clinic services and other ambulatory service furnished by a rural health clinic (which are otherwise included in the state plan).
/X/ Provided / / No limitations / X/ With limitations*
/ / Not provided.

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).
Provided: / / No limitations /X/ With limitations*

~~d. Ambulatory services offered by a health center receiving funds under section 329, 330 or 340 of the Public Health Service Act to a pregnant woman or individual under 18 years of age.~~
~~/X/ Provided / / No limitations / X/ With limitations*~~

3. Other laboratory and x-ray services.
Provided: / / No limitations /X/ With limitations*

*Description provided on Attachment.

LIMITATIONS ON SERVICES

l . Inpatient Hospital Services

Selected non-emergency surgical and medical services provided in an inpatient setting require pre-admission screening for medical necessity. Such screening shall be accomplished by a professional medical review organization, or by OMAP. A notice of prior authorization of payment must be issued. Non-emergency inpatient services, excluding maternity and newborn admissions, provided to enrollees in a Managed Care Organization require authorization by the Plan. Transfers or admissions for the purpose of providing rehabilitative services must be prior authorized by the professional medical review organization or by a contracted Managed Care Organization. A notice of prior authorization of payment must be issued - The professional medical review organization may require a second opinion before granting prior authorization.

Services identified by the Division as not covered or services deemed not to be medically necessary are not reimbursed by the Division.

2.a Outpatient Hospital Services

Outpatient services do not require prior authorization with the exception of services identified below:

a. Non-emergency outpatient services provided to clients enrolled in a Physician Care Organization or Health Maintenance Organization require prior authorization from the PCO or HMO.

b. Most physical therapy, occupational therapy, speech-language therapy, audiological services, prosthetic and orthotic supplies, oxygen, specific vision services, specific drugs, durable medical equipment, selected surgical procedures, and non-emergency dental services require prior authorization when delivered in an outpatient setting.

Reimbursement for outpatient non-emergency hospital services in non-contiguous out-of-state hospitals must be prior authorized. Non-contiguous out-of-state hospitals are defined as those hospitals located more than 75 miles from Oregon. Emergency services are those determined by a licensed health care professional to be essential to prevent death, relieve service pain, and/or treat acute illness or injury.

LIMITATIONS OF SERVICES (Continued)

b. Rural Health Clinic Services

Rural Health Clinic Services (RHC) is limited to otherwise covered services provided by licensed physicians and/or certified nurse practitioners in Rural Health Clinics certified by the Department of Health and Human Services. In addition to the above provider types, Maternity Case Management (MCM) services provided through a Rural Health Clinic may be provided by physician assistant, certified nurse midwife, direct entry midwife, social worker, or a registered nurse with a minimum of two years related and relevant work experience employed by the Rural Health Clinic. Specific services not within the recognized scope of practice of the provider of MCM services must be referred to an appropriate discipline.

c. Federally Qualified Health Center (FQHC) Services

Limited to ambulatory services

3. Clinical laboratory and pathology services and procedures*

*performed by any provider are reimbursable only after the provider is certified by HCFA as meeting the requirements of the Clinical Laboratory Improvement Amendments of 1988 (CLIA) and HCFA has notified OMAP of the assignment of a ten-digit CLIA number. Enforcement of compliance with CLIA requirements will occur only after notification in writing from HCFA.

*are provided subject to the rules and procedures set forth in the Medical-Surgical Services Administrative Rules and Billing Instructions for Oregon Medical Assistance Programs.

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4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: __ No limitations X With limitations*

4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

4.c. Family planning services and supplies for individuals of childbearing age.

Provided: __ No limitations X With limitations*

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a ~~skilled~~ nursing facility or elsewhere.

Provided: X ____ With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: __ No limitations X With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services.

Provided: __ No limitations X With limitations*

__ Not provided

* Description provided on Attachment.

4.a. Nursing Facility Services for age 21 or Over

Nursing facility service is subject to a maximum cost reimbursement.

4.b. Early and Periodic Screening. Diagnosis and Treatment of those Under Age 21

Dental screening, diagnosis and treatment begin at age 18 months.

Coverage of transplants and transplant-related services is available for individuals under the age of 21 as described in Attachment 3.1-E.

All medically necessary diagnosis and treatment services permitted under Medicaid statute will be furnished to EPSDT recipients. Services not currently in the state plan, but that are available to EPSDT recipients are hospice, case management, and respiratory care services, if medically necessary. The service limitations delineated in Attachment 3.1-A do not apply to EPSDT recipients if the service is determined to be medically necessary by the Office of Medical Assistance Programs medical or dental consultants.

4.c. Family Planning Services

Family planning services are provided subject to the rules and procedures set forth in the Medical-Surgical Services Administrative Rules and Billing Instructions for Oregon Medical Assistance programs.

LIMITATIONS ON SERVICES

5. a. and b. Physicians Services

Payment for physician services is subject to published rules and instructions, and prior authorization of selected elective rehabilitative procedures. Other selected procedures are not covered based upon unproven efficacy and/or non-coverage by Medicare and other major third party payers and after concurrence by appropriate provider representation. The DMAP Medical-Surgical Services guide sets forth the procedures for which payment will not be made, for which prior authorization is required, or for which other program controls are applied. All rules and instructions governing billing and payment are set forth in the guide. The Current Procedural Terminology (CPT) and HCPCS codes are the basis of medical terminology and procedure descriptions.

Reimbursement for non-emergency services provided by out-of-state physicians, other than in contiguous areas, must be prior authorized. However, payment of services to foster children and children in subsidized adoption who are placed by the Children's Services Division anywhere in the United States or Canada is on the same basis as services provided in Oregon.

The Division may disallow payment for physicians' services provided during inpatient hospitalizations in which prior approval was required but not obtained.

6. a. Podiatrist Services

Selected procedures require prior authorization of payment. Routine foot care is excluded from coverage.

LIMITATIONS ON SERVICES (Cont.)

6.b. Optometrist Services

Coverage includes all vision services for children and pregnant women (including routine vision exams, fittings, repairs, therapies and materials) provided by ophthalmologists, optometrists and opticians.

DMAP will not provide routine vision services and material to non-pregnant adults age 21 and older, except for clients with specific medical diagnoses.

Some services have Prior authorization requirements and are limited in number of visits or quantity of service pursuant to Oregon Administrative rule and the 1115 demonstration waiver.

6.c. Chiropractor Services

Coverage for Chiropractic and Osteopathic manipulation services are in accordance with 42 CFR 440.60 and is subject to the prioritized list of services as approved by CMS under an 1115 Demonstration Waiver. Services may be limited by number of days or visits. Oregon Administrative Rules describes prior authorization requirements, and limitations of services and payments for enrolled providers.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.

/X/ Provided: / / No limitations / X / With limitations*

/ / Not provided.

c. Chiropractors' services.

/X/ Provided: / / No limitations / X/ With limitations

/ / Not provided.

d. Other practitioners' services.

/X/ Provided: Identified on attached sheet with description of limitations, if any.

/ / Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: / / No limitations /X/ With limitations*

b. Home health aide services provided by a home health agency.

Provided: / / No limitations /X/ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided: / / No limitations /X/ With limitations*

*Description provided on Attachment.

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AMOUNT, DURATION, AND SCOPE OF MEDICAL
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d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

8. Private duty nursing services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

*Description provided on Attachment.

LIMITATIONS ON SERVICES (Cont.)

6. d. Other Practitioner Services

Naturopaths are covered for services within their scope of practice as defined in Oregon Revised Statutes.

Direct Entry midwives are covered for services within their scope of practice as defined in Oregon Revised Statutes.

Acupuncturists are covered for services within their scope of practice as defined in Oregon Revised Statutes.

Denturists are covered for services within their scope of practice as defined in Oregon Revised Statues.

Dental hygienists with a Limited Access Permit (LAP) are covered for services within their scope of practice as defined in Oregon Revised Statutes.

Nurse Anesthetist are covered for services within their scope of practice as defined in Oregon Revised Statues.

7. a. Home Health Care Services

Coverage and provider qualifications are in accordance with 42 CFR 440.70. Intermittent or part-time nursing services are provided to eligible clients in their homes according to a written plan of treatment. Home health services must be prescribed by a physician and the signed order must be on file at the Home Health Agency. The plan of care must be reviewed and signed by the physician every 60 days to continue services. Prior authorization is required for home health services. Home Health services are provided by a registered nurse when no home health agency is available. Services are provided by home health agencies that meet conditions for participation in Medicare. Services are not covered if not medically appropriate, Medical Social Worker services, Registered Dietician counseling or services that are not funded under the prioritized list of services as approved by CMS under an 1115 Demonstration Waiver. Services requiring prior authorization are: Skilled nursing services and all therapy services. Services may be limited by number of days or visits as outlined in the Health Service Commissions (HSC) prioritized list of services or Oregon Administrative Rules for Home Health Care Services.

7. b. Services of Home Health Aide

Services of a home health aide, employed by a Home Health Agency, giving personal care are provided according to a plan of treatment. All requirements listed for Home Health Services above apply to Home Health Aide services.

7. c. Medical Supplies in the Patient's Home

Medical supplies, equipment and appliances for use of the patient in their own home are provided. DMAP Durable Medical Equipment and Medical Supplies Administrative rule and Home Health Care ervices Administrative rule describe services provided, prior authorization requirements, and limitations of services and payments.

LIMITATIONS ON SERVICES (Cont.)

7d. Physical, Occupational, Speech Therapy in Patient's Home

Coverage and provider qualifications are in accordance with 42 CFR 440.110. Coverage and limitations are specified in The HSC prioritized list of services as approved by CMS under an 1115 Demonstration Waiver. Therapy services require prior authorization except for initial evaluations or re-evaluations. Services may be limited by number of days or visits as outlined in the Health Service Commissions (HSC) prioritized list of services or Oregon Administrative Rules. Services that are not covered are services that are not medically appropriate, diagnoses not funded on the HSC prioritized list, back to school classes, hippo-therapy and work hardening. Physical therapy, occupational therapy, and speech pathology are provided according to a plan of treatment. DMAP Home Health Care Services Administrative Rules describes services provided, prior authorization requirements, and limitations of services for providers.

8. Private Duty Nursing Services

Coverage and provider qualifications are in accordance with 42 CFR 440.80. Coverage and limitations are specified in The HSC prioritized list of services as approved by CMS under an 1115 Demonstration Waiver. Private duty nursing is only covered in a patient's residence. Services that are not covered are services that are not medically appropriate, diagnoses not funded on the HSC prioritized list or the service is for the sole purpose to allow clients family to go to work or school, or allow respite for caregivers or family. DMAP's Oregon Administrative Rules and the Medically Fragile In-Home Supports Administrative Rules in conjunction with the HSC prioritized list specify prior authorization requirements, and limitations of services for the provider. Private duty nursing services are provided according to a plan of treatment and reviewed every 60 days to continue services.

AMOUNT, DURATION AND SCOPE OF MEDICAL
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9. Clinic services.

/X/ Provided: / / No limitations /X/ With limitations*
/ / Not provided.

10. Dental services.

/X/ Provided: / / No limitations /X/ With limitations*
/ / Not provided.

11. Physical therapy and related services.

a. Physical therapy.

/X/ Provided: / / No limitations /X/ With limitations*
/ / Not provided.

b. Occupational therapy.

/X/ Provided: / / No limitations /X/ With limitations*
/ / Not provided.

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

/X/ Provided: / / No limitations /X/ With limitations*
/ / Not provided.

*Description provided on Attachment.

LIMITATIONS ON SERVICES

9. Clinic Services

Payment for clinic services is in accordance with 42 CFR 440.90, and is subject to published rules and instructions, and prior authorization of payment for selected elective and rehabilitative procedures. Other selected procedures are not covered based on unproven efficacy and/or non-coverage by Medicare and other major third party payers, and after concurrence by appropriate provider representation. The AFS practitioner services guides set forth the procedures for which payment will not be made, for which prior authorization is required, or for which other program controls are applied. All rules and instructions governing billing and payment are set forth in the guides. The Current Procedural Terminology (CPT) and HCPCS codes are the basis for medical terminology and procedure descriptions.

Reimbursement for non-emergency services provided by out-of-state clinics, other than in contiguous areas, must be prior authorized. However, payment for services to foster children and children in subsidized adoption who are placed by the Children's Services Division anywhere in the United States or Canada is made on the same basis as services provided in Oregon.

LIMITATIONS ON SERVICES (Cont.)

10. Dental Services

Coverage and provider qualifications are in accordance with 42 CFR 440.100 and 440.120, Coverage and limitations are specified in The HSC prioritized list of services as approved by CMS under an 1115 Demonstration Waiver. General categories of Dental services that are not included/funded on the HSC prioritized list are considered cosmetic in nature such as; veneer procedures, overhang removal, tooth bleaching. Dental services requiring prior authorization are: crowns; complete, immediate or partial dentures; oral surgical services; and orthodontics.

Dental Services provided are:
Preventive services; dental examinations; restorative services (fillings, crowns); diagnostic services (radiology/diagnostic imaging/oral pathology) that are medically and dentally necessary; Periodontics; Removable Prosthodontics; Endodontics; Oral and Maxillofacial Surgery; Orthodontics; Adjunct services, EPSDT services

Dental Services limited for non pregnant adults, age 21 and older are:
No crowns; Endodontics only for anterior or bicuspid teeth and no apexification/recalcification procedures; Periodontics; Removable Prosthodontics (Full dentures restricted to once in a lifetime for recent edentulous; resin partial dentures; adjustments and repairs of dentures); No alveoplasty; and No office visit for observation

11a. Physical Therapy
Coverage and provider qualifications are in accordance with 42 CFR 440.110(a). Coverage and limitations are specified in The HSC prioritized list of services as approved by CMS under an 1115 Demonstration Waiver. Physical therapy services require prior authorization except for initial evaluations or re-evaluations. Services may be limited by number of days or visits as outlined in the Health Service Commissions (HSC) prioritized list of services or Oregon Administrative Rules. Services that are not covered are services that are not medically appropriate, diagnoses not funded on the HSC prioritized list, back to school classes, hippo-therapy and work hardening. Physical therapy is provided according to a plan of treatment. DMAP Physical and Occupational Therapy Administrative Rules describe services provided, prior authorization requirements, and limitations of services for providers.

11b. Occupational Therapy
Coverage and provider qualifications are in accordance with 42 CFR 440.110(b). Coverage and limitations are specified in The HSC prioritized list of services as approved by CMS under an 1115 Demonstration Waiver. Therapy services require prior authorization except for initial evaluations or re-evaluations. Services may be limited by number of days or visits as outlined in the Health Service Commissions (HSC) prioritized list of services or Oregon Administrative Rules. Services that are not covered are services that are not medically appropriate, diagnoses not funded on the HSC prioritized list, back to school classes, hippo-therapy and work hardening. Occupational therapy is provided according to a plan of treatment. DMAP Physical and Occupational Therapy Administrative Rules describe services provided, prior authorization requirements, and limitations of services for providers.

LIMITATIONS ON SERVICES (Cont.)

11c. Services for Individuals with Speech, Hearing and Language Disorders

Speech pathology or audiology services are provided according to a plan of treatment. OMAP Speech-Language Pathology, Audiology and Hearing Aid Services Guide describes services provided, prior authorization requirements, and limitations of services and payments.

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12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

/X/ Provided: / / No limitations /X/ With limitations*
/ / Not provided.

b. Dentures.

/X/ Provided: / / No limitations /X/ With limitations*
/ / Not provided.

c. Prosthetic devices.

/X/ Provided: / / No limitations /X/ With limitations*
/ / Not provided.

d. Eyeglasses.

/X/ Provided: / / No limitations /X/ With limitations*
/ / Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services-

/X/ Provided: / X / No limitations / / With limitations*
/ / Not provided.

*Description provided on Attachment.

LIMITATIONS ON SERVICES (Cont.)

12.a. Prescribed Drugs

Reimbursement is available to covered outpatient drugs of any manufacturer that has entered into and complied with an agreement under Section 1927(a) of Title XIX of the Social Security Act, which are prescribed for a medically accepted indication. Drugs subject to limitations are those outlined under Section 1927(d)(4) of Title XIX of the Social Security Act.

The Department will maintain a list of drugs to be referred to as the Practitioner Managed Preferred Drug List (PDL). The PDL is a listing of prescription drugs that the Department has determined represents the most effective drug(s) at the best possible price for the selected drug classes. The PDL will include other drugs in the class that are Medicaid reimbursable and which the FDA has determined to be safe and effective if the relative cost is less than the average net cost for each drug class. When pharmaceutical manufacturers enter into supplemental rebate agreements with DHS that reduces the cost of their drug below that of the average net cost for the class, their drug will also be included in the PDL. The PDL is developed with a governor appointed committee, the Health Resource Commission (HRC), in coordination with the Drug Utilization Review Board. The HRC conducts an evidence-based evaluation of selected classes of prescription drugs covered by the Department. The HRC will make drug effectiveness recommendations to the Department.

A practitioner may prescribe any Medicaid reimbursable, FDA approved drug that is not listed on the PDL, however if the drug is not on the PDL the prescriber must obtain a Prior Authorization (PA). Mental Health drugs in therapeutic class 7 and 11, clients with a prescription written prior to 1/1/2010 and a drug in a class that has not been evaluated for the PDL are exempt from the PA requirement In order to obtain a PA the practitioner may phone or fax a 24/7, toll-free number to reach the health plan's pharmacy benefits manager. The prescriber will speak with a pharmacy technician or with a registered pharmacist who will ask about the medical diagnosis being treated and whether he or she has tried a generic or another drug on the preferred drug list. Prior approval is granted when a medical diagnosis is covered by the Oregon Health Plan HSC list of health services and medical history or patient risk indicates the drug is needed. Approvals or denial responses are issued within 24 hours of the prior authorization request. If prior approval is denied, both the physician and patient receive a letter explaining why and outlining appeal procedures. Pharmacies are authorized to dispense a 72 hour supply of a prior authorized product in the event of an emergency. The program complies with requirements set forth in Section 1927 (d)(5) of the Social Security Act pertaining to prior authorization programs.

Regardless of the PDL, prescriptions shall be dispensed in the generic form unless practitioner requests otherwise subject to the regulations outlined in 42 CFR 447.512.

The state utilizes The Oregon State University College of Pharmacy for literature research and the state DUR (Drug Utilization Review) Board as the Prior Authorization committee. Criteria used to place drugs on Prior Authorization is based upon safety, efficacy and clinical outcomes as provided by the product labeling of the drug.

LIMITATIONS ON SERVICES (Cont.)

12.a. Prescribed Drugs

The state is in compliance with section 1927 of the Social Security Act. The state will cover drugs of federal rebate participating manufacturers. The state is in compliance with reporting requirements for utilization and restrictions to coverage. Pharmaceutical manufacturers can audit utilization data. The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification.

In addition the State has the following provisions for the Supplemental rebate Program:

The state will be negotiating supplemental rebates in addition to the federal rebates provided for in Title XIX under the national rebate program. Supplemental rebate agreements between the state and a pharmaceutical manufacturer will be separate from the federal rebates received under the national rebate program.

CMS has authorized Oregon to enter into " The Sovereign States Drug Consortium (SSDC)" Medicaid Multi-State purchasing pool in relation to supplemental rebates.

Supplemental rebates agreements are unique to each state. The Centers for Medicare and Medicaid Services (CMS) has authorized a rebate agreement between the state and a drug manufacturer that provides supplemental rebates for drugs provided to the Medicaid program, submitted to CMS on 6/19/2003 and entitled, "State of Oregon, Supplemental Rebate Agreement". The supplemental rebate agreement submitted to CMS on 7/15/09 amends the 6/19/03 version of the "State of Oregon, Supplemental Rebate Agreement" authorized under Transmittal 03-02, approved 11/4/03.

- Funds received from supplemental rebates will be reported to CMS.
- The state will remit the federal portion of any supplemental rebates collected at the same percentage basis as applied under the national rebate agreement.

All drugs covered by the program, irrespective of a prior authorization agreement, will comply with the provisions of the national drug rebate agreement.

LIMITATIONS ON SERVICES (Cont.)

12a. Prescribed Drugs (Cont.)

340BProgram:

A program to be phased in starting with a single clinic and adding covered entities if program is determined to be successful. The program will subscribe to all federal and state regulations and adhere to HRSA guidelines for operating a contract pharmacy, including product ownership and ordering, billing and reconciliation, and audit process elements. Covered entities and their contract pharmacies will establish and maintain a tracking system suitable to prevent diversion thus ensuring that (1) only eligible patients of the covered entity receive medications, (2) only eligible Medicaid patient prescriptions are reimbursed by the Department, and (3) duplicate discounting from State Medicaid rebate formulations is prevented.

LIMITATIONS ON SERVICES (Cont.)

12.b. Dentures

Coverage and provider qualifications are in accordance with 42 CFR 440.100 and 440.120. Removable Prosthodontics (Full and partial dentures) are provided to children as medically and dentally necessary. Dental services requiring prior authorization are; Full or partial dentures.

Dentures limited for non pregnant adults, age 21 and older:
Removable Prosthodontics (Full dentures are restricted to once in a lifetime for recent edentulous; resin partial dentures; adjustments and repairs of dentures.

Dentures are covered for children under the EPSDT Program.

12.c. Prosthetic Devices

Prosthetic devices are provided. DMAP Durable Medical Equipment and Medical Supplies rules describes services provided, prior authorization requirements and limitations of services.

12.d. Eyeglasses

DMAP covers all vision services for children and pregnant women (including routine vision exams, fittings, repairs,and materials) provided by ophthalmologists, optometrists and opticians.

DMAP will not provide routine vision services and materials to adults 21 and over, except for clients with specific medical diagnoses.

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b. Screening services.

/ / Provided: / / No limitations / / With limitations*
/X/ Not provided.

c. Preventive services.

/X/ Provided: / / No limitations /X/ With limitations*
/ / Not provided.

d. Rehabilitative services.

/X/ Provided: / / No limitations /X/ With limitations*
/ / Not provided.

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

/X/ Provided: / / No limitations /X/ With limitations*
/ / Not provided.

b. Skilled nursing facility services.

/ / Provided: / / No limitations / / With limitations*
/X/ Not provided.

c. Intermediate care facility services.

/ / Provided: / / No limitations / / With limitations*
/X/ Not provided.

* Description provided on Attachment.

LIMITATIONS ON SERVICES (Cont.)

13.c. Preventive Services

Immunization is provided for individuals against diphtheria, pertussis, tetanus, polio, measles (rubeola), mumps, rubella (German measles) where such immunization is not available without cost through a local Health Department.

Immunizations are provided for individuals in conjunction with exposure to or affliction with specific disease entities. Such entities include rabies, influenza, pneumococcal pneumonia, hepatitis, botulism, snake bite, etc., as well as some of those mentioned above where such immunization is not available without cost through the local Health Department, or other source.

Payment will be made for vaccines prescribed by a physician as a legend drug (such practice is followed to protect nursing home residents against influenza or pneumonia where there has been exposure or likelihood of exposure).

13d. Rehabilitative Services in Psychiatric Treatment Centers

Rehabilitation services are the core medical or remedial services to be provided on a state-wide basis to eligible Medicaid recipients through facilities comparable to day treatment centers. All participating facilities must meet Children's Services Division and Mental Health Division standards for day treatment programs and therefore have the capacity and professional staffing to provide complete services in all designated core areas. These core areas are defined as follows:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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LIMITATIONS ON SERVICES (Cont.)

13.c. Preventive Services: Disease management services

Eligible clients are enrolled in the voluntary program and may "opt-out" or disenroll at any time. The Disease Management (DM) program adds additional services for individuals determined to be in groups with high-risk chronic and medical conditions. Individuals enrolled in the program maintain eligibility for state plan and waivered services at all times. All DM services include professional medical risk assessments, evidence-based interventions that promote adherence to the clients medical treatment plan, education, counseling, direct assistance in the coordination of services with other systems and acute interventions as necessary will be provided by trained licensed Registered Nurse or other licensed care professional.

The Disease Management program is one-on-one interaction intended to provide evidence-based interventions that are both medically and psychosocially focused to those with chronic conditions and disease. Reduction of barriers to care is crucial to achieve improved health status. The DM program is designed to ensure that clients better understand and manage their chronic health condition(s) such as, but not limited to, asthma, diabetes, heart failure (CHF), coronary artery disease (CAD) and chronic obstructive pulmonary disease (COPD). The program does this by incorporating multiple levels of program modalities, along with collaborative healthcare practice models, evidence base guidelines, self-care management, lifestyle changes and adherence to a prescribed plan of care. The services offered to participants include medical assessments, goal oriented care plans, disease and dietary education, instruction in self management of the condition/disease and clinical outcome monitoring. These services utilize 24/7 Nurse Line and Audio Health Library. Mailings, outbound telephonic calls and Community Based RN service delivery are included. Each member receives a customized care plan developed based on gaps in the member's knowledge. Once enrolled, a specially trained registered nurse conducts a comprehensive assessment to learn critical information about the member that will impact the care management approach for the member and may lead to an adjustment of the member's risk profile. The assessment includes things such as, self-reported health care utilization, relevant co-morbidities, medication usage, functional, medical and psychosocial status, readiness to change and self-management and health maintenance practices or risk for non-adherence to recommended care. Additionally barriers to care are assessed and interventions to reduce or eliminate identified barriers are explored to allow the member to focus on improving their health status. Care plans are based on information obtained from the member, their provider treatment plan, and the member's readiness to change. In addition to the condition-specific needs of the member, the care plan addresses co-morbidities and psychosocial issues; it is designed to ensure continuity, quality and effectiveness of care, Nurses monitor and measure member's understanding and compliance with care plan goals at ongoing regular scheduled intervals and on member's needs.

Medical claims and pharmacy data are used in a predictive modeling process to achieve preliminary population-based risk stratification, from this information clients are identified for enrollment in the DM Program. Additionally, Clients may also be enrolled if the Client or the individual's Case Manager or physician requests enrollment.

Members and their personal physician are notified of the program through an outbound mail campaign. Then, specially trained professionals make outbound calls to enroll members into the care management program. A participant may request to opt-out of the program at any time, for any reason by calling the program 800 number, their self-sufficiency case worker, or the DMAP Client Advisory Service Unit. The member's status reason is changed to a "disenrolled" status in the disease management application to reflect this preference. However, the member still remains eligible to receive all other program level services such as the 24/7 Nurse Advice Line as members are maintained in the database so they can be easily re-enrolled at anytime at their request.

The State will contract with one or more Disease Management vendors, based upon region, who's trained registered nurses and other licensed health care professionals provide Disease Management services. All of the clients in the DM program have free choice of medical practitioners.

(1) Medical/Social and Psychological Evaluations are:

(a) ordered or prescribed by a physician or other licensed practitioner of the healing arts within the scope of his/her practice and as defined by state law;

(b) provided by qualified professionals, e.g., medical evaluations are carried out by physicians or other licensed practitioners of the healing arts as defined by state law, psychological evaluations are carried out by licensed qualified psychologists and medical social histories are carried out by qualified social workers and medical or nursing personnel;

(c) provided either directly by the facility or provided by other qualified professionals on a referral basis. Such evaluations must be ordered or prescribed by a physician or other licensed practitioners of the healing arts within the scope of his/her practice as defined by state law; other evaluation services such as speech and hearing evaluations and neurological evaluations are provided either directly by the facility or provider or by other qualified professionals on a referral basis;

(d) directed toward the formulation of a diagnosis and/or treatment plan which specifies the type, amount and duration of treatment projected to remedy the defined physical or mental disorders or mental deficiencies of the patient.

(2) Comprehensive Treatment Plan is:

(a) the development, periodic review and revision of the treatment plan under the direction of a physician or other licensed practitioner of the healing arts within the scope of his/her practice and as defined by state law from data contained in the medical/social and psychological evaluation which specifies the type and duration of treatment needed to remedy the defined physical or mental disorders or mental deficiencies of the patient.

(3) Psychotherapy Services include:

(a) individual psychotherapy services when provided directly by a qualified staff member in accordance with the goals specified in a medical treatment plan written and ordered or prescribed by a physician or licensed practitioner of the healing arts as defined by state law:

(b) group psychotherapy services when provided in accordance with goals specified in a written medical treatment plan as described in (a) above and limited to five (5) individuals per each staff person;

(c) patient centered family therapy services which include the recipient's family members and are delivered in accordance with goals as specified in a medical care treatment plan as described in (3)(a) above.

(4) Developmental Therapy is:

(a) treatment which is ordered or prescribed by a physician;

(b) provided directly by a qualified therapist;

(c) part of a treatment plan which specifies therapy modality and projected amount and duration of treatment to restore the patient to his optimal level of development;

(d) directed toward the rehabilitation of defined physical or mental disorders or mental deficiencies in the areas of sensomotor, communicative and effective development;

(e) there must be a minimum ratio of one (1) qualified therapist for every five (5) individuals involved in group developmental therapy.

(5) Other Therapies are:

(a) other therapies provided in accordance with a physician's authorized medical care treatment plan such as speech and hearing therapy, physical therapy and occupational therapy;

(b) provided by licensed staff members or other licensed professionals-on a referral basis.

(6) Patient-centered Consultation is:

(a) related to a specific patient;

(b) provided by a licensed or certified health professional staff member;

(c) provided in accordance with the physician authorized medical care plan to the staff of other agencies, other care/treatment providers and/or family members and others whose involvement and cooperation is important to the success of the treatment plan.

(7) The maximum number of days allowed for a combination of all the services is limited to the prescription of the physician-approved treatment plan, and the contracted level of service.

LIMITATION ON SERVICES

13.d. Rehabilitative Mental Health Services

Mental health rehabilitative services include coordinated assessment, therapy, daily structure/support, consultation, medication management, skills training and interpretive services. The Mental Health and Developmental Disability Services Division (the Division) may provide these services in various settings, including residential. Each contract or subcontract provider of rehabilitative services establishes a quality assurance system and a utilization review process. Each contract or subcontract provider, in conjunction with a representative quality assurance committee, writes a quality assurance plan to implement a continuous cycle of measurement, assessment and improvement of clinical outcomes based upon input from service providers, clients and families served, and client representatives.

The Division provides mental health rehabilitative services through approved Comprehensive Services Providers (CSPS) or Mental Health 0rganizations (MHOs). The CSPs or MHOs may provide services directly, or through subcontract providers, in a variety of settings. For CSP subcontract providers, the Division must grant a certificate of approval for the scope of services to be reimbursed.

Licensed Medical Practitioners (LMPs), defined below, provide ongoing medical oversight. LMPs document the medical necessity and appropriateness of services by approving comprehensive mental health assessments and individualized treatment plans at least annually.

Clinical Supervisors, defined below, provide documented clinical oversight, at least every three months, of the effectiveness of mental health treatment services delivered by Qualified Mental Health Associates (QMHAs) and by Qualified Mental Health Professionals (QMHPs).

An "LMP" means a person who meets the following minimum qualifications as documented by the Local Mental Health Authority (LMHA) or designee:

1. Holds at least one of the following educational degrees and valid licensure:
   a. Physician licensed to practice in the State of Oregon;
   b. Nurse Practitioner licensed to practice in the State of Oregon; or
   c. Physician's Assistant licensed to practice in the State of Oregon.

2. Whose training, experience and competence demonstrates the ability to conduct a comprehensive mental health assessment and provide medication management.

A "Clinical Supervisor" means a QMHP with at least two years of post graduate clinical experience in a mental health treatment setting who subscribes to a professional code of ethics. The clinical Supervisor, as documented by the LMHA, demonstrates the competency to oversee and evaluate the mental health treatment services provided by a QMHA or QMHP.

A "QMHP" means a Licensed Medical Practitioner or any other person meeting the following minimum qualifications as documented by the LMHA or designee:

1. Graduate degree in psychology;
2. Bachelors degree in nursing and licensed by the State of Oregon;
3. Graduate degree in social work;
4. Graduate degree in a behavioral science field;
5. Graduate degree in a recreational, art, or music therapy; or
6. Bachelor's degree in occupational therapy and licensed by the state of Oregon; and
7. Whose education and experience demonstrates the competencies to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess family, social and work relationships; conduct a mental status examination; document a multi axial DSM diagnosis; write and supervise a treatment plan; conduct a comprehensive mental health assessment; and provide individual, family, and/or group therapy within the scope of their training.

A "QMHA" means a person delivering services under the direct supervision of a QMHP who meets the following minimum qualifications as documented by the LMHA or designee:

1. A bachelor's degree in a behavioral sciences field; or
2. A combination of at least three year's relevant work, education, training or experience; and
3. Has the competencies necessary to:
   a. Communicate effectively;
   b. Understand mental health assessment, treatment and service terminology and to apply the concepts; and
   c. Provide psychosocial skills development and to implement interventions prescribed on a treatment plan within their scope of practice.

Only LMPs, QMHPs, or QMHAs may deliver the mental health treatment services specified in the Division's Rehabilitative Services Payment Schedule.

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LIMITATION ON SERVICES

13.d. Rehabilitative Alcohol & Drug Services

Alcohol and drug rehabilitative services are provided upon recommendation of a physician to eligible clients through comprehensive agencies or facilities granted a Letter of Approval by the Office of Alcohol and Drug Abuse Programs, Department of Human Resources. The services to be provided include assessment, outpatient treatment, methadone dispensing, treatment monitoring, consultation, and acupuncture.

The services will be provided by any person meeting the following minimum qualifications:

Physician licensed to practice in Oregon;

Graduate Degree in Psychology;

Graduate Degree in Social Work;

Graduate Degree in Nursing and licensed in the State of Oregon;

Acupuncturist licensed to practice in Oregon;

Any other person whose education and experience meet the standards and qualifications established by the State Office of Alcohol and Drug Abuse Programs through administrative rule.

LIMITATION ON SERVICES

13.d. School-Based Rehabilitative Services

School-based rehabilitative services are health-related services that:

a) address the physical or mental disabilities of a child;
b) recommended by health care professionals; and
c) are identified in a child's Individual Education Plan (IEP) or Individual Family Service Plan (IFSP).

School-based services are delivered by providers who meet the federal requirements listed below, and who operate within the scope of their practitioner's license and/or certification pursuant to state law as follows:

1. Physical Therapists that meet the federal requirements at 42 CFR 440.110(a), and are licensed by the State Physical Therapist Licensing Board.

Physical Therapy Evaluations and Treatments**:** assessing, preventing or alleviating movement dysfunction and related functional problems; obtaining and interpreting information; and coordinating care and integrating services relative to the student receiving treatments such as:

- Neuromotor or neurodevelopmental assessment;
- Assessing and treating problems related to musculo-skeletal status;
- Gait, balance, and coordination skills;
- Oral motor assessment;
- Adaptive equipment assessment;
- Gross and fine motor development;
- Observation of orthotic devices; and
- Prosthetic training.

2. Occupational Therapists that meet the federal requirements at 42 CFR 440.110(b), and are licensed by the State Occupational Therapy Licensing Board.

Occupational Therapy Evaluations and Treatments: Assessing, improving, developing, or restoring functions impaired or lost through illness, injury or deprivation, improving ability to perform tasks for independent functioning when functions are lost or impaired, preventing through early intervention, initial or further impairment or loss of function; and obtaining and interpreting information; and coordinating care and integrating services relative to the student receiving services such as:

LIMITATION ON SERVICES (continued)

- Neuromuscular and musculo-skeletal status (muscle strength and tone, reflex, joint range of motion, postural control, endurance);
- Gross and fine motor development;
- Feeding or oral motor function;
- Adaptive equipment assessment;
- Prosthetic or orthotic training;
- Neuromotor or neurodevelopmental assessment;
- Gait, balance and coordination skills;

3. Speech Pathologists that meet the federal requirements at 42 CFR 440.110(c), and are licensed by the State Board of Examiners for Speech Pathology and Audiology or hold a Certificate of Clinical Competency from the American Speech and Hearing Association.

Speech Evaluation and Therapy Treatments**:** Assessment of children with speech and/or language disorders; diagnosis and appraisal of specific speech and/or language disorders; referral for medical and other professional attention, necessary for the rehabilitation of speech and/or language disorders; provision of speech or language services for the prevention of communicative disorders; and obtaining and interpreting information; and coordinating care and integrating services relative to the student receiving services such as:

- Expressive language;
- Receptive language;
- Auditory processing, discrimination, perception and memory;
- Vocal quality;
- Resonance patterns;
- Phonological;
- Pragmatic language;
- Rhythm or fluency;
- Feeding and swallowing assessment.

4. Audiologists that meet the federal requirements at 42 CFR 440.110(c), and are licensed by the State Board of Examiners for Speech Pathology and Audiology or hold a Certificate of Clinical Competency from the American Speech and Hearing Association.

Audiological Evaluation and Services: Assessment of children with hearing loss; determination of the range, nature and degree of hearing loss, including the referral for medical or other professional attention for restoration or rehabilitation due to hearing disorders; provision of rehabilitative activities, such as language restoration or rehabilitation, auditory training, hearing evaluation and speech conversation, and determination of the child's need for individual amplification; obtaining and interpreting information; and coordinating care and integrating services relative to the student receiving services such as:

LIMITATION ON SERVICES (continued)

- Auditory acuity (including pure tone air and bone conduction), speech detection, and speech reception threshold;
- Auditory discrimination in quiet and noise;
- Impedance audiometry, including tympanometry and acoustic reflex;
- Central auditory function;
- Testing to determine the child's need for individual amplification;
- Auditory training;
- Training for the use of augmentative communication devices.

5.a. Registered Nurses and Licensed Practical Nurses must have graduated from a state-approved nursing program with a practical nursing certificate, diploma, or an associate, baccalaureate or Masters Degree in nursing; or from an equivalent program in a school of nursing outside of the United States or its jurisdictions and must have passed the State Board Test Pool Examination (SBTPE) before 1988, or the National Council Licensure Examination (NCLEX) after 1988; and be licensed to practice in Oregon by the Oregon State Board of Nursing. A Licensed Practical Nurse (LPN) may participate in the implementation of the plan of care for providing care to clients under the supervision of a licensed Registered Nurse, Nurse Practitioner, or Physician.

5.b. Nurse Practitioners that meet the federal requirements at 42 CFR 440.166, and are licensed by the Oregon State Board of Nursing to practice in Oregon as a Nurse Practitioner.

Nurse Evaluation and Treatment Services: Assessments, treatment services, and supervision of delegated health care services provided to prevent disease, disability, other health conditions or their progression; prolong life; and promote physical and mental health and efficiency. Including any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of practice under state law, for maximum reduction of physical or mental disability and restoration of a recipient to his or her best possible functional level. Supervision for services provided to coordinating care and integrating nursing tasks and services that can be performed in the educational setting such as:

- Monitoring patient's seizure activity for breathing patterns, onset/duration of seizure, triggers/auras, level of consciousness, support after seizure, administering medication as ordered;
- Monitoring/providing treatment for high and low blood sugar, checking urine keytones, blood glucose testing, carbohydrate calculations, assisting with insulin administration;
- Ventilator Care suctioning, equipment management;
- Tracheotomy Care changing dressings, emergency trach replacement, suctioning, changing "nose", provide humidification as necessary;
- Catheterization assisting with or performing procedure for catheterization, monitor urinary tract infections, performing skin integrity checks;

LIMITATION ON SERVICES (continued)

- Gastrostomy Tube feeding administering tube feedings per physician order, monitoring skin status around the tube, emergency treatment for button dislodgement;
- Medication pumps, e.g., insulin pump, calculate carbohydrate amounts in food/snacks, provide insulin bolus per physician order, emergency disconnect procedure, monitoring blood sugar;
- Medication management, e.g., monitoring signs and symptoms for medication administration, administering medications, observing for side effects.

6.a. Certified Social Worker Assistant (CSWA) or Licensed Clinical Social Worker (LCSW): must possess a master's degree from an accredited college or university accredited by the Council on Social Work Education and have completed the equivalent of two years of full-time experience in the field of clinical social work in accordance with rules of the Oregon State Board of Clinical Social Workers for a LCSW or whose plan of practice and supervision has been approved by the board, for a CSWA working toward LCSW licensure under the supervision of a LCSW for two years of post masters clinical experience and is licensed by the State Board of Clinical Social Workers to practice in Oregon.

6.b. Psychologists must have one of the following: a doctoral degree in psychology obtained from an approved doctoral program in psychology accredited by the American Psychological Association (APA) or a doctoral program in psychology accredited individually or as part of an institutional accreditation by another private or governmental accrediting agency, when the association's or agency's standards and procedures have been approved by the State Board of Psychologist Examiners by rule; and have two years of supervised employment under the direction of a psychologist licensed in Oregon or under the direction of a person considered by the board to have equivalent supervisory competence.

6.c. Psychiatrists must be licensed to practice medicine and surgery in the State of Oregon; and possess a valid license from the Oregon Licensing Board for the Healing Arts.

Mental Health Evaluation and Treatment Services Assessments and treatment services, to prevent disease, disability, other health conditions or their progression; prolong life; and promote physical and mental health and efficiency. Including any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of practice under state law, for maximum reduction of physical or mental disability and restoration of a recipient to his or her best possible functional level. Coordinating care and integrating out patient mental health services that can be performed in the educational setting such as:

- Mental health assessment;
- Psychological testing (non-educational cognitive and adaptive testing);

LIMITATION ON SERVICES (continued)

- Assessment of motor language, social, adaptive, and/or cognitive functioning by standardized developmental instruments;
- Behavioral health counseling and therapy;
- Psychotherapy (group/individual).

Services for physical therapy, occupational therapy, speech therapy, hearing services, nursing services, and mental health services must be recommended by a physician or other practitioner of the healing arts within the scope of practice under state law and provided to a recipient by or under the supervision of a qualified physical therapist, occupational therapist, speech pathologist, audiologist, Nurse, Nurse Practitioner, Psychiatrist, Psychologist, or Social Worker qualified and licensed to deliver the service.

Medicaid covered services and treatments are provided in accordance with Oregon's Medicaid program's Prioritized List of Health Services to recipients receiving services pursuant to an IEP/IFSP eligible under IDEA in the educational setting. The above-listed therapy services and treatments are examples of services that may be provided to eligible recipients in an educational setting under Oregon's Medicaid program.

13.e. Behavior Rehabilitation Services

Behavior Rehabilitation Services are provided to children/youth to remediate debilitating psycho-social, emotional and behavioral disorders. To provide early intervention, stabilization and development of appropriate coping skills upon the recommendation of a licensed practitioner of the healing arts within the scope of their practice within the law. Prior approval is required.

Service Description

Behavior Rehabilitation Services may be provided in a variety of settings and consist of interventions to help children/youth acquire essential coping skills. Specific services include milieu therapy, crisis counseling, regular scheduled counseling and skills training. The purpose of this service is to remediate specific dysfunctions which have been explicitly identified in an individualized written treatment plan that is regularly

LIMITATION ON SERVICES

reviewed and updated. Client centered treatment services may be provided individually or in groups and may include the child's/youth's biological, adoptive or foster family. Treatment is focused upon the needs of the child/youth, not the family unit. These services may be in conjunction with or in support of any other professional treatment services the child/youth may be receiving as required by the diagnosed condition.

The services will include crisis intervention and counseling on a 24-hour basis to stabilize the child's/youth's behavior until resolution of the problem is reached, or until the child/youth can be assessed and treated by a qualified Mental Health Professional or licensed Medical Practitioner.

Regular scheduled counseling and therapy is provided to remediate specific dysfunctions which have been explicitly identified in the treatment plan.

Skill training is provided to assist the child/youth in the development of appropriate responses to social and emotional behaviors, peer and family relationships, self-care, conflict resolution, aggression reduction, anger control, and to reduce or eliminate impulse and conduct disorders.

Milieu therapy refers to those activities performed with children/youth to normalize their psycho-social development and promote the safety of the child/youth and stabilize their environment. The child/youth is monitored in structured activities which may be developmental, recreational, academic, rehabilitative, or a variety of productive work activities. As the child/youth is monitored, planned interventions are provided to remediate the identified dysfunctional or maladaptive behaviors and promote their replacement with more developmentally appropriate responses.

Population To Be Served.

The population serviced will be EPSDT eligible children/youth who have primary mental, emotional and behavioral disorders and/or developmental disabilities that prevent them from functioning at developmentally appropriate levels in their home, school, or community. They exhibit such symptoms as drug and alcohol abuse, anti-social behaviors that require close supervision and intervention and structure, sexual behavior problems, victims of severe family conflict, behavioral disturbances often resulting from psychiatric disorders of the parents, medically compromised and developmentally disabled children/youth who are not otherwise served by the State Mental Health Developmental Disability Services Division.

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Provider Qualifications**.**

Program Coordinator: Responsibilities include supervision of staff, providing overall direction to the program, planning and coordinating program activities and delivery of services, and assure the safety and protection of children/youth and staff.

The Minimum Qualifications- A Bachelor's Degree, preferably with major study in psychology, Sociology, Social Work, Social Sciences, or a closely allied field, and two years experience in the supervision and management of a residential facility for care and treatment of children/youth.

Social Service Staff: Responsibilities include Case Management and the development of service plans; individual, group and family counseling; individual and group skills training; assist the Child Care Staff in providing appropriate treatment to children/youth, coordinate services with other agencies; document treatment progress.

The Minimum Qualifications- A Masters Degree with major study in Social Work or a closely allied field and one year of experience in the care and treatment of children/youth, or a Bachelor's Degree with major study in Social Work, psychology, Sociology, or a closely allied field and two years experience in the care and treatment of children/youth.

Child Care Staff: Responsibilities include direct supervision and control of the daily living activities of children/youth, assisting social service staff in providing individual, group and family counseling, skills training, provide therapeutic interventions to children/youth as directed by the individual treatment plans to address behavioral and emotional problems as they arise, monitor and manage the children's/youth's behavior to provide a safe, structured living environment that is conducive to treatment.

Minimum Qualifications- Require that no less than 50% of the Child Care Staff in a facility have a Bachelor's Degree. Combination of formal education and experience working with children/youth may be substituted for a Bachelor's Degree. Child Care are members of the treatment team and work under the direction of a qualified Social Service staff or a Program Coordinator.

14.a. Services for individuals age 65 or older in institutions for mental disease

Payments for persons age 65 or older in psychiatric hospitals will be made for individuals who have had a pre-admission screening except in an emergency, and certified eligible for payment by the Mental Health and Developmental Disability Services Division or its designee.

LIMITATIONS ON SERVICES

13.c. Preventive Services for HIV Infected Individuals

Coverage of HIV/AIDS Prevention Services are provided subject to OMAP rules.

HIV/AIDS Prevention Services are provided for individuals seeking HIV/AIDS counseling and testing services and to all HIV seropositive clients. These interventions aim to control and/or stop the spread of HIV/AIDS through prevention efforts and to prevent secondary or opportunistic infections. The services include the provision of medical services as well as the management of behavioral and nutritional factors and HIV-risk reduction techniques.

Providers of HIV/AIDS Prevention Services are trained and certified by the HIV/AIDS Prevention Services Program by the Oregon Health Division, following the protocols established by the Oregon Health Division for this program.

AMOUNT, DURATION AND SCOPE OF MEDICAL
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15.a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(A) of the Act, to he in need of such care.

[X] Provided [ ] No limitations [X] With limitations*
[ ] Not Provided.

b. Including such services in a public institution (or district part thereof) for the mentally retarded or

[X] Provided [ ] No limitations [X] With limitations*
[ ] Not Provided.

16. Inpatient psychiatric facility services for individuals under 22 years of age.

[X] Provided [ ] No limitations [X] With limitations*
[ ] Not Provided.

17. Nurse-midwife services.

[X] Provided [ ] No limitations [X] With limitations*
[ ] Not Provided.

18. Hospice care (in accordance with section 1905(o) of the Act.

[X] Provided [ ] No limitations [X] With limitations*
[ ] Not Provided.

* Description provided on Attachment.

LIMITATIONS ON SERVICES

15.a. Intermediate Care Facilities' Services

Intermediate care facility services are provided subject to maximum cost reimbursement.

15.b. Intermediate Care Facilities for the Mentally Retarded or Persons with Related Conditions (ICF/MR)

Intermediate care facilities for the mentally retarded or persons with related conditions are provided within the limitations set forth in Oregon Administrative Rules 309-43-000 through 309-43-200.

16. Inpatient Psychiatric Facility Services for Individuals Under age 21

Payment for persons under age 21 in inpatient psychiatric facilities will be made for individuals who have had a pre-admission screening in accordance with 42 CFR 441 Subpart D, except in an emergency, and who are certified as eligible for payment by the Mental Health and Developmental Disability Services Division or its designee.

17. Nurse Midwife Services

Nurse Midwife and other services within the scope of practice of a licensed nurse practitioner are provided on the same basis as physician services.

LIMITATIONS ON SERVICES (Cont'd)

18. Hospice Care

Hospice care services arc provided for physician-certified terminal illnesses subject to the waiver demonstration approved Prioritized List of Health Services and service limitations in administrative rules. Hospice services include acute, respite, home care and bereavement services provided to meet the physical, psychosocial, spiritual. and other special needs of the patient during the final stages of illness, dying and bereavement period. This includes pain and symptom management and palliative services. Administrative rules require the use of a Medicare certified hospice unless one is not available in the area, in which case a hospice accredited. by the Oregon Hospice Association is allowed to be used. Oregon Administrative Rules require the following: No payment will be made for room and board. However, if an individual resides in a nursing facility and elects hospice, the hospice will bill Medicaid for the hospice care provided and for the cost of room and board (no less than 90% of the nursing facility per diem rate). Upon receipt of the reimbursement for the cost of the room and board. the hospice provider will forward to the nursing facility.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

X Provided: X With limitations
___ Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2) of the Act.

___ Provided: ___ With limitations*
X Not provided.

20. Extended services for pregnant women

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

X Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

__ Additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on Attachment.

LIMITATIONS ON SERVICES

20.a. Extended Services to Pregnant Women

Pregnancy-related and post-partum services provided for 60 days after the pregnancy ends include:

1. Major categories of service:

   a. inpatient hospital services, with the limitations specified in Attachment 3.1-A, page l.a;
   b. outpatient hospital services, with the limitations specified in Attachment 3.1-A, page l.a;
   c. laboratory and X-ray services, with limitations specified in Attachment 3.1-A, page l.b;
   d. physician services, with the limitations specified in Attachment 3.1-A, page 2.a;
   e. clinic services, with limitations specified in Attachment 3.1-A, page 4.a;
   f. prescribed drugs, with limitations specified in Attachment 3.1-A, page 5.a;
   g. diagnostic services;
   h. nurse-midwife services, with limitations specified in Attachment 3.1-A, page 7.a;
   i. transportation, with limitations specified in Attachment 3.1-A, page 7.a;
   j. all emergency medical services.

2. Additional Services to Pregnant Women:

   a. An initial needs assessment to assess the basic needs of the expectant mother, provided by a licensed physician, physician's assistant, nurse practitioner, social worker, or a registered nurse with a minimum of two years of experience, or by an individual under the supervision of one of the above practitioners.

   b. Ongoing case management including development and monitoring to assist the expectant mother in obtaining and effectively utilizing the necessary health and related social services, provided by provider of a type described in Attachment 3.1-A, page 8a Section 20.a.2.a.

LIMITATIONS ON SERVICES

20.a. Extended Services to Pregnant Women

2. c. High risk management provided to expectant mothers, identified as being at risk for a low birth weight baby who have demonstrated an inability to follow medical treatment and other service plan parameters. Identification of risk will be made by a licensed physician or nurse practitioner with services provided by a provider of a type described in Attachment 3.1a, page 8a Section 20.a.2a.

d. Nutritional counseling for expectant mothers who have clinical indications identified and for which adequate services are not available from a local Women Infants and Children Program (WIC), provided by a registered dietician, or; an individual with a bachelor's degree in a nutrition related field with two years of related work experience.

e. Home visits, requiring a home assessment and specified training and education, are available to all pregnant women. These services are limited to a maximum of four home visits per pregnancy. These services can be provided by any provider qualified for Maternity Case Management Services.

b. Services for any other medical conditions that may complicate pregnancy include:

1. Major categories of services:

a. inpatient hospital services, with the limitations specified in Attachment 3.1-A, page 1.a;

b. outpatient hospital services, with the limitations specified in Attachment 3.1-A, page l.a;

c. rural health clinic services and other ambulatory services, with limitations specified in Attachment 3.IA, page 1.b;

d. laboratory and X-ray services, with limitations specified in Attachment 3.1-A, page l.b;

e. physician services, with the limitations specified in Attachment 3.1-A, page 2.a;

f. home health services, with limitations specified in Attachment 3.1-A, page 2.a.;

LIMITATIONS ON SERVICES (cont.)

g. private duty nursing services, with limitations specified in Attachment 3.1-A, page 3.a;

h. clinic services,, with limitations specified in Attachment 3.1-A, page 4.a;

I. physical therapy and related services, with limitations specified in Attachment 3.lA, page 4.b;

j. prescribed drugs with limitations specified in Attachment 3.1-A: page 5.a;

k. diagnostic services;

l. nurse-midwife services, with limitations specified in Attachment 3.1-A, page 7.a;

m. transportation, with limitations specified in Attachment 3.1-A, page 7.a.;

n. all emergency medical services.

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21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a ~~qualified~~ eligible provider (in accordance with section 1920 of the Act).

/ / Provided / / No limitations / / With limitations*
/x/ Not provided

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

/ / Provided / / No limitations / / With limitations*
/x/ Not provided

23. Certified Pediatric or family nurse practitioners' services.

/ / Provided / / No limitations /X/ With limitations*

*Description provided in Attachment.

LIMITATIONS ON SERVICES

23. Nurse Practitioner Services

1. Services within the scope of practice of a licensed nurse practitioner are provided on the same basis as physician services.

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AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

[X] Provided [ ] No limitations [X] With limitations*

[ ] Not Provided:

b. Services provided in Religious Nonmedical Health Care Institutions.

[ ] Provided [ ] No limitations [ ] With limitations*

[X] Not Provided:

c. Reserved

d. Nursing facility services for patients under 21 years of age.

[X] Provided [X] No limitations [ ] With limitations*

[ ] Not Provided:

e. Emergency hospital services.

[X] Provided [X] No limitations [ ] With limitations*

[ ] Not Provided:

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

[X] Provided [ ] No limitations [X] With limitations*

[ ] Not Provided:

*Description provided on Attachment.

LIMITATIONS ON SERVICES (Cont.)

24.a. Transportation

All non-emergency medical transportation requires authorization of payment for medical appropriateness to a medical service covered under the Medical Assistance Programs. Non-emergency transportation for full-benefit dual eligible beneficiaries to obtain their
P&I Part D prescription drugs requires authorization of payment, and non-emergent transportation may be provided whether or not the prescription drug is covered under the Medical Assistance Programs.

Authorization of payment is not required for emergency transportation.

Transportation to and from school may be claimed as a Medicaid service when the child receives a medical service in school on a particular day when both the SBHS covered service and the need for medically necessary transportation are included in the child's IEP/IFSP and the transportation provided is adapted to serve the needs of the disabled child pursuant to 42 CFR 440.170 (a)(1). An IEP should include only specialized services that a child would not otherwise receive in the course of attending school. Transportation may also be billed to Medicaid when a child resides in an area that does not have school bus transportation (such as those areas in close proximity to a school) but has a medical need for transportation that is noted in the IEP, and when a child receives a Medicaid covered IDEA service at an off-site facility or is transported to a provider in the community.

LIMITATIONS ON SERVICES

24f. Personal Care Services (42 CFR 440,170(f))

Specific personal care services must be prescribed by a physician in accordance with a plan of treatment or authorized for the individual in accordance with a service plan approved by the State or designee. The services are provided by an individual who is qualified to provide such services and who is not a member of the individuals immediate family. The services may be furnished in a home or other location.

Personal Care tasks include:

1) Basic personal hygiene - providing or assisting with:

   a) bathing (tub, bed bath, shower);
   b) shampoo, hair grooming;
   c) shaving;
   d) nail care - hands;
   e) nail care - feet (only with RN approval);
   f) foot care;
   g) dressing;
   h) skin care - application of emollients if approved by physician, repositioning (see 5b).

2) Bowel and bladder care:

   a) assisting on and off toilet, commode or bedpan, diapering;
   b) external cleansing of perineal area;
   c) external cleansing of Foley catheter - after demonstrating technique to RN;
   d) emptying catheter drainage bag - after demonstrating technique to RN;
   e) changing colostomy or ileostomy bag for individual with stabilized condition;
   f) encouraging adequate fluid intake;
   g) maintenance bowel care, with RN approval.

3) Assisting client to take medications:

   a) open and properly reseal medication containers if client unable to do so;
   b) observe to assure client taking medication as ordered by physician;
   c) remind appropriate person when prescription refill needed;
   d) administration of stabilized, maintenance medication(s).

4) Assist oxygen:

   a) maintain clean equipment;
   b) assist with maintaining adequate supply.

LIMITATIONS ON SERVICES

24f. Personal Care Services (42 CFR 440.170(f)) (Cont.)

5) Assist with mobility, transfers and comfort:

a) assist with ambulation with or without aids;
b) assure repositioning every two hours or more often for bedridden or wheelchair-using individuals clients;
c) encourage active range-of-motion exercises when indicated;
d) assist with passive range-of-motion exercise if ordered by physician and RN has observed and approved technique;
e) assist with transfers with or without mechanical devices.

6) Nutrition:

a) prepare nutritional meals;
b) plan and prepare special diets as ordered by physician;
c) assure adequate fluid intake;
d) feed if necessary.

7) Care of confused, mentally or physically disabled client:

a) assure maximum safety of client;
b) provide or assist with approved activities.

8) First aid and handling of emergencies:

a) discussed and approved at time of first visit;
b) maintain and prioritize emergency notification system.

9) Perform housekeeping tasks necessary to maintain the client in a healthy and safe environment.

10) Arrange and assist client to and from necessary appointments-

11) Observation of client status and reporting of any significant changes to the appropriate case manager or other person as designated by the care plan.

12) Tasks delegated by a nurse.

Personal care services are provided subject to rules and procedures set forth in Oregon Administrative Rules.

State OREGON

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

__ provided X not provided

26. Personal care services furnished to an individual who is not an impatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (c) furnished in a home.

X Provided:
- X State Approved (Not Physician) Service Plan Allowed
- X Services outside the Home Also Allowed
- X Limitations Described on Attachment

__ Not Provided.

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 2 to Attachment 3.1-A.

X Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

___ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

OMB Approved 0938-1024

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

28. _X__ Self-Directed Personal Assistance Services, as described in Supplement _3__ to Attachment 3.1-A.

__X__ Election of Self-Directed Personal Assistance Services: By virtue of this submittal, the State elects Self-Directed Personal Assistance Services as a State Plan service delivery option.

____ No election of Self-Directed Personal Assistance Services: By virtue of this submittal, the State elects not to add Self-Directed Personal Assistance Services as a State Plan service delivery option.

Targeted Case Management
HIV/AIDS

Target Group:

The "target" group for this amendment shall consist of individuals who are eligible for Title XIX Medical Assistance Coverage as categorically eligible and who meet the following criteria:

- Have a documented HIV infection or a diagnosis of AIDS, *whether symptomatic or asymptomatic*.
- Are receiving case management services from providers who are licensed or certified by the Oregon Department of Human Services (DHS), and provide service under contract to the DHS Division of Medical Assistance Programs (DMAP).

The target group will not include individuals under age 65 residing in an institution for Mental Disease (IMD) or individuals involuntarily living in secure custody of law enforcement, judicial or penal systems.

For case management services provided to individuals in medical institutions:

☐ Target group comprised of individuals transitioning to a community setting and case management services will be made available for up to ____ consecutive days of the covered stay in the medical institution.

Areas of state in which services will be provided:

☒ Entire State

☐ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of services:

☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount duration and scope.

1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

Definition of services:

HIV/AIDS case management is defined as services furnished to assist individuals living with HIV or AIDS, eligible under the State Plan, in obtaining timely and coordinated access to needed medical, psycho-social, educational and other services, with the goal of improving overall health and well-being.

Within HIV case management, the case manager plays a pivotal role in assuring that the patient has access to and adheres to the treatment schedules and care services recommended by authorized providers. Case Management includes the following service categories:

Assessment and periodic reassessment of individual needs: This activity consists of interactive interviews and evaluations performed by the case manager that would occur at least annually to determine the need for any medical, educational, psycho-social or other services. These interviews primarily involve the gathering of information from the eligible individual but will also include the collection of information from other sources such as family members, medical providers, social workers, and educators, as necessary, to form a complete assessment of the individual. Through the assessment, the case manager is able to collect, analyze, synthesize and prioritize information which identifies individuals needs, resources, and strengths. These assessment activities include:

- Evaluation of individual's history;
- Evaluation of the extent and nature of individual's needs (medical, social, educational, and other services) and related documentation;
- Evaluation of the capacity of the individuals to meet their personal needs and adhere to service advice and recommendations made;
- Evaluation of the capacity of the individual's social network and available human services agencies/ organizations to address the eligible individual's needs;
- Reevaluation of individuals to identify unresolved and or emerging needs, to guide appropriate revisions in the care plan (Reassessment).

Development (and periodic revision) of a specific care plan:

All eligible individualss of case management will have a current care plan developed and mutually agreed upon by both the case manager and the individuals (or the individual's authorized health care decision maker). The care plan:

- Is based on the information collected through the assessment;
- Specific documentation of goals and actions needed to address the medical, psycho-social, educational, and other services needed by the individual;
- Clear course of action to respond to the assessed needs of the eligible individual;
- Identification of at least one self-management goal to be included in their Care Plan;
- Documentation of the individual's success in achieving their self-management goal(s).

*Referral and related activities***:**

- To help an eligible individual obtain needed services including activities that help link and individual with:
- Medical, social, educational providers; or
- Other programs and services that are capable of providing needed services, such as making referrals to providers for needed services, assist in scheduling appointments for the individual as needed;
- Remind and motivate individual to adhere to the treatment and care services schedules established by providers;

Monitoring and follow-up activities:
This consists of case management activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs. The level and frequency of monitoring and follow-up activities is determined through the use of an HIV-specific acuity scale and contact may be with the individual, family members, providers, or other entities or individuals to determine whether the following conditions are met:

- Services are being furnished in accordance with the individual's care plan;
- Services in the care plan are adequate; and
- Eligible individual is adhering to the medical treatment, psycho-social and education services that have been recommended and authorized as part of the care plan;
- Changes in the needs or status of the individual, if any, are appropriately reflected through necessary adjustments in the care plan and service arrangements with providers.

Case management may include:

- Contact with non-eligible individuals, which are directly related to identifying the needs and supports for helping the eligible individual to access services.

Qualifications of providers:
The minimum education or qualification requirements for case managers authorized to provide HIV case management through this amendment are as follows:

1. Oregon licensed registered nurse (RN) or
2. Bachelor of Social Work, or other related health or human service degree from an accredited college or university

Additionally, all case managers must have documented evidence of completing the Department of Human Services (DHS), HIV Care and Treatment-designated HIV Case Manager Training to be considered as a licensed provider of case management services. Furthermore, all HIV case managers are expected to participate in DHS-designated on-going training for case managers.

Freedom of Choice:
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

- Eligible individuals will have free choice of the providers of case management services within the specified geographic area identified in this plan.
- Eligible individuals will have free choice of the providers of other medical care under the plan.

Freedom of Choice Exception:
☐ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services:
The State assures that:

- Case management services will not be used to restrict an individual's access to other services under the plan[Section 1902(a)(19)];
- Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services[Section 1902(a)(19)];
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan [42 CFR 431.10(e)].

Limitations:
Case Management does not include the following:

- Activities not consistent with the definition of case management services under section 6052 of the Deficit Reduction Act; The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred. (2001 SMD)

- Activities integral to the administration of foster care programs; or (2001 SMD)

- Activities for which third parties are liable to pay. (2001 SMD)

Targeted Case Management- EI/ECSE

Target Group:
Preschool children with disabilities, birth until three years of age who are eligible for Early Intervention (EI) services or Three years of age to eligibility for public school who are eligible for Early Childhood in Special Education (ECSE) may be referenced as (EI/ECSE).

For case management services provided to individuals in medical institutions:
☐ Target group comprised of individuals transitioning to a community setting and case management services will be made available for up to 180 consecutive days of the covered stay in the medical institution.

Areas of state in which services will be provided:
☒ Entire State

☐ Only in the following geographic areas (authority of section 1915(g) (1) of the Act is invoked to provide services less than Statewide)

Comparability of services:
☐ Services are provided in accordance with section 1902(a) (10) (B) of the Act.

☒ Services are not comparable in amount duration and scope.

1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

Definition of services:

Case management services are services furnished to preschool children with disabilities eligible for EI/ECSE services in the target group, eligible under the State Plan, to assist and enable the eligible child to gain access to needed medical, social, educational, developmental and other appropriate services in coordination with the child's Individualized Family Service Plan (IFSP). Case Management includes the following assistance:

Comprehensive assessment and periodic reassessment conducted annually in conjunction with the eligible child's IFSP to determine the child's need for any medical, educational, psycho-social, developmental or other services.

These assessment activities include:

- Taking recipient's history
- Identifying the child's needs and completing related documentation
- Gathering information from other sources such as family members, medical providers, social workers, IFSP Team members and educators (if necessary), to form a complete assessment of the child of the extent and nature of child's needs (medical, social, educational, developmental and other services)

Development (and periodic revision) of a specific care plan in coordination with the child's IFSP that:

- is based on the information collected through the assessment process;
- specifies the medical, social, educational, and other services needed by the child and course of action to address those needs;
- includes activities such as ensuring the active participation of the eligible child's family (or authorized health care decision maker) and others to determine and develop goals; and
- identify an appropriate course of action addressing the eligible child's needs in a coordinated effort with the family or authorized health care decision maker and other IFSP team members to respond to the identified needs of the eligible child.

*Referral and related activities***:** These are services that are intended to help an eligible individual obtain needed services in a timely manner that optimize health and well-being, including activities that:

- Link an individual with medical, social, educational providers or
- Other programs and services that are capable of providing needed services,
- Assist in scheduling appointments for the individual as needed
- Remind and motivate individual and the individual's family to adhere to the treatment and care services schedules established by providers.

Monitoring and follow-up activities: contacts either in person or by other means of communication that are necessary to ensure the care plan in coordination with the eligible child's IFSP is implemented and adequately addresses the eligible child's needs and which may be with the child and family members, IFSP team members, providers, or other entities or individuals. These monitoring and follow up activities must be conducted at least once annually to review and revise a child's services specified on an IFSP but may be conducted as frequently as necessary, to determine whether the following conditions adequately meet the individual's needs to gain access to medical, social, educational, developmental and other appropriate services in coordination with the eligible child's IFSP:

- Services are being furnished in accordance with the individual's care meet the needs as identified in the child's IFSP and carried out in accordance with the child's care plan ;
- services provided in support of the child's care plan are adequate; and
- the service coordinator/targeted case manager in consultation with the family and other IFSP team members, make adjustments as necessary in the care plan for new or additional arrangements to adequately meet the individual's needs.

Case management may include:

Contact with non-eligible individuals, which are directly related to identifying the needs and supports for helping the eligible individual to access services.

Qualifications of providers:
EI/ECSE TCM Supervisors must be employees of the Education Service District (ESD) contracting agency or the EI/ECSE subcontracting agency, must possess a minimum of a master's degree in early childhood special education or a related field, and have three years experience with infants, toddlers, young children, and families.
All EI/ECSE Service Coordinators/Targeted Case Managers must:

- be employees of the ESD contracting agency or the EI/ECSE subcontracting agency
- possess a minimum of a baccalaureate degree in early childhood special education or a related field; or
- possess a minimum of a baccalaureate degree and a valid license necessary to practice in Oregon, including Teacher Standard and Practices Comission (TSPC) licensure in their area of discipline or State licensure in their area of discipline; and
- have at least three years experience with infants, toddlers, young children and families.

In addition to the above, all must have demonstrated knowledge and understanding about:

- Service coordination to assist clients in gaining access to needed medical, social, educational, developmental or other services
- The Oregon EI/ECSE program;
- The Individuals with Disabilities Education Improvement Act;
- The nature and scope of services available under the Oregon EI/ECSE program.

Freedom of Choice:
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

- Eligible recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.
- Eligible recipients will have free choice of the providers of other medical care under the plan.

Freedom of Choice Exception:

☐ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services:
The State assures that:

- Case management services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services.
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose**.**

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i) The name of the individual;
(ii) The dates of the case management services;
(iii)The name of the provider agency (if relevant) and the person providing the case management service;
(iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved;
(v) Whether the individual has declined services in the care plan;
(vi) The need for, and occurrences of, coordination with other case managers;
(vii) A timeline for obtaining needed services;
(viii) A timeline for reevaluation of the plan.

Limitations:
Case Management does not include the following:

- Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

- Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

- FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

Target Group:

The "target" group for this amendment shall consist of individuals who are eligible for Title XIX Medical Assistance Coverage as categorically eligible and who have been diagnosed with either latent or active Tuberculosis *whether symptomatic or asymptomatic* and who require active medical or surgical treatment. All eligible clients *should be* receiving case management services from providers who are licensed or certified by the Department of Human Services (DHS) and provide service under contract to the DHS, Division of Medical Assistance Programs (DMAP).

The target group will not include individuals under age 65 residing in an institution for Mental Disease (IMD) or individuals involuntarily living in secure custody of law enforcement, judicial or penal systems.

For case management services provided to individuals in medical institutions:

☐ Target group comprised of individuals transitioning to a community setting and case management services will be made available for up to _____ consecutive days of the covered stay in the medical institution.

Areas of state in which services will be provided:

☒ Entire State

☐ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of services:

☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount duration and scope.

1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

Definition of services:

Tuberculosis case management is defined as services furnished to assist individuals suffering from Tuberculosis, eligible under the State Plan, in obtaining timely and coordinated access to needed medical, psycho-social, educational and other services, with the goal of improving overall health and well-being.

Because Tuberculosis can be highly contagious, case management for this disease involves aggressive coordination and planning to ensure that the client has access to the right treatment and adheres to the treatment schedules and care services recommended by authorized providers.

Case Management includes the following assistance:
Comprehensive assessment and periodic reassessment of individual needs: This activity consists of interactive interviews and evaluations performed by the case manager that would occur as soon as client is enrolled in the TCM program. The case manager may use either a health department-designed form for investigating communicable diseases or may use the TB Case Monitoring Sheet to conduct the initial assessment. These interviews primarily involve the gathering of information from the eligible individual but will also include the collection of information from other sources such as family members, medical providers, social workers, and educators, as necessary, to form a complete assessment of the individual. Through the assessment, the case manager is able to collect, analyze, synthesize and prioritize information which identifies individual needs, resources, and strength. These assessment activities include:

- Evaluation of individual's history;
- Evaluation of the extent and nature of individual's needs (medical, social, educational, and other services)
- Evaluation of the capacity of the individual to meet their personal needs and adhere to service advice and recommendations made
- Evaluation of the capacity of the individual's social network and available human services agencies/ organizations to address the eligible individual's needs
- Reevaluation of individual to identify unresolved and or emerging needs, to guide appropriate revisions in the care plan (Reassessment).

Development (and periodic revision) of a specific care plan: An individualized, patient-centered case management plan will be developed for each individual of case management with the goal of timely access to and successful completion of Tuberculosis therapy. The plan should be individualized to address unique challenges to access and to facilitate full adherence to the care services prescribed by the authorized provider. The plan will be developed and mutually agreed upon by both the case manager and the individual (or the individual's authorized health care decision maker). The care plan will be based on the information collected through the assessment and will include the following:

- Specific documentation of goals and actions needed to address the medical, psycho-social, educational, and other services needed by the individual;
- Clear course of action to respond to the assessed needs of the eligible individual;
- Documentation of the individual's success in achieving their care services and treatment goal(s).

*Referral and related activities***:** These are services that are intended to help an eligible individual obtain needed services in a timely manner that optimize health and well-being, including activities that:

- Link an individual with medical, social, educational providers or;

- Other programs and services that are capable of providing needed support services including food vouchers, transportation, child care and housing assistance;
- Assist in scheduling appointments for the individual as needed;
- Remind and motivate individual to adhere to the treatment and care services schedules established by providers.

Monitoring and follow-up activities: This consists of case management activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs. Because of the severity of the illness and intensity of support needs, it is expected that case management contact will occur at least on a monthly basis during the course of the illness. The level and frequency of monitoring and follow-up activities is determined based on the assessment and contact may be with the individual, family members, providers, or other entities or individuals. Monitoring and follow-up activities could include:

- Arranging for food vouchers,
- Addressing housing challenges or needs
- Coordinating care services and medical appointments and arranging transportation to the appointments
- Facilitation of consultations from and coordination between local Health Officer, Department of Human Services (DHS) Tuberculosis Program and/or one of the national Tuberculosis centers.

The goal of monitoring efforts is to ensure that:

- services are being furnished in accordance with the individual's care plan;
- eligible individual is adhering to the medical treatment, psycho-social and education services that have been recommended and authorized as part of the care plan
- services in the care plan are adequate; and
- changes in the needs or status of the individual, if any, are appropriately tracked and reported to providers, and are reflected through necessary adjustments in the care plan and service arrangements with providers.

Case management may include:
Contact with non-eligible individuals, which are directly related to identifying the needs and supports for helping the eligible individual to access services.

Qualifications of providers:
The minimum education or qualification requirements for case managers authorized to provide Tuberculosis case management through this amendment are as follows:

- Oregon licensed registered nurse (RN)
- Bachelor of Social Work, or other related health or human service degree from an accredited college or university.

Additionally, all case managers must have documented evidence of completing the CDC Self-Study Modules on TB 1-9 with passing certificates and the Department of Human Services (DHS), Tuberculosis Case Manager Training Program course to be considered as a licensed provider of Tuberculosis case management services.

Freedom of Choice:
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

- Eligible individuals will have free choice of the providers of case management services within the specified geographic area identified in this plan.
- Eligible individuals will have free choice of the providers of other medical care under the plan.

Freedom of Choice Exception:

☐ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services:
The State assures that:

- Tuberculosis case management services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services.
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Limitations:
Case Management does not include the following:

- Activities not consistent with the definition of case management services under section 6052 of the Deficit Reduction Act; The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred. (2001 SMD)

- Activities integral to the administration of foster care programs; or (2001 SMD) and

- Activities for which third parties are liable to pay. (2001 SMD)

Targeted Case Management
Substance Abusing Pregnant Women and Substance Abusing Parents with Children under Age 18

Target Group:
Medicaid eligible individuals that are Substance Abusing Pregnant Women and Substance Abusing Parents of children under age 18, who are identified, through referral from

individuals, providers or community agencies, to have alcohol and/or drug addiction issues, but who are not yet ready to actively engage in addiction treatment services.

For case management services provided to individuals in medical institutions:

☐ Target group comprised of individuals transitioning to a community setting and case management services will be made available for up to 180 consecutive days of the covered stay in the medical institution.

Areas of state in which services will be provided:
☐ Entire State

☒ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide) Polk, Yamhill, Linn, Benton, Jackson and Marion.

Comparability of services:
☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount duration and scope.

1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

Definition of services:
Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Case Management includes the following assistance:
Comprehensive assessment and periodic reassessment of individual needs:
These assessment activities include:

- Taking client history;
- Evaluation of the extent and nature of individual's needs (medical, social, educational, and other services) and completing related documentation;

- Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.
- Evaluation of the capacity of the individual to meet their personal needs and adhere to service advice and recommendations made
- Evaluation of the capacity of the individual's social network and available human services agencies/ organizations to address the eligible individual's needs

- Reevaluation (reassessment) of individual will occur at a minimum on an annual basis or as needed to identify unresolved and or emerging needs, to guide appropriate revisions in the care plan (Reassessment).

Development (and periodic revision) of a specific care plan: The care plan will be based on the information collected through the assessment and will include the following:

- Specifies the goals and actions needed to address the medical, psycho-social, educational, and other services needed by the individual;
- Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- Identify a course of action to respond to the assessed needs of the eligible individual.

Referral and related activities (Such as scheduling appointments for the individual) to help an eligible individual obtain needed services including:

- Activities that help link and individual with medical, social, educational providers; or
- Other programs and services that are capable of providing needed services (including food vouchers, transportation, child care and housing assistance to address identified needs and achieve goals specified in the care plan;

Monitoring and follow-up activities:
Activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the individual's needs. The activities, and contact, may be with the individual, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary; including at least one annual monitoring to assure following conditions are met:

- Services are being furnished in accordance with the individual's care plan;
- Services in the care plan are adequate; and
- If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and to service arrangements with providers.

Case management may include contact with non-eligible individuals, which are directly related to identifying the needs and supports for helping the eligible individual to access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
Case managers will possess a combination of education and experience necessary to support case planning, referral and client monitoring to effectively engage individuals who are identified as having potential substance abuse issues or conditions that are lacking readiness to engage in active treatment. This experience will demonstrate an understanding of issues relating to substance abuse, as well as needed community supports and linkages that will

enable the individual to prepare for treatment. In addition, providers must demonstrate continuous sobriety under a nonresidential or independent living condition for the immediate past two (2) years.

The Department will authorize locally-based agencies that are licensed, certified or have received a letter of approval from the Addictions and Mental Health Division. Individuals may provide these services if verified by an agency holding a letter of approval from the Addictions and Mental Health Division. Qualified Case Managers must meet the following qualifications as outlined in Oregon Administrative Rule:
1. Licensed Medical Providers, Qualified Mental Health Professionals, Qualified Mental Health Associates; or
2. Who possess certification as an Alcohol and Drug Counselors (CADC) levels I, II or III; or
3. Have completed a Peer Services Training Program following a training curriculum approved by the Addictions and Mental Health Division and is:

a. A self-identified person currently or formerly receiving mental health services; or

b. A self-identified person in recovery from a substance use disorder, who meets the abstinence requirements for recovering staff in alcohol and other drug treatment programs; or

c. A family member of an individual who is a current or former recipient of addictions or mental health services.

These providers must have oversight by a Clinical Supervisor meeting the requirements in Oregon Administrative Rule, in alcohol and other drug treatment programs, certified or licensed by a health or allied provider agency to provide addiction treatment, and have one of the following qualifications:
1. Five years of paid full-time experience in the field of alcohol and other drug counseling; or
2. A Bachelor's degree and four years of paid full-time experience in the social services field, with a minimum of two years of direct alcohol and other drug counseling experience; or
3. A Master's degree and three years of paid full-time experience in the social services field with a minimum of two years of direct alcohol and other drug counseling experience.
Providers will have continuing education requirements as specified by the agency providing Clinical Supervision specific to alcohol and other drug treatment.

Freedom of Choice (42 CFR 441.18(a)(1):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

- Eligible individuals will have free choice of the providers of case management services within the specified geographic area identified in this plan.
- Eligible individuals will have free choice of the providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

☐ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):
The State assures the following:

- Case management services (including targeted case management) will not be used to restrict an individual's access to other services under the plan;
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services;
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose**.**

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual;
(ii) The dates of the case management services;
(iii)The name of the provider agency (if relevant) and the person providing the case management service;
(iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved;
(v) Whether the individual has declined services in the care plan;
(vi) The need for, and occurrences of, coordination with other case managers;
(vii) A timeline for obtaining needed services; (viii) A timeline for re-evaluation of the plan.

Limitations:

Case Management does not include the following:

- Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).
- Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))
- FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

Section 1915(g) of the Social Security Act is Authority for this Amendment.

Target Group (Section A of Supplement 1, State Plan Preprint)

The target group consists of individuals served by tribal programs within the State of Oregon, or receiving services from a Federally recognized Indian tribal government located in the State of Oregon, and not receiving case management services under other Title XIX programs. The target group includes elder care; individuals with diabetes; children and adults with health and social service care needs; and pregnant women. These services will be referred to as Tribal Targeted Case Management Services. This amendment does not include case management services funded by Title IV and XX of the Social Security Act, and federal and or state funded parole and probation, or juvenile justice programs.

Definition of Services (Section D of Supplement, State Plan Preprint)

Tribal Targeted Case management services are those services, which include:

(1) Assessment

After the need for tribal targeted case management services has been determined, the tribal case manager assesses the specific areas of concern, family strengths and resources, community resources and extended family resources available to resolve those identified issues. At assessment, the tribal case manager makes preliminary decisions about needed medical, social, educational, or other services and the level or direction tribal case management will take.

(2) Case Planning
The tribal case manager develops a case plan, in conjunction with the client and family (where applicable), to identify the goals and objectives, which are designed to resolve the issues of concern identified through the assessment process. Case planning includes setting of activities to be completed by the tribal case manager, the family and client. This activity will include accessing medical, social, educational, and other services to meet the clients' needs.

(3) Case Plan Implementation
The tribal case manager will link the client and family with appropriate agencies and medical, social, educational or other services through calling or visiting these resources. The tribal case manager will facilitate implementation of agreed-upon services through assisting the client and family to access them and through assuring the clients and

providers fully understand how these services support the agreed-upon case plan.

(4) Case Plan Coordination

After these linkages have been completed, the tribal case manager will ascertain, on an ongoing basis, whether or not the medical, social, educational, or other services have been accessed as agreed, and the level of involvement of the client and family. Coordination activities include, personal, mail and telephone contacts with provider s and others identified by the case plan, and well as meetings with the client and family to assure that services are being provided and used as agreed

5) Case Plan Reassessment

In conjunction with the individual, the tribal case manager will determine whether or not medical, social, educational or other services continue to be adequate to meet the goals and objectives identified in the case plan. Reassessment decisions include those to continue, change or terminate those services. Reassessment will also determine whether the case plan itself requires revision. This may include assisting clients to access different medical, social, educational or other needed services beyond those already provided. Reassessment activities include, staffing and mail, personal, and telephone contacts with involved parties.

Provider Organizations

A Tribal case management provider must be an organization certified as meeting the following criteria:

A. A minimum of three years experience of successful work with Native American children, families, and elders involving a demonstrated capacity to provide all core elements of tribal case management, including: Assessment, Case Planning, Case Plan Implementation, Case Plan Coordination, and Case Plan Reassessment.

B. A minimum of three years case management experience in coordinating and linking community medical, social, educational or other resources as required by the target population.

C. Administrative capacity to ensure quality of services in accordance with tribal, state, and Federal requirements.

D. Maintain a sufficient number of case managers to ensure access to targeted case management services.

Qualifications of Case Managers within Provider Organizations:

- Completion of training in a case management curriculum.
- Basic knowledge of behavior management techniques, family dynamics, child development, family counseling techniques, emotional and behavioral disorders, and issues around aging.
- Skill in interviewing to gather data and complete needs assessment, in preparation of narratives/reports, in development of service plans, and in individual and group communication.
- Ability to learn and work with state, federal and tribal rules, laws and guidelines relating to Native American child, adult and elder welfare and to gain knowledge about community resources and link tribal members with those resources.

Freedom of Choice (Section F of Supplement 1, State Plan Preprint)

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management
2. Eligible recipients will have free choice of the providers of other medical Care under the plan.

(a) When an individual is served through an approved Section 1915(b) waiver, the terms of that waiver will govern freedom of choice of the providers of other medical care under the plan.

Payment (Section *G* of Supplement 1, State Plan Preprint)

Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. This amendment does not include case management services funded by Title IV and XX of the Social Security Act, and federal and or state funded parole and probation, or juvenile justice programs.

Targeted Case Management-Babies First/CaCoon

Target Group:

Targeted case management (TCM) services will be provided to Medicaid eligible infants and preschoolers through four years of age who have risk factors (listed below) for poor health outcomes. TCM services will be provided to Medicaid eligible children up to age 21, who have a diagnosis or very high risk factor listed below.

Medical Risk Factors	Diagnosis

(Birth through 4 yrs)	(Birth – to 21 yrs)
Drug exposed infant	Heart Disease
Alcohol Exposed infant	Chronic Orthopedic Disorders
Infant HIV positive	Neuromotor disorders including cerebral palsy and brachial palsy
Maternal PKU or HIV Positive	Cleft lip and palate and other congenital defects of the head, face
Intracranial hemorrhage grade I or II	Genetic disorders, e.g. cystic fibrosis, neurofibromatosis
Seizures or maternal history of seizures	Multiple minor anomalies
Perinatal asphyxia	Metabolic disorders, e.g. PKU
Small for gestational age	Spina Bifida
Very low birth weight (1500 grams or less)	Hydrocephalus or persistent ventriculomegaly
Mechanical ventilation for 72 hrs or more prior to discharge	Microcephaly and other congenital or acquired defects of the CNS
Neonatal hyperbilirubinemia	Hemophilia
Congenital Infection (TORCHS)	Organic speech disorders
CNS infection	Hearing Loss
Head trauma or near drowning	Traumatic Brain Injury
Failure to grow	Fetal Alcohol Spectrum Disorder
Suspect vision impairment	Autism, autism spectrum disorder
Family history of childhood onset hearing loss	Behavioral or mental health disorder WITH developmental delay
Prematurity	Chromosomal disorders
Lead exposure	Positive newborn blood screen
Suspect hearing loss:	HIV, seropositive conversion
Other risk factors not listed	Visual Impairment
Social Risk Factors	**Very High Medical Risk Factors**
Maternal Age 16 years or less	Intraventicular hemorrhage (grade III or IV) or periventricular leukomalacia (PVL) Or chronic subdurals
Parents with developmental disabilities or intellectual impairment	Perinatal asphyxia accompanied by seizures
Parental alcohol or substance abuse	Seizure disorder

Social Risk Factors	**Very High Medical Risk Factors**
At-risk caregiver	Oral-motor dysfunction requiring specialized feeding program (including gastrostomy)
Concern of parent/provider	Chronic lung disorder
Parent with limited financial resources	Suspect neuromuscular disorder
Parent with history of mental illness	**Developmental Risk Factors**

Parent with child welfare history	Developmental Delay
Parent with domestic violence history	**Other**
Other evidence based social risk factors	Other chronic conditions not listed

For case management services provided to individuals in medical institutions:

☐ Target group comprised of individuals transitioning to a community setting and case management services will be made available for up to 180 consecutive days of the covered stay in the medical institution.

Areas of state in which services will be provided:
☒ Entire State

☐ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of services:
☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount duration and scope.

1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

Definition of services:
Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:
Comprehensive assessment and periodic reassessment of individual needs:
These annual assessment activities (more frequent with significant change in condition) include:

- Evaluation of individual's history;
- Evaluation of the extent and nature of individual's needs (medical, social, educational, and other services) and completing related documents.

- Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.
- Annual review or more often as indicated by change in individual needs.
- *Development (and periodic revision) of a specific care plan that* is based on the information collected through the assessment that:

- Specifies the goals and actions to address the medical, psycho-social, educational, and other services needed by the individual;
- Includes activities such as ensuring the active participation of the eligible individual, working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- Identifies a course of action to respond to the assessed needs of the eligible individual.

Referral and related activities (Such as scheduling appointments for the individual) to help an eligible individual obtain needed services including:

- Activities that link an individual with medical, social, educational providers or other programs and services that are capable of providing needed services, that are capable of providing needed support services (including food vouchers, transportation, child care and housing assistance) to address identified needs and achieve goals specified in the care plan;

Monitoring and follow-up activities: Activities and contacts necessary to ensure the care plan is implemented and adequately addresses the individual's needs. These activities, and contacts, may be with the individual, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary; including at least one annual monitoring. Monitoring and follow-up activities are ongoing and can be performed monthly or as needed and could include:

- Ongoing face-to-face or other contact to conduct follow-up activities with the participating eligible client or the client's health care decision maker(s), family members, providers or other entities or individuals when the purpose of the contact is directly related to managing the eligible client's care to ensure the service plan is effectively implemented;
- Services are being furnished in accordance with the individual's care plan;
- Services in the care plan are adequate; and
- Changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.
- Frequency of monitoring is based on the documented client needs.

Case management includes contacts with non-eligible individual's, that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

Qualifications of providers:

Babies First/CaCoon Targeted Case Managers may be an employee of a Local County Health Department, or other public or private agency contracted by a Local County Health Department. The case manager must be:

- a licensed registered nurse with one year of experience in community health, public health, child health nursing;

- be a Community Health Workers, Family Advocates or Promotoras working under the supervision of a licensed registered nurse.

The minimum qualifications of the Community Health Workers, Family Advocates or Promotoras are as follows: High School Graduate, or GED with additional course work in human growth and development, health occupations or health education and 2 years experience, in public health, mental health or alcohol drug treatment settings, or any satisfactory combination of experience and training which demonstrates the ability to perform case management duties. The case manager must work under the policies, procedures, and protocols of the State Title V MCH Program.

Provider organizations must be certified by the single state agency as meeting the following criteria:

1. Demonstrated capacity to provide all core elements of case management services including:
   a. Comprehensive client assessment
   b. Comprehensive care/service plan development
   c. Linking/coordination of services
   d. Monitoring and follow-up of services
   e. Reassessment of the client's status and needs
2. Demonstrated case management experience in coordinating and linking such community resources as required by the target population.
3. Demonstrated experience with the target population.
4. A sufficient number of staff to meet the case management service needs of the target population.
5. An administrative capacity to insure quality of services in accordance with state and federal requirements.
6. A financial management capacity and system that provides documentation of services and costs.
7. Capacity to document and maintain individual case records in accordance with state and federal requirements.
8. Demonstrated ability to meet all state and federal laws governing the participation of providers in the state Medicaid program.
9. Ability to link with the Title V Statewide MCH Data System or provide another statewide computerized tracking and monitoring system.

Freedom of Choice (42 CFR 441.18(a)(1):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

- Eligible individuals will have free choice of the providers of case management services within the specified geographic area identified in this plan.
- Eligible individuals will have free choice of the providers of other medical care under the plan.

Freedom of Choice Exception(§1915(g)(1) and 42 CFR 441.18(b)):

☐ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):

The State assures the following:

- Case management services (including targeted case management) will not be used to restrict an individual's access to other services under the plan.

- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services.
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.
Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows:
(i)The name of the individual;
(ii) The dates of the case management services;
(iii)The name of the provider agency (if relevant) and the person providing the case management service;
(iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved;
(v) Whether the individual has declined services in the care plan;
(vi) The need for, and occurrences of, coordination with other case managers;
(vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.
Limitations:
Case Management does not include the following:

- Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).
- Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))
- FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

Target Group:
Targeted case management services are provided to eligible Medicaid recipients who:

- Have a developmental disability; and
- Are enrolled in the Developmental Disability Comprehensive Waiver (#0117.R04.00); or
- Are enrolled in one of the model waivers (#'s 40193, 40194, and 0565); or
- Receive only case management services.

Developmental disability is a disability attributable to mental retardation, autism, cerebral palsy, epilepsy, or other neurological handicapping condition which requires training similar to that required by persons with mental retardation, and the disability:

- Originates before the person attains the age of 22 years, except that in the case of mental retardation the condition must be manifested before the age of 18;
- Has continued, or can be expected to continue, indefinitely; and
- Constitutes a substantial handicap to the ability of the individual to function in society.

For case management services provided to individuals in medical institutions:

☒ Target group comprised of individuals transitioning to a community setting and case management services will be made available for up to 180 consecutive days of the covered stay in the medical institution.

Areas of state in which services will be provided:

☒ Entire State

☐ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of services:

☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount duration and scope.

1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

Definition of services:
Targeted case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services.

Targeted case Management includes the following assistance:

Assessment and periodic reassessment of individual needs:

These annual assessment (more frequent with significant change in condition) activities include:

- Taking client history;
- Evaluation of the extent and nature of recipient's needs (medical, social, educational, and other services) and completing related documentation;
- Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

Development (and periodic revision) of a specific care plan that:

- is based on the information collected through the assessment;
- specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- identifies a course of action to respond to the assessed needs of the eligible individual.

*Referral and related activities***:**

To help an eligible individual obtain needed services including activities that help link and individual with:

- Medical, social, educational providers; or
- Other programs and services capable of providing needed services to address identified needs and achieve goals specified in the care plan such as making referrals to providers for needed services, and scheduling appointments for the individual.

Monitoring and follow-up activities:

Activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the individual's needs. The activities, and contact, may be with the individual, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary; including at least one annual monitoring to assure following conditions are met:

- Services are being furnished in accordance with the individual's care plan;
- Services in the care plan are adequate; and
- If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and to service arrangements with providers.

Targeted case management may include contact with non-eligible individuals, that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services;

providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Case managers are employees of a Community Developmental Disabilities Program (CDDP), or employees of Seniors and People with Disabilities Division (SPD), or other public or private agency, contracted by a local community mental health authority or the Seniors and People with Disabilities Division (SPD).

Case managers must have a minimum of:

- A bachelor's degree in behavioral science, social science, or closely related field; or
- A bachelor's degree in any field and one year of human services related experience; or
- An associate's degree in a behavioral science, or closely related field and two years human services related experience.

Freedom of Choice (42 CFR 441.18(a)(1):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act. Eligible recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

☒ Providers of targeted case management services are limited to employees of a Community Developmental Disabilities Program (CDDP), or other public or private agency contracted by a local community mental health authority or the Seniors and People with Disabilities Division (SPD).

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):

The State assures that:

- Targeted case management services will not be used to restrict an individual's access to other services under the plan; [section 1902(a)(19)]
- Individuals will not be compelled to receive target case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services; [section 1902(a)(19)]
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.[42 CFR 431.10(e)]

Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate

payments made to public agencies or private entities under other program authorities for this same purpose**.**

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i) The name of the individual;
(ii) The dates of the case management services;
(iii)The name of the provider agency (if relevant) and the person providing the case management service;
(iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved;
(v) Whether the individual has declined services in the care plan;
(vi) The need for, and occurrences of, coordination with other case managers;
(vii) A timeline for obtaining needed services;
(viii) A timeline for reevaluation of the plan.

Limitations:

- Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).
- Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))
- FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

Target Group:

Targeted case management services are provided to adults with developmental disabilities who are enrolled in the 1915(c) Support Services Waiver (#0375). This target group is comprised of individuals who meet the level of care requirement and have chosen to self-direct home and community-based services. This choice is based on information provided by case managers prior to waiver enrollment that participants or their support team will be required to self-direct services included under this waiver.

Developmental disability is a disability attributable to mental retardation, autism, cerebral palsy, epilepsy, or other neurological disabling condition which requires training similar to that required by persons with mental retardation and the disability:

- Originates before the person attains the age of 22 years, except that in the case of mental retardation the condition must be manifested before the age of 18;
- Has continued, or can be expected to continue, indefinitely; and
- Constitutes a substantial limitation to the ability of the individual to function in society.

Areas of state in which services will be provided:

☒ Entire State

☐ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of services:

☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount duration and scope.

1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

Definition of services:

Targeted case management services are services furnished to assist individuals, eligible under the State Plan or Support Services Waiver, in gaining access to needed medical, social, educational and other services. Targeted case Management includes the following assistance:

Assessment and periodic reassessment of individual needs:

These annual assessment activities (more frequent with significant change in condition) include:

- Taking client history;
- Evaluation of the extent and nature of recipient's needs (medical, social, educational, and other services) and completing related documentation;
- Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

Development and periodic revision of a specific care plan:
The care plan includes:

- Information collected through the assessment;
- Goals and actions to address the medical, social, educational, and other services needed by the individual;
- Activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- A course of action to respond to the assessed needs of the eligible individual.

*Referral and related activities***:**
These activities are designed to assist eligible individuals in obtaining services from:

- Medical, social, educational providers; or
- Other programs and services capable of providing needed services, such as referrals to providers for needed services and scheduling appointments for the individual.

Monitoring and follow-up activities:
Activities and contact necessary to ensure the care plan is implemented and adequately addresses the individual's needs. The activities and contact may be with the individual, his or her family members, providers, other entities or individuals. The contact will be conducted as frequently as necessary, but at least annually, to assure the following conditions are met:

- Services are being furnished in accordance with the individual's care plan;
- Services in the care plan are adequate; and
- If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and to service arrangements with providers.

The Case Record includes:

- the name of the individual;
- the dates of case management services;
- the name of the provider agency (if relevant) and the person providing the case management service;
- the nature, content, units of case management services received, and whether goals

specified in the care plan have been achieved;
- whether the individual has declined services in the care plan;
- the need for, and occurrences of, coordination with other case managers;
- a timeline for obtaining needed services; and
- a timeline for reevaluation of the plan;

Targeted case management may include contact with non-eligible individuals, which are directly related to identifying the needs and supports for helping the eligible individual to access services.

Qualifications of providers:

Personal agents providing case management services are paid employees of a Support Services Brokerage. Each personal agent who provides case management must have a minimum of:
- An undergraduate degree in a human services field and at least one year experience in the area of developmental disabilities; or
- Five years of equivalent training and work experience related to developmental disabilities; and
- Knowledge of the public service system for developmental disability services in Oregon.

Freedom of Choice:

The State assures that the provision of targeted case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act. Eligible recipients will have free choice of the providers of targeted case management services within the specified geographic area identified in this plan.

Freedom of Choice Exception:

☒ Providers of targeted case management services are limited to employees of a Support Services Brokerage under contract with the Division of Seniors and People with Disabilities (SPD).

Access to Services:
The State assures that:

- Targeted case management services will not be used to restrict an individual's access to other services under the plan [section 1902(a)(19)];
- Individuals will not be compelled to receive targeted case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services [section 1902(a)(19)].
- Personal agents do not exercise the State Medicaid Agency's authority to authorize or deny the provision of other services under the plan.

Limitations:
Targeted Case Management does not include the following:

- Activities not consistent with the definition of targeted case management services under section 6052 of the Deficit Reduction Act;

- The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred. (2001 SMD)

- Activities for which third parties are liable to pay. (2001 SMD)

CASE MANAGEMENT SERVICES

Section 1915(g) of the Social Security Act is the authority for this amendment.

Target Group: (Section A of Supplement 1 State Plan Preprint)

Medicaid eligible parents age 14 and over who receive Aid to Families with Dependent Children (AFDC) benefits.

Definition of Services: (Section D of Supplement 1, State Plan Preprint)

Case management services are those covered services needed by the target group to identify barriers to self-sufficiency, identify the medical, social, educational and other services necessary to remove those barriers, and facilitate access to those services. Case management includes screening and assessment, plan development, referrals to service provider, evaluation of the appropriateness of the training, service coordination, monitoring of the client and problem resolution.

1. Screening and Assessment: The case manager gathers information to identify the client's strengths, interests, vocational aptitudes and any services needed to remove barriers to self-sufficiency. It includes collecting information, testing abilities and aptitudes, evaluating the tests, informal observations and information from service providers. Assessment first occurs at intake and is an ongoing, continuous collection of information to evaluate the effectiveness of support services and monitor the client's progress.

2. Case Plan Development: The case manager develops a case plan, consisting of a written outline of employment and training goals for a client to attain self-sufficiency. A plan may include activities to prepare the client for employment, services to remove barriers to employment, training and job search. The plan also includes which support service payments will be needed.

3. Referrals to Service Providers: The case manager will send clients to service providers for medical, social, educational and other services.

4. Evaluation of Appropriateness of Training: The case manager evaluates the appropriateness of training offered by a services provider. The training must meet the

needs of the client as specified in the case plan.

5. Service Coordination: The case manager will coordinate the delivery of services to the client by the service provider and assist the client in getting the needed services.

6. Monitoring of the Client: The case manager will monitor the client's success in completing the activities called for in the case plan.

7. Problem Resolution: The case manager will resolve problems between the client and the service provider.

Qualification of Providers: (Section E of Supplement 1, State Plan Preprint)

Case management providers must be certified by the Oregon Medicaid Single State Agency as qualified to provide case management services to this target group. The criteria for qualifying as a provider are as follows:

1. Provider Organizations:

   Demonstrated ability to provide all core elements of Case Management through at least three years of prior experience.

   Demonstrated ability to coordinate and link community resources required through at least three years of prior experience.

   At least three years experience with the target group.

   Sufficient staff and/or agreements with community organizations to have the administrative capacity to ensure quality of services in accordance with state and federal requirements.

   Financial management system which provides documentation of services and costs.

   Capacity to document and maintain individual case records in accordance with state and federal requirements.

   Demonstrated ability to assure referrals consistent with section 1902(a)(23), freedom of choice of providers.

Ability to provide linkage with other case managers to avoid duplication of Case Management services.

Ability to determine that the client is included in the target group.

Ability to access systems to track the provision of services to the client.

2. Qualifications of Case Managers:

Completion of training in case management curriculum.

Basic knowledge of behavior management techniques.

Skill in interviewing to gather data and complete needs assessment, in preparation of narratives/reports, in development of service plans, and in individual and group communication.

Knowledge of state and federal requirements related to the teen parents/JOBS program.

Ability to use community resources.

Targeted Case Management
CAF Self sufficiency

(Reserved for future use)

State of Oregon

Name and address of State Administering Agency, if different from the State Medicaid Agency.

_____

_____

I. Eligibility

The State determines eligibility for PACE enrollees under rules applying to community groups.

A. __X__ The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are:

(If this option is selected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the State determines eligibility for PACE enrollees. Please note that these groups must be covered under the State's Medicaid plan.)

In accordance with Appendix C, page 2, item b. of Oregon's Home and Community Based Waiver (#0185.90 R2), the applicable group is the group of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are those individuals with a special income level equal to 300% of the SSI Federal benefit (FBR).

B. _____ The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II - Compliance and State Monitoring of the PACE Program.

C. __X__ The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver(s).

Regular Post Eligibility

1. __X__ SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a). Sec. 435.726--States which do not use more restrictive eligibility requirements than SSI.

1. Allowances for the needs of the:

(A.) Individual (check one)

1._X_The following standard included under the State plan (check one):

(a) _____SSI
(b) _____Medically Needy
(c) _____The special income level for the institutionalized
(d) _____Percent of the Federal Poverty Level: _____%
(e) _X__Other (specify): SSI + state supplement_____

2.___The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

3.____The following formula is used to determine the needs allowance:

_____
_____

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B.) Spouse only (check one):

1.____ SSI Standard
2.____ Optional State Supplement Standard
3.____ Medically Needy Income Standard
4.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
5____ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.

6._____ The amount is determined using the following formula: The amount allowed in Sec. 1924 of the Act _____
_____

7.____ Not applicable (N/A)

(C.) Family (check one):
1._X_ AFDC need standard
2.____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3.___ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
4.____ The following percentage of the following standard that is not greater than the standards above:_____% of_____ standard.
5.____ The amount is determined using the following formula:
_____
6.____ Other
7.____ Not applicable (N/A)

(2). Medical and remedial care expenses in 42 CFR 435.726.

Regular Post Eligibility

2. _____ 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) 42 CFR 435.735--States using more restrictive requirements than SSI.

1. Allowances for the needs of the:
(A.) Individual (check one)

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B.) Spouse only (check one):

1._____The following standard under 42 CFR 435.121:

_____

2._____The Medically needy income standard

_____

3.____The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

4 .____The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.

5._____The amount is determined using the following formula:

_____

6._____Not applicable (N/A)

(C.) Family (check one):

1.____AFDC need standard

2_____Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3.____The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

4.____The following percentage of the following standard that is not greater than the standards above:_____% of_____ standard.

5.____ The amount is determined using the following formula:

_____

6.____ Other

7.____ Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.

Spousal Post Eligibility

3. _X__ State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a.) Allowances for the needs of the:

1. Individual (check one)

(A).____The following standard included under the State plan (check one):

1. _____SSI
2. _____Medically Needy
3. _____The special income level for the institutionalized
4. _____Percent of the Federal Poverty Level: _____%
5. _____Other (specify):_____

(B).____The following dollar amount: $_____

Note: If this amount changes, this item will be revised.

(C)_____The following formula is used to determine the needs allowance: _____

_____

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community: _____

_____

_____

II. Rates and Payments

A. The State assures HCFA that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service.

1.___ Rates are set at a percent of fee-for-service costs
2.___ Experience-based (contractors/State's cost experience or encounter date)(please describe)
3.___ Adjusted Community Rate (please describe)
4._X_ Other (please describe)

The acute care portion of the UPL was based on the fee-for service claims data and the managed care encounter data. The long-term care portion of the UPL was based on fee-for-service claims data and some costs that on not in the MMIS database. Once the UPL was developed each portion was set at different percentages of the UPL. See Attachment to Supplement 2 to Attachment 3.1-A for complete description of the rate methodology.

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

Price Waterhouse Coopers, 333 Market St, San Francisco did the work on the medical portion of the UPL and the initial work on the long-term care portion of the UPL.

C. The State will submit all capitated rates to the HCFA Regional Office for prior approval.

III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

State of Oregon
PACE Rate Methodology and Upper Payment Limit Calculation

The following information is organized and is consistent with the format of the resource document which reflects the PACE: Upper Payment Limit and Capitation Rates development for the current PACE Contract calendar year. The Upper Payment Limit and PACE Capitation rates were developed and submitted by Oregon DHS Actuarial Service Unit. The Upper Payment Limits calculated for the PACE program were done in a manner that provided the best estimate of the per capita cost of providing comparable services to the PACE-eligible population if those eligibles were not enrolled in PACE. PACE-eligibles are persons living in Multnomah County who are age 55 and older who are Medicaid eligible (which excludes SLMB and QMB-only who are not Medicaid eligible and Medically Needy individuals) and are long term care eligible in service priority categories Levels 1- 13.

Acute Care:

The assumptions used in calculating the PACE acute care UPLs were the same as those used to develop the Oregon Health Plan per capita costs. The methods consider the mix of delivery systems used in the Oregon Health Plan (OHP), which includes capitated and non-capitated programs. These assumptions include trends, completion factors, and adjustments for data issues and programmatic changes. Where appropriate these assumptions have been modified for the PACE-eligible population and contract period.

1. A data file was created to identify the PACE-eligible population excluding PACE enrollees. This file was matched against the OHP eligibility file to determine enrollment periods in Fee-for-service or managed care for this population.
2. The resulting eligibility information was matched against the claim or encounter data for the PACE-eligible population.
3. The data was summarized to obtain total charges (encounter data) and total paid amounts (fee-for-service) by service category and demographic groupings.
4. The resulting eligibility information was used to develop member months of eligibility within each delivery system which were used as the denominator in the calculation of per capita costs. Appropriate adjustments were made for missing data and budget issues.
5. Trend rates were developed for various service categories, eligibility groups, and delivery systems.
6. Cost-to-charge ratios by service category were calculated and applied to encounter data for services that are provided through managed care plans. Since the cost information for encounter data is charges not paid claims, the cost-to charge ratios were used to convert this information to a cost basis.

7. Total projected costs per member per month were calculated for each service delivery

arrangement and demographic grouping. PMPM amounts, representing unadjusted UPLs were then calculated from a blend of the managed care and FFS PMPMs. The weights used to blend the PMPMs were the PACE eligible member months in each delivery system.

8. Smoothing techniques were applied to the unadjusted UPLs to improve predictability. The smoothing process was cost-neutral in the aggregate.

Long Term Care:
The LTC component of the PACE UPL was developed in a similar manner to the acute care UPL. However, because the LTC services for the PACE-eligible population are paid on a fee-for service basis the rate development is restricted to experience in that delivery system. Additionally, certain services appropriate for inclusion in the UPL, but not included in the MMIS system, were identified and their costs were included in the calculation. These included client contribution paid directly by the individuals to providers, including payments to nursing homes, assisted living and residential care facilities and to adult foster homes. Home-delivered meals are another cost category that is not reported through MMIS data. These costs were allocated by demographic group based on the distribution of costs for nursing facility and Home and Community Based Care (HCBC) services. (P&I)

The general process by which the LTC UPL was calculated is as follows:

1. The data file containing identification information and dates of eligibility for PACE-eligible individuals in Multnomah County was created. PACE participants were excluded from this population.
2. This eligibility information was matched against the nursing facility and HCBC claims data to create the claims experience for the Multnomah County PACE-eligible population.
3. Claim data was summarized to obtain information on total amounts for the data period by service category and demographic grouping.
4. Non-MMIS costs were added. Since this data was available only on a statewide basis, the costs were converted to a PMPM amount to allow for their inclusion in the UPL. An assumption was made that Multnomah County costs in these areas are comparable to the statewide population. These costs were allocated to the demographic groupings proportionately to the total of the nursing home and HCBC costs.
5. The PACE eligibility information was used to develop member months of eligibility. These figures were then used as the denominator in the calculation of per capita costs.
6. An adjustment was made for the relative expected cost of PACE-eligibles with survival priority scores of 1-13 relative to the total PACE-eligible population.
7. Trend rates were developed for various service categories.
8. Total projected LTC costs PMPM were calculated for each demographic grouping.

Final Upper Payment Limits

The per capita costs reflect the expected claims costs per person per month under each delivery system, plus an administrative allowance. Since PACE enrollees can come from either fee-for-service or managed care, these costs are blended based on the distribution of PACE eligible member months between the delivery systems. Smoothing techniques were applied to the UPLs to mitigate the effects of small populations in certain cohorts. The UPLs are kept separate and a percentage of each UPL is used for the LTC and acute care portion of the PACE rate. The PACE rate is currently paid by four eligibility categories; Blind & Disabled (age 55-64) with and without Medicare and Old Age Assistance (age 65+) with and without Medicare.

i. Eligibility

The State determines eligibility for Self-Directed Personal Assistance Services:

A. _____In the same manner as eligibility is determined for traditional State Plan personal care services, described in Item 24 of the Medicaid State Plan.

B. __**X**_In the same manner as eligibility is determined for services provided through a 1915(c) Home and Community-Based Services Waiver*****.

***** *1915(c) Aged and Physically Disabled Waiver # 0185.90.R2, will be referenced in this document as the "APD waiver" or APD waiver services.*

ii. Service Package

The State elects to have the following included as Self-Directed Personal Assistance Services:

A. _____ State Plan Personal Care and Related Services, to be self-directed by individuals eligible under the State Plan.

B. __**X**___ Services included in the following section 1915(c) Home and Community-Based Services waiver(s) to be self directed by individuals eligible under the waiver(s). The State assures that all services in the impacted waiver(s) will continue to be provided regardless of service delivery model. Please list waiver names and services to be included.

Aged and Physically Disabled Waiver # 0185.90.R2: In-home services include ADL care (i.e. eating/nutrition, dressing, bathing/personal hygiene, mobility, bowel and bladder care, and behavior plan) and IADL care (i.e. medication management, transportation, meal preparation, shopping, laundry, and housekeeping). Services are provided in the residence of the individual. In-home services may be provided on an hourly or live-in basis.

iii. Payment Methodology

A. __**X**___The State will use the same payment methodology for individuals self-directing their PAS under section 1915(j) than that approved for State plan personal care services or for section 1915(c) Home and Community-Based waiver services.

B. _____The State will use a different payment methodology for individuals self-directing their PAS under section 1915(j) than that approved for State plan personal care services or for section 1915(c) Home and Community-Based waiver services. Amended Attachment 4.19-B page(s) are attached.

iv. Use of Cash

A. __**X**___ The State elects to disburse cash prospectively to participants self-directing personal assistance services. The State assures that all Internal Revenue Service (IRS) requirements regarding payroll/tax filing functions will be followed, including when participants perform the payroll/tax filing functions themselves.

B. _____ The State elects not to disburse cash prospectively to participants self-directing personal assistance services.

v. Voluntary Disenrollment

The State will provide the following safeguards in place to ensure continuity of services and assure participant health and welfare during the period of transition between self-directed and traditional service delivery models.

Participants may voluntarily disenroll from this program by communicating with their case manager. Individuals who voluntarily disenroll will transition to the APD waiver In-Home Services program, in which the State pays the homecare worker directly. Case managers will work with the participants to create a plan that includes a worker chosen from the SPD homecare worker registry. Should participants be unable to hire a homecare worker suitable to them, they may use an existing contracted in-home agency to meet their needs.

Disenrollment, for reasons other than Medicaid ineligibility, will not cause a reduction in participant's benefits that were determined based on their assessments and service plans.

vi. Involuntary Disenrollment

A. The circumstances under which a participant may be involuntarily disenrolled from self-directing personal assistance services, and returned to the traditional service delivery model are noted below.

Involuntary disenrollment will occur when a participant proves to be unable to self-direct purchase and payment of care services, when a surrogate proves incapable of acting in the best interest of the participant, or when persons invalidate the terms of their Participation Agreement. The participant will be reinstated into the APD waiver In-Home Services program.

Involuntary disenrollment may result from any of the following:

1. *A provider claim of non-payment of wages where the consumer or his/her representative cannot show proof of payment.*
2. *Evidence that the Medicaid cash benefit was used for illegal purposes in accordance with local, state or federal statutes.*
3. *Evidence that the Medicaid cash benefit was used for purposes other than those that meet the individual's care needs.*
4. *Failure to comply with legal or financial obligations as an employer of domestic workers or unwillingness to participate in counseling and training to remedy lack of compliance.*
5. *Inability to manage the cash benefit as evidenced by:*
    a. *Overdrafts of the consumer's designated bank account;*
    b. *Non-compliance with recommendations for training or use of community resources; or*
    c. *Failure to maintain health and well-being by obtaining adequate personal care as evidenced by:*
        i. *Declines in physical functional status which are not attributable to changes in health status; or*
        ii. *Substantiated complaints of the consumer's self-neglect, neglect, or other abuse on the part of the consumer or surrogate.*

B. The State will provide the following safeguards in place to ensure continuity of services and assure participant health and welfare during the period of transition between self-directed and traditional service delivery models.

Disenrollment, for reasons other than Medicaid ineligibility, will not cause a reduction in participant's benefits that were determined based on their assessments and service plans. The case manager is responsible for disenrolling the participant and assists the participant in transitioning to the APD waiver program. The case managers will assist the participant in rectifying any of the problems listed in "A." above before taking steps to disenroll the participant from the program.

If the issues cannot be rectified, the case manager will issue to participants a formal notice prior to any action taken to disenroll them from the program, whether they opt to transition into the APD waiver In-Home Services program or not. The notice will include information about the participant's rights to an administrative hearing if they disagree with the action and the right to continuing benefits under the 1915(j) until a final order is issued.

vii. Participant Living Arrangement

Any additional restrictions on participant living arrangements, other than homes or property owned, operated, or controlled by a provider of services, not related by blood or marriage to the participant are noted below.

Participants must demonstrate the ability to assess and plan for care by maintaining a stable living situation, defined as continuous occupancy at a given residence for three months prior to application. If health issues or a no-fault situation has prompted a move within the three months, proof of any three consecutive months of occupancy during the past year is acceptable.

In the event a participant moves from their own home to a substitute home such as an assisted living facility, an adult foster home, a residential care facility or into a nursing home, he or she will be considered ineligible for the program, disenrolled and transitioned to the 1915(c) waiver In-Home Services program, if appropriate.

Participants live in their own home and not the home of the provider, whether or not the provider is related by blood or marriage.

viii. Geographic Limitations and Comparability

A. __**X**__ The State elects to provide self-directed personal assistance services on a statewide basis.

B. _____ The State elects to provide self-directed personal assistance services on a targeted geographic basis. Please describe:_____

C. _____ The State elects to provide self-directed personal assistance services to all eligible populations.

D. ___ The State elects to provide self-directed personal assistance services to targeted populations. Please describe*:*

E. _____ The State elects to provide self-directed personal assistance services to an unlimited number of participants.

F. _____ The State elects to provide self-directed personal assistance services to _____ (insert number of) participants, at any given time.

ix. Assurances

A. The State assures that there are traditional services, comparable in amount, duration, and scope, to self-directed personal assistance services.

B. The State assures that there are necessary safeguards in place to protect the health and welfare of individuals provided services under this State Plan Option, and to assure financial accountability for funds expended for self-directed personal assistance services.

C. The State assures that an evaluation will be performed of participants' need for personal assistance services for individuals who meet the following requirements:
   i. Are entitled to medical assistance for personal care services under the Medicaid State Plan; or
   ii. Are entitled to and are receiving home and community-based services under a section 1915(c) waiver; or
   iii. May require self-directed personal assistance services; or
   iv. May be eligible for self-directed personal assistance services.

D. The State assures that individuals are informed of all options for receiving self-directed and/or traditional State Plan personal care services or personal assistance services provided under a section 1915(c) waiver, including information about self-direction opportunities that is sufficient to inform decision-making about the election of self-direction and provided on a timely basis to individuals or their representatives.

E. The State assures that individuals will be provided with a support system meeting the following criteria:
   i. Appropriately assesses and counsels individuals prior to enrollment;
   ii. Provides appropriate counseling, information, training, and assistance to ensure that participants are able to manage their services and budgets;

iii. Offers additional counseling, information, training, or assistance, including financial management services:
   1. At the request of the participant for any reason; or
   2. When the State has determined the participant is not effectively managing their services identified in their service plans or budgets.

F. The State assures that an annual report will be provided to CMS on the number of individuals served through this State Plan Option and total expenditures on their behalf, in the aggregate.

G. The State assures that an evaluation will be provided to CMS every 3 years, describing the overall impact of this State Plan Option on the health and welfare of participating individuals, compared to individuals not self-directing their personal assistance services.

H. The State assures that the provisions of section 1902(a)(27) of the Social Security Act, and Federal regulations 42 CFR 431.107, governing provider agreements, are met.

I. The State assures that a service plan and service budget will be developed for each individual receiving self-directed PAS. These are developed based on the assessment of needs.

J. The State assures that the methodology used to establish service budgets will meet the following criteria:
   i. Objective and evidence based, utilizing valid, reliable cost data.
   ii. Applied consistently to participants.
   iii. Open for public inspection.
   iv. Includes a calculation of the expected cost of the self-directed PAS and supports if those services and supports were not self-directed.
   v. Includes a process for any limits placed on self-directed services and supports and the basis/bases for the limits.
   vi. Includes any adjustments that will be allowed and the basis/bases for the adjustments.
   vii. Includes procedures to safeguard participants when the amount of the limit on services is insufficient to meet a participant's needs.
   viii. Includes a method of notifying participants of the amount of any limit that applies to a participant's self-directed PAS and supports.

ix. Does not restrict access to other medically necessary care and services furnished under the plan and approved by the State but not included in the budget.

x. Service Plan

The State has the following safeguards in place, to permit entities providing other Medicaid State Plan services to be responsible for developing the self-directed personal assistance services service plan, to assure that the service provider's influence on the planning process is fully disclosed to the participant and that procedures are in place to mitigate that influence.

Entities or individuals that have responsibility to develop service plans do not provide other direct services to participants.

xi. Quality Assurance and Improvement Plan

The State's quality assurance and improvement plan is described below, including:

i. How it will conduct activities of discovery, remediation, and quality improvement in order to ascertain whether the program meets assurances, corrects shortcomings, and pursues opportunities for improvement; and

Anyone may file a complaint with the Governor's Advocacy Office (GAO) in the Office of the Director of the Department of Human Services or with the local SPD or AAA office. Local SPD and AAA offices have the responsibility to resolve any complaints that are brought to them. In the event that the GAO receives the complaint, they will enter it in a database and forward the complaint to the appropriate branch office or responsible program entity to initiate the resolution process. SPD central office can access monthly reports on the types of complaints filed, the outcomes and whom the complaint involves.

There is no limitation on the types of complaints an individual may file. The majority of complaints are regarding client benefits or dissatisfaction with the case manager. The goal is to remedy complaints at the lowest level possible.
After the local office receives a complaint from the consumer directly or via the GAO, the remediation process begins. The process includes:

* *Participant contacted by local program supervisor within a mandated time-frame, at which time an in-person or telephone meeting is scheduled (participant may have a formal or informal support person/advocate present during the meeting);*
* *Fact finding and research is conducted by the local office prior to participant contact, during the meeting session, and following the meeting using a variety of sources and methods;*
* *Once the complaint is resolved satisfactorily, a letter of determination may be sent to the participant form is sent to the participant (optional on a case-by-case basis), and the GAO and next-level manager are notified;*
* *If the complaint is not resolved, it is referred to next management level for review and follow-up.*

If the complaint cannot be resolved at the local office and service area levels, a Central Office team will assume reexamination and continuance of complaint process. The participant may pursue the grievance through the GAO or the appropriate federal program authority, including the court system.

ii. The system performance measures, outcome measures, and satisfaction measures that the State will monitor and evaluate.

System Performance Indicators, and Participant Outcome and Satisfaction Measures
System performance indicators will be used to measure and track program activities and processes to assure that participant access, choice and satisfaction are achieved. Participant-centered outcome and satisfaction measures will be used to assure that service delivery meets the needs of the participant as determined in the Service Plan and are timely, efficient and effective, as directed by the participant.

The following performance and outcome measures will be used:
1. *Participant enrollment processes are timely and accurate.*
2. *Participant-directed In-Home Services begin in a timely manner.*
3. *Overall costs for participant-directed In-Home Service program clients are comparable to or less than total costs for APD Waiver In-Home Service clients.*
4. *Participants are given a choice of participant-directed or APD Waiver In-Home services.*
5. *Participants have positive experiences with their care arrangements and service delivery.*
6. *The number of voluntary and involuntary program disenrollments is low.*

7. *The participant is able to address and reduce any unmet needs, with Case Manager assistance, if necessary.*
8. *Support for participants in delaying or avoiding admissions to nursing facilities is enhanced.*
9. *The Home Care Worker Registry can be utilized to support participant-directed service provisions.*
10. *Home Care Workers are subject to criminal history checks.*
11. *Home Care Workers provide services as agreed upon with and scheduled by the participant.*
12. *Participants pay Home Care Workers accurately and in a timely manner.*
13. *Case Managers provide accurate and timely responses to participants to address their needs.*
14. *The proportion of abuse, neglect, misappropriation and exploitation, and protective services reports is low.*
15. *The Service Plans of participants have a health and safety risk assessment and strategies/protocols to address identified risks.*

SPD will continuously monitor the health and welfare of all participants receiving services through this option. One of the central activities to the whole SPD service delivery system is the well-developed and consistent case management structure. Case managers assess for service needs, develop care plans, and authorize services. The assessment process includes a discussion and documentation of the participant's strengths, limitations and preferences.

SPD will ensure that individuals receiving 1915(j) services are safe and secure in their homes, taking into account their informed and expressed choices by continuing to perform the following activities:

- *Conducting on-site, random sample reviews by the Performance Evaluation Team at each SPD and AAA office every two years. The review includes a home visit with the participant to verify the information from the participant's file; and*
- *Local SPD /AAA offices will conduct an annual review of a 1% sample of individuals in services. Data is submitted to SPD for analysis, reports and follow-up where appropriate.*

SPD has a variety of ongoing QA improvements to further ensure the health and welfare of participants. These projects include:

- *An SPD consumer satisfaction survey, conducted every 2 years, to assess satisfaction in self-directed services; beginning January 2008; and*
- *Distribution of an emergency preparedness handbook to all in-home service participants.*
-

SPD maintains, and participates in, systems and procedures that promote financial accountability in all home and community-based waiver services by conducting the following activities:

- *Internal audits of various SPD programs, including all in-home programs, by the DHS Internal Audit staff;*
- *External periodic audit activities by Oregon's Secretary of State staff; and*
- *SPD's Research, Planning and Rate Setting Unit reviewing monthly in-home services and caseload counts for both the APD waiver and the 1915(j) in-home services.*

xii. Risk Management

A. The risk assessment methods used to identify potential risks to participants are described below.

During initial plan of care development and subsequent annual reviews, the individual's case manager conducts an assessment using the CA/PS tool to review risk factors for health, safety and protective services with the individual. If the case manager identifies health or medication risks to a recipient living at home, he or she may refer a Registered Nurse under contract with SPD to conduct a nursing assessment and may authorize follow-up visits. If appropriate, the RN develops a registered nurse plan of care for the participant and provider to follow, may delegate nursing tasks to the provider, and establish a monitoring schedule. Nursing delegation consists of training and observing that the provider is able to perform the task.

During the assessment, the case manager may also identify other risks and will assess the individual's ability to make an informed decision. In instances where the individual has the ability to make informed choices, the case manager will discuss alternatives, which may mitigate the risk. Individuals who demonstrate the lack of ability to understand the consequences of their decisions may be better served under the APD waiver In-Home Services program and those options will be discussed with them. Although not mandated, the state may request that a representative be selected in cases where the participant lacks the ability to make an informed decision. The participants have the right to choose their own representative. If the participant appears to be at significant risk, the case manager may refer the case for protective services or guardianship services in the absence of legal representatives to assist with decision-making.

B. The tools or instruments used to mitigate identified risks are described below.

The case manager assigned the ongoing service case conducts an assessment of the participant using a standardized electronic tool, CA/PS, that will identify the individual's ability to perform activities of daily living, instrumental activities of daily living (self-management tasks), and determine the individual's ability to address health and safety concerns and his or her preferences to meet those needs. The case manager discusses and documents any risks or potential risks to the individual's health and safety identified in the assessment. CA/PS captures the participant's strengths and weaknesses with environmental issues and lifestyle choices. If indicated, the case manager can utilize tools within the CA/PS such as the Timed Get Up Go, the Mini-Mental Status Exam or the Depression Scale. Outcomes from these tests will prompt the case manager to make a referral to either a contracted RN or the Office of Mental Health and Addiction Services.

The State also utilizes various policies and procedures to mitigate risk factors for individuals. These include:

- *Review and discussion with participant of risks identified in CA/PS;*
- *Criminal history checks of all homecare workers;*
- *Trainings for case managers to identify and mitigate risks to participants; and*
- *Local SPD offices investigate community complaints under its Adult Protective Services function.*

The State provides a Criminal History Check at no cost to participants for all providers. However, the participant maintains the ability to decide whether, or not, to employ the provider. As a program truly governed by self-direction, this program allows the participant to recruit, hire, train, and fire the provider of their choice.

C. The State's process for ensuring that each service plan reflects the risks that an individual is willing and able to assume, and the plan for how identified risks will be mitigated, is described below.

Extensive and thorough assessment activities of the participant's ADL, IADL and 24-hour needs are conducted in CA/PS on behalf of program participants at program implementation, annually, and whenever the participant indicates that their service needs have changed. The assessment process identifies the participant's ability to perform activities of daily living, self-management tasks, and determine the consumer's ability to address health and safety concerns.

Through interaction with the participant, the case manager may identify other risks

associated with vulnerability to abuse and will assess the individual's ability to make an informed decision. The CA/PS tool captures the discussion and agreement between the participant, case manager and any others that may be a part of the assessment. The participant is questioned about her or his ability to complete ADL and IADL tasks, their preference in how the tasks are done, and any strengths or weaknesses associated with each task. Certain risk factors are discussed, i.e. falls, depression, environmental concerns. Once the assessment is complete, the case manager and participant decide who is going to meet any unmet need. The participant can decline to have a provider deliver the service. This information is captured on the plan of care and is signed by the participant and case manager.

D. The State's process for ensuring that the risk management plan is the result of discussion and negotiation among the persons designated by the State to develop the service plan, the participant, the participant's representative, if any, and others from whom the participant may seek guidance, is described below.

As stated above, assessment activities are conducted on behalf of program participants at program implementation, annually thereafter, and whenever the participant indicates that their service needs have changed. During initial plan of care development and subsequent reviews, the individual's case manager conducts an assessment using the CA/PS tool to review risk factors for health and protective services with the individual, to offer resources to the individual and to plan appropriate safeguards. The participant's assigned case manager may discuss their concerns with and make suggestions to the participant and refer the participant to community resources. Case managers are responsible for assessing the participant's level of care and developing a plan of care in accordance with the participant's choice of services to be provided. The case manager addresses all of the met or unmet needs of the participant through the assessment and discussion with the participant and provides the participant with a copy of the plan of care for signature by all parties for the authorized services. The case manager will consult with the participant every year to reassess, review, verify and discuss the appropriate services are being offered and performed. All plans are developed with input from the participant, participant's representative and anyone else the participant wants involved.

xiii. Qualifications of Providers of Personal Assistance

A. __**X**___ The State elects to permit participants to hire legally liable relatives, as paid providers of the personal assistance services identified in the service plan and budget.

B. _____ The State elects not to permit participants to hire legally liable relatives, as paid providers of the personal assistance services identified in the service plan and budget.

xiv. Use of a Representative

A. __**X**___ The State elects to permit participants to appoint a representative to direct the provision of self-directed personal assistance services on their behalf.

i. ____ The State elects to include, as a type of representative, a State-mandated representative. Please indicate the criteria to be applied.

B. _____ The State elects not to permit participants to appoint a representative to direct the provision of self-directed personal assistance services on their behalf.

xv. Permissible Purchases

A. __**X**__ The State elects to permit participants to use their service budgets to pay for items that increase a participant's independence or substitute for a participant's dependence on human assistance.

B. _____ The State elects not to permit participants to use their service budgets to pay for items that increase a participant's independence or substitute for a participant's dependence on human assistance.

xvi. Financial Management Services

A. _____ The State elects to employ a Financial Management Entity to provide financial management services to participants self-directing personal assistance services, with the exception of those participants utilizing the cash option and performing those functions themselves.

i. ____ The State elects to provide financial management services through a reporting or subagent through its fiscal intermediary in accordance with section 3504 of the IRS Code and Revenue Procedure 80-4 and Notice 2003-70; or

ii. ____ The State elects to provide financial management services through vendor organizations that have the capabilities to perform the

required tasks in accordance with section 3504 of the IRS Code and Revenue Procedure 70-6. (When private entities furnish financial management services, the procurement method must meet the requirements set forth Federal regulations in 45 CFR section 74.40 – section 74.48.)

iii. ____ The State elects to provide financial management services using "agency with choice" organizations that have the capabilities to perform the required tasks in accordance with the principles of self-direction and with Federal and State Medicaid rules.

B. __**X**___ The State elects to directly perform financial management services on behalf of participants self-directing personal assistance services, with the exception of those participants utilizing the cash option and performing those functions themselves.

State Agency _____Oregon_____

MEDICAID PROGRAM: REQUIREMENTS RELATING TO
COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation (s)	Provision (s)
1935(d)(1)	Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

TN No. __05-08 Approval Date _11/3/05 Effective Date __1/1/06
Supersedes TN No. _____

State Agency _____Oregon_____

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation (s)		Provision (s)
1927(d)(2) and 1935(d)(2)	1.	The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit–Part D.
	_X	The following excluded drugs are covered:
	_X_	(a) agents when used for anorexia, weight loss, weight gain (see specific drug categories below)
	_X_	(b) agents when used to promote fertility (see specific drug categories below)
	_X_	(c) agents when used for cosmetic purposes or hair growth (see specific drug categories below)
	_X_	(d) agents when used for the symptomatic relief cough and colds (see specific drug categories below)
	_X_	(e) prescription vitamins and mineral products, except prenatal vitamins and fluoride (see specific drug categories below)
	_X_	(f) nonprescription drugs (see specific drug categories below)

TN No. __05-08 Approval Date _11/3/05 Effective Date __1/1/06
Supersedes TN No. _____

State Agency _____Oregon_____

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation (s)		Provision (s)
1927(d)(2) and 1935(d)(2)	_X_	(g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific drug categories below)
	_X_	(h) barbiturates (see specific drug categories below)
	_X_	(i) benzodiazepines (see specific drug categories below)

All categories listed above are subject to the 'limitations of Services' and Prior Authorization program as described in Attachment 3.1-A page 5-a,5-b and 5-c or outlined in the approved 1115 Waiver.

__ No excluded drugs are covered.

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S):

The following services are provided.

For children (under age 21) and pregnant women all services described in Attachment 3.1-A, except 3.1-A 15.a and 15.b and 3.1-A 16.

.

*Description provided on Attachment

State/Territory: OREGON

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Aged, Blind & Disabled

1. Inpatient hospital services other than those provided in an institution for mental diseases.

/ / Provided / / No limitation / / With limitations*

2.a. Outpatient hospital services.

/ / Provided / / No limitation / / With limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise covered under the plan).

/ / Provided / / No limitation / / With limitations*

c. See below

3. Other laboratory and X-ray services.

/ / Provided / / No limitation / / With limitations*

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

/ / Provided / / No limitation / / With limitations*

b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

/ / Provided

c. Family planning services and supplies for individuals of childbearing age.

/ / Provided / / No limitation / / With limitations*

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

/ / Provided / / No limitation / / With limitations

*Description provided on Attachment.

State/Territory: Oregon

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Aged, Blind, Disabled

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a skilled nursing facility, or elsewhere.

/ / Provided / / No limitation / / With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

/ / Provided / / No limitation / / With limitations*

*Description provided on Attachment.

State/Territory: OREGON

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Aged, Blind, Disabled

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

   a. Podiatrists' Services

      / / Provided / / No limitation / / With limitations*

   b. Optometrists' Services

      / / Provided / / No limitation / / With limitations*

   c. Chiropractors' Services

      / / Provided / / No limitation / / With limitations*

   d. Other Practitioners' Services

      / / Provided / / No limitation / / With limitations*

7. Home health services

   a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

      / / Provided / / No limitation / / With limitations*

   b. Home health aide services provided by a home health agency.

      / / Provided / / No limitation / / With limitations*

   c. Medical supplies, equipment, and appliances suitable for use in the home.

      / / Provided / / No limitation / / With limitations*

   d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

      / / Provided / / No limitation / / With limitations*

*Description provided on Attachment.

State/Territory: OREGON

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Aged, Blind & Disabled

8. Private duty nursing services.

/ / Provided / / No limitation / / With limitations*

9. Clinic services.

/ / Provided / / No limitation / / With limitations*

10. Dental services.

/ / Provided / / No limitation / / With limitations*

11. Physical therapy and related services.

a. Physical therapy.

/ / Provided / / No limitation / / With limitations*

b. Occupational therapy.

/ / Provided / / No limitation / / With limitations*

c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist.

/ / Provided / / No limitation / / With limitations*

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

/ / Provided / / No limitation / / With limitations*

b. Dentures.

/ / Provided / / No limitation / / With limitations*

*Description provided on attachment-

State/Territory: OREGON

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S): Aged, Blind and Disabled

c. Prosthetic devices.

/ / Provided / / No limitation / / With limitations*

d. Eyeglasses.

/ / Provided / / No limitation / / With limitations*

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

a. Diagnostic services.

/ / Provided / / No limitation / / With limitations*

b. Screening services.

/ / Provided / / No limitation / / With limitations*

c. Preventive services.

/ / Provided / / No limitation / / With limitations*

d. Rehabilitative services.

/ / Provided / / No limitation / / With limitations*

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

/ / Provided / / No limitation / / With limitations*

b. Skilled nursing facility services.

/ / Provided / / No limitation / / With limitations*

*Description provided on Attachment.

State/Territory: OREGON

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Aged, Blind and Disabled

c. Intermediate care facility services.

/ / Provided / / No limitation / / With limitations*

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(a) of the Act, to be in need of such care.

/ / Provided / / No limitation / / With limitations*

b. Including such services in a public institution (or district part thereof) for the mentally retarded or persons with related conditions.

/ / Provided / / No limitation / / With limitations*

16. Inpatient psychiatric facility services for individuals under 22 years of age.

/ / Provided / / No limitation / / With limitations*

17. Nurse-midwife services.

/ / Provided / / No limitation / / With limitations*

18. Hospice care (in accordance with section 1905(o) of the Act.

/ / Provided / / No limitation / / With limitations*

*Description provided on attachment.

State/Territory: OREGON

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): AGED, BLIND, DISABLED

19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

___ Provided: ___ With limitations*

___ Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2) of the Act.

___ Provided: ___ With limitations*

___ Not provided.

20. Extended services for pregnant women.

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and for any remaining days in the month in which the 60th day falls.

___ Provided: + ___ Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy,

___ Provided: + ___Additional coverage ++ ___ Not provided.

21. Certified pediatric or family nurse practitioners' services.

___ Provided: ___ No limitations ___ With limitations*

___ Not provided.

\+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

++ Attached is a description of increases in covered services beyond limitations for all groups described in this Attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment-

State/Territory: OREGON

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Aged, Blind and Disabled

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

[ ] Provided [ ] No limitations [ ] With limitations*

[ ] Not Provided:

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

[ ] Provided [ ] No limitations [ ] With limitations*

[ ] Not Provided:

b. Services provided in Religious Nonmedical Health Care Institutions..

[ ] Provided [ ] No limitations [ ] With limitations*

[ ] Not Provided:

c. Reserved.

d. Nursing facility services provided for patients under 21 years of age.

[ ] Provided [ ] No limitations [ ] With limitations*

[ ] Not Provided:

e. Emergency hospital services.

[ ] Provided [ ] No limitations [ ] With limitations*

[ ] Not Provided:

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and furnished by a qualified person under supervision of a registered nurse.

[ ] Provided [ ] No limitations [ ] With limitations*

[ ] Not Provided:

STATE OREGON

24. Pediatric or family nurse practitioners' services as defined in Section 1905(a)(21) of the Act (added by Section 6405 of OBRA '89).

/ / Provided / / No Limitations / / With Limitations*

*Description provided on Attachment.

State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Aged, Blind, Disabled

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25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

___ Provided ___ Not Provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home setting.

___ Provided: ___ State Approved (Not Physician) Service Plan Allowed

___ Services Outside the Home Also Allowed

___ Limitations Described on Attachment

___ Not provided.

27. Program of Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 2 to Attachment 3.1-A.

___ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

___ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

STATE PLAN UNDER TITLE XlX 0F THE SOCIAL SECURITY ACT

STATE OF OREGON

STANDARDS AND METHODS TO ASSURE HIGH QUALITY CARE

Standards and quality of care are assured by the medical community. All hospitals and skilled nursing facilities have utilization review processes. All medical and dental procedures must be provided by duly licensed and qualified practitioners.

ATTACHMENT 3.1-D

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF OREGON

Methods of Providing Transportation

Transportation including expense for transportation and other related travel expenses necessary to secure medical examinations and or treatment when determined by agency to be necessary in the individual case. "Travel expenses" are defined to include the cost of transportation for the individual by ambulance, taxi cab, common carrier, or other appropriate means; the cost of outside meals and lodging in route to, while receiving medical care, and returning from a medical resource; and the cost of an attendant to accompany if medically or otherwise necessary. The cost of an attendant may include transportation, meals, lodging, and salary of the attendant, except that no salary shall be paid a member of the patient's family.

Note: Change in att. Number required by AT-82-30.
Change in title authorized by AFS letter to Region X dated 4-26-83.

TRANSPLANT SERVICES

1. a. All transplants require prior authorization, except kidney and cornea transplants. Kidney and cornea transplants require prior authorization only if performed out-of-state. Evaluations for possible transplants also require prior authorization separate from the prior authorization for the actual transplant.

   b. An emergency transplant is one in which medical necessity requires that a covered transplant be performed less than 5 days after determination of the need for a transplant, and, upon review, all transplant criteria are met.

   c. Transplant services are provided for eligible clients when covered under the client's benefit package, covered by the Health Services Commission's Prioritized List of Health Services, and OMAP transplant criteria are met.

   d. Prior authorization requests for all covered transplants must be initiated by the client's in-state referring physician.

2. The following types of transplants and transplant-related procedures are covered under the Medical Assistance program:

   (a) Bone Marrow, Autologous and Allogeneic,
   (b) Bone Marrow Harvesting and Peripheral Stem Cell Collection, Autologous,
   (c) Cord blood, Allogeneic,
   (d) Cornea,
   (e) Heart,
   (f) Heart-Lung,
   (g) Kidney,
   (h) Liver,
   (i) Liver-Kidney,
   (j) Simultaneous Pancreas and Kidney transplants, and Pancreas after Kidney transplants,
   (k) Peripheral Stem Cell, Autologous and Allogeneic,
   (l) Single Lung,
   (m) Bilateral Lung,
   (n) Any other transplants the Health Services Commission and the Oregon Legislature determine are to be added to the Prioritized List of Health Services.

3. Non-Covered Transplant Services

The following types of transplants are not covered by the Oregon Medical Assistance program:

(a) Any transplants not listed in Section (2).

(b) Second bone marrow transplants are not covered except for tandem autologous transplants for multiple myeloma.

(c) Transplants that are considered experimental or investigational, or which are performed on an experimental or investigational basis, as determined by OMAP.

4. Transplant Centers

Transplant services will be reimbursed only when provided in a transplant center which provides quality services, demonstrates good patient outcomes and compliance with all OMAP facility criteria. The transplant center must have provided transplant services for a period of at least two years and must have completed a minimum of 12 cases in the most recent year. The patient and graft survival rates must be equal to or greater than the appropriate standard indicated in this rule.

(a) An experienced and proficient transplant team and a well established transplant support infrastructure at the same physical location as the transplant service is required for transplant services rendered to OMAP clients. OMAP transplant center criteria must be met individually by a facility to demonstrate substantial experience with the procedure.

(b) A transplant facility is required to report to OMAP, within a reasonable period of time, any significant decrease in its experience level or survival rates, the departure of key members of the transplant team or any other major changes that could affect the performance of transplants at the facility. Changes from the terms of approval may lead to withdrawal of OMAP approval for coverage of transplants performed at the facility.

(c) Fully Capitated Health Plans that contract with non-OMAP contracted transplant facilities must require that the transplant centers meet at a minimum the above transplant center criteria, and develop and use appropriate transplant facility criteria to evaluate and monitor for quality services at the transplant facility.

(d) Transplant centers which have less than two years experience in solid organ transplant may be reimbursed, at OMAP's discretion, for allogeneic or autologous bone marrow transplants upon completion of two years of experience in bone marrow transplantation with patient survival rates equal to or exceeding those defined in Section (5) below.

5. Standards for Transplant Centers:

(a) Heart, heart-lung and lung transplants:

(1) Heart: one-year patient survival rate of at least 80 %.

(2) Heart-lung: one-year patient survival rate of at least 65 %.

(3) Lung: one-year patient survival rate of at least 65 %.

(b) Bone Marrow (autologous and allogeneic), Peripheral Stem Cell (autologous and allogeneic), and cord blood (allogeneic) transplants:

(1) one-year patient survival rate of at least 50 %.

(c) Liver and liver-kidney transplants:

(1) one-year patient survival rate of at least 70 % and a one-year graft survival rate of at least 60 %.

(d) Simultaneous pancreas-kidney and pancreas-after-kidney transplants:

(1) one-year patient survival rate of at least 90 % and one-year graft survival rate of at least 60 %.

(e) Kidney transplant:

(1) one-year patient survival rate of at least 92% and one-year graft survival rate of at least 85%.

6. Selection of transplant centers by geographic location:

(a) If the services are available in the state of Oregon, reimbursement will not be made to out-of-state transplant centers.

(b) Out-of-state centers will be considered only if:

(1) the type of transplant required is not available in the state of Oregon and/or the type of transplant (e.g., liver transplant) is available in the state of Oregon but the Oregon transplant center does not provide that type of transplant for all clients or all covered diagnoses, (e.g., pediatric transplants).

(2) it would be cost effective as determined by OMAP. For example, if the transplant service is covered by the client's benefit package and the client's primary insurer (i.e., Medicare) requires the use of an out-of-state transplant center.

CRITERIA FOR TRANSPLANTS

1. Generally, all transplants must meet the following criteria with no contraindications, and any specific criteria additionally noted:
   (a) The client must have a maximum probability of a successful clinical outcome, i.e., the probability of the client's survival after transplant for a period of five years or more, must be at least 20 percent as supported by medical literature.
   (b) Prior authorization for a transplant will only be given for a client in whom irreversible disease has advanced to the point where conventional therapy offers no prospect for prolonged survival and there is no reasonable alternative medical or surgical therapy.
   (c) A client considered for a solid organ transplant must have a poor prognosis of less than a 50% chance of survival for eighteen months without a transplant as a result of poor functional status.
   (d) Second solid organ transplants must meet all criteria and applicable practice guidelines.
   e) All alternative medically accepted treatments that have a one year survival rate comparable to that of transplantation must have been tried or considered.
   (f) Requests for transplant services for children suffering from early congenital heart disease or early cardiopulmonary disease may be approved before attempting alternative treatments if medical evidence suggests an early date of transplant is likely to improve outcome.
   (g) Both the transplant center and the specialists' evaluations recommend that the transplant be authorized.

2. Donor leukocyte infusions are covered only when:
   (a) an early failure or relapse post allogeneic bone marrow transplant occurs
   (b) peripheral stem cells are from the original allogeneic donor.

3. Allogeneic bone marrow transplants are covered when criteria for antigen match is met.

4. Liver-kidney transplant is covered only for medically-documented diagnosis of Caroli's disease.

5. Simultaneous Pancreas-Kidney (SPK) is covered only for the diagnosis of Type I diabetes mellitus along with endstage renal disease.

6. Pancreas after Kidney (PAK) transplant will be considered for clients diagnosed with insulin dependent Type I diabetes after prior successful renal transplant

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State OREGON
COORDINATION OF TITLE XIX WITH PART B OF TITLE XVIII

The following method is used to provide the entire range of benefits under Part B of title XVIII to the groups of Medicare-eligible individuals indicated:

/X/ A. Buy-in agreement with the Secretary of HHS. This agreement covers:

1. / / Individuals receiving SSI under title XVI or State supplementation who are categorically needy under the State's approved title XIX plan.

Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

/ / Yes / / No

2. / / Individuals receiving SSI under title XVI, State supplementation, or a money payment under the State's approved title IV-A plan, who are categorically needy under the State's approved title XIX plan.

Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

/ / Yes / / No

3. /X/ All individuals eligible under the State's approved title XIX plan.

/ / B. Group premium payment arrangement entered into with the Social Security Administration. This arrangement covers the following groups:

/X/ C. Payment of deductible and coinsurance costs. Such payments are made in behalf of the following groups:

All Medicaid eligible persons who are also Medicare eligible, with a maximum-combined Medicare/Medicaid payment not to exceed Oregon's Medicaid fee.

This relates only to comparability of devices - benefits under XVIII to what groups - not how XIX pays. . . . if State has buy-in (which covers premium), it does not check #3 for same group-only if it does #3 for another group, e.g. does #1 for money payment receipts and #3 for non-$-receipts. How it handles deductibles and coinsurance for money payment receipts is a matter for reimbursement Attachment.