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State/Territory Name: Oregon

State Plan Amendment (SPA) #: 16-0012

This file contains the following documents in the order listed:

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

Division of Medicaid & Children's Health Operations

January 19, 2017

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

RE: Oregon State Plan Amendment (SPA) Transmittal Number 16-012

Dear Ms. Saxton:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of Oregon State Plan Amendment (SPA) Transmittal Number 16-012. This SPA is being submitted to expand the period of time available for Targeted Case Management (TCM) activities to include pregnancy.

This SPA is approved effective January 1, 2017.

If there are additional questions please contact me, or your staff may contact Bill Vehrs at bill.vehrs@cms.hhs.gov or at (503) 399-5682.

Sincerely,

Digitally signed by David L. Meacham -S

[redacted]

David L. Meacham
Associate Regional Administrator

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **16-0012**

2. STATE: Oregon

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

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

4. PROPOSED EFFECTIVE DATE
1/1/17

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.169 and 441

7. FEDERAL BUDGET IMPACT:
a. FFY 2017 $0
b. FFY 2018 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Supplement 1 to Attachment 3.1-A, pages 27-31.d
Attachment 4.19-B, page 4i

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Supplement 1 to Attachment 3.1-A, pages 27-31
Attachment 4.19-B, page 4i

10. SUBJECT OF AMENDMENT: This transmittal is being submitted to expand the period of time available for TCM activities to include pregnancy.

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME Lori Coyner, MA

14. TITLE: Medicaid Director, OHA

15. DATE SUBMITTED: 11/9/2016

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

ATTN: Jesse Anderson, State Plan Manager

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 11/09/16

18. DATE APPROVED: 1/19/2017

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 1/1/17

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]
Digitally signed by David L. Meacham -S
Date: 2017.01.20 15:26:49 -08'00'

21. TYPED NAME: David L. Meacham

22. TITLE: Associate Regional Administrator

23. REMARKS:

FORM HCFA-179 (07-92)

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

CASE MANAGEMENT SERVICES

Targeted Case Management
Public Health Nurse Home Visiting,
Expanded Babies First CaCoon and Nurse-Family Partnership

Target Group:
Targeted case management (TCM) services will be provided to Medicaid eligible perinatal women, infants and children through four years of age who have one or more risk factors for poor perinatal, birth and other poor health outcomes, or parent of said child listed in Table 1. For the purposes of this State Plan Amendment, *Perinatal* is defined as the period inclusive of pregnancy through two years postpartum, to the child's second birthday. Services to a parent (primary caregiver) could be available during this same two year period following the birth of the child.

TCM services will also be provided to Medicaid eligible Children and Youth with Special Health Care Needs (CYSHCN), up to age 21, who have one or more diagnosis or very high risk factor listed in Table 2 below. Children with Special Health Care needs are "those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally".

Table 1

Perinatal and Parental Eligibility Criteria
Pregnant woman with chronic health condition that places perinatal-infant outcomes at high risk (e.g., diabetes, hypertension, obesity, cognitive impairment, malignancy, asthma, HIV, seizure disorder, renal disease, systemic lupus erythematosus)
Pregnant woman with complications of pregnancy (e.g., preterm labor, multiple gestation, infections, oligohydramnios, polyhydramnios)
Pregnant woman with inadequate prenatal care
Pregnant woman with history of poor birth outcomes (e.g., preterm delivery, low birth weight infant, birth anomaly, fetal chromosomal abnormality, intrauterine growth restriction (IUGR), other complication to infant)
Perinatal woman with history of child abuse
Perinatal woman with tobacco use (current or recent within one year)
Perinatal woman with substance use/abuse includes any teratogenic substance (e.g., alcohol, opioids, current or recent within one year)

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CASE MANAGEMENT SERVICES

Table 1 (Cont)

Perinatal and Parental Eligibility Criteria
Perinatal woman with mental health condition
Perinatal woman experiencing intimate partner violence (current or recent within one year)
Perinatal woman of race/ethnicity with established health inequities (includes refugees)
Perinatal woman with inadequate resources to meet basic needs (e.g., shelter, food, utilities)
Perinatal woman with exposure to environmental hazards
Perinatal woman age 18 years or less
Perinatal woman who has not completed high school
Perinatal woman experiencing an unsupportive partner, and/or lack of social supports
Perinatal woman with history of incarceration
Pregnant woman who meets Nurse-Family Partnership (NFP) evidence based eligibility criteria, as defined by the NFP National Service Office
Parent of eligible child

Table 2

Infant and Children Eligibility Criteria (one or more criteria are required	**Diagnosis** (Birth – to 21 yrs)
Infant born to mother enrolled in Expanded Babies First! or Nurse-Family Partnership	Endocrine disorders, e.g. diabetes
Referral from medical provider or social services for nurse home visiting	Malignancy
Teratogen exposed infant exposed infant (e.g., alcohol, opioids)	Cardiovascular disorders
	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

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CASE MANAGEMENT SERVICES

Table 2 (Cont)

Infant and Children Eligibility Criteria (one or more criteria are required	**Diagnosis** (Birth – to 21 yrs)
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 or other environmental exposure	Positive newborn blood screen
Suspect hearing loss	HIV, seropositive conversion
Other risks for growth and development delay	Visual Impairment
Social Determinants of Health	**Very High Medical Risk Factors**
Maternal age 18 years or less	Intraventicular hemorrhage (grade III or IV) or periventricular leukomalacia (PVL) or chronic subdurals
Parents with cognitive impairment	Perinatal asphyxia accompanied by seizures
Parental substance use/abuse (e.g., alcohol, opioids current or recent within one year)	Seizure disorder
Parent did not complete high school	Oral-motor dysfunction requiring specialized feeding program (including gastrostomy)

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CASE MANAGEMENT SERVICES

Table 2 (Cont)

Social Determinants of Health	**Very High Medical Risk Factors**
	Chronic lung disorder
Parent with inadequate resources to meet basic needs for housing, food, shelter, utilities.	Suspect neuromuscular disorder
Parent with mental health condition	**Developmental Risk Factors**
Parent with history of abuse of neglect (child welfare agency involvement)	Developmental Delay
Parent experiencing intimate partner violence, current or within one year	**Other**
Parent with history of incarceration	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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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CASE MANAGEMENT SERVICES

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:

- Taking and evaluating client history;
- Identify and evaluating the extent and nature of individual's needs and completing related documentation; and
- Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible 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 includes the following:

- Specifies the goals and actions to address the medical, psycho-social, educational, and other services needed by the eligible 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 but not limited to 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 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;

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CASE MANAGEMENT SERVICES

Monitoring and follow-up activities (Cont):

- 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 individuals, who 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:

Public Health Nurse (Expanded Babies First/CaCoon, Nurse-Family Partnership) Targeted Case Managers may be an employee of a Local County Health Department, under the jurisdiction of the Local Public Health Authority or other public or private agency contracted by a Local Public Health Authority. The case manager must be:

- A licensed registered nurse with experience in community health, public health, child health nursing;
- A Community Health Worker, Family Advocate or Promotora 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 two 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 Maternal and Child Health Program.

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CASE MANAGEMENT SERVICES

Qualifications of providers (Cont):

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 Maternal and Child Health program Data 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.

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CASE MANAGEMENT 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 §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

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CASE MANAGEMENT SERVICES

Limitations (Cont):

- Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 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))

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Targeted Case Management-Public Health Nurse Home Visiting, Expanded Babies First CaCoon and Nurse-Family Partnership

"Unit" is defined as one encounter per visit. A unit consists of at least one documented contact with the individual (or other person acting on behalf of the individual) and any number of documented contacts with other individuals or agencies identified through the case planning process. Case management providers are paid on a unit-of-service basis that does not exceed 1 unit (encounter) per day.

The rate for reimbursement of the case management services is computed as follows:

Compute the	Total Annual Medicaid Encounters
Compute the	Total Annual Program Expenditures
Divide	Calculate Average Cost Per Encounter
Examine	Extreme values, develop "reasonable range"
Equals	AVERAGE COST PER ENCOUNTER

The total annual expenditures of providing targeted case management includes:

- Targeted case management staff salary and other personnel expenses;
- Supervisory salary and other personnel expenses;
- Administrative support salary and other personnel expenses;
- Services and supply expenses; and
- Expenses (General government service charges, worker's comp, property insurance, etc).

The Agency's rates are statewide rates, both public and private provider receive the same rate. The rates are set as of 9/2/2012 and are effective for services on or after that date. All rates are published on the Agency's website at http://www.oregon.gov/oha/healthplan/Pages/tcm-policy.aspx.