Table of Contents

State/Territory Name: Oregon

State Plan Amendment (SPA) #: 20-0001

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1301 Young Street, Suite 900
Dallas, Texas 75202

Medicaid and CHIP Operations Group

March 4, 2020

Patrick Allen, Director
Oregon Health Authority
500 Summer Street Northeast, E-5
Salem, Oregon 97301-1079

RE: Oregon State Plan Amendment (SPA) Transmittal Number OR-20-0001

The Centers for Medicare & Medicaid Services (CMS) has completed its review of the enclosed State Plan Amendment (SPA), Transmittal Number OR-20-0001. This SPA adds clarifying language that the Department pays the PACE capitation rate based on a consumer's Medicare status. This change does not affect the PACE rate methodology.

This SPA is approved effective January 1, 2020. Enclosed is a copy of the CMS-179 summary form, as well as the approved pages for incorporation into the Oregon State Plan.

If there are any questions concerning this approval, please contact me or you may contact Shante Shaw at Shante.Shaw@cms.hhs.gov or at 206-615-2346.

Sincerely,

[redacted]

Bill Brooks, Director
Division of Managed Care Operations

cc:
Lori Coyner, OHA
Dana Hittle, OHA
Jesse Anderson, OHA
Teri Mcclain, OHA

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: **20-0001**

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
1/1/20

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:
1905(a)(26) and 1934

7. FEDERAL BUDGET IMPACT:
a. FFY 2020 $0
b. FFY 2021 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Supplement 2 to Attachment 3.1-A, page 1, 6-9

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Supplement 2 to Attachment 3.1-A, page 1, 6-9

10. SUBJECT OF AMENDMENT: This transmittal is being submitted in compliance with a federal change in regulation that requires the Department pay a PACE consumer by their Medicare status. This change does not affect the PACE rate methodology, but rather adds clarifying language that the Department pays the PACE capitation rate based on a consumer's Medicare status.

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: State Medicaid Director, OHA

15. DATE SUBMITTED: 1/22/20

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

ATTN: Jesse Anderson, State Plan Manager

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 1/22/2020

18. DATE APPROVED: 3/4/2020

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 1/1/2020

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Bill Brooks

22. TITLE: Director, Division of Managed Care Operations

23. REMARKS:

FORM HCFA-179 (07-92)

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

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

Name and address of State Administering Agency, if different from the State Medicaid Agency.
Oregon Department of Human Services, 500 Summer St. NE, Salem, OR 97301

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 and CFR 435.218). 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: Groups as provided under 42 CFR 435.236 Individuals in institutions who are eligible under a special income group with income under 300% of SSI).

(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.)

Spousal impoverishment eligibility rules apply.

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 0185.R05.01.

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

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

II. Rates and Payments

A. The State assures CMS 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 Amount Would Otherwise Have Paid (AWOP) is based on the fee-for service claims data and the managed care encounter data. The long-term care portion of the AWOP is based on fee-for-service claims data and some costs that are not in the MMIS database. Once the AWOP is developed each portion is set at different percentages of the AWOP.

B. The State Medicaid Agency assures that the rates are set in a reasonable and predictable manner by the Oregon DHS/OHA Actuarial Services Unit, using cost/eligibility data from within the three calendar years (or plan years, if different) prior to the year in which rate calculations are being performed.

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

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

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

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.

Program of All-inclusive Care for the Elderly (PACE) Rate Methodology and Amount That Would Have Otherwise Been Paid (AWOP) Calculation

The following information discusses the benefits, data, assumptions, and methods used for the Amount That Would Have Otherwise Been Paid (AWOP) and the Capitation Rates development for the Program of All-inclusive Care for the Elderly (PACE) Contracts. The AWOP and PACE Capitation rates are periodically developed and submitted by a qualified actuary, either employed or retained by the Oregon Health Authority (OHA). The AWOP calculated for each PACE program are done in a manner that provides the best estimate of the per member per month cost of providing comparable acute medical and long-term care services to the PACE-eligible population in the PACE service area, if those eligible were not actually enrolled in PACE. PACE-eligible individuals, for the purposes of Medicaid, are persons living in a PACE service area who are age 55 years or older, meet the state's eligibility criteria for a nursing facility level of care with a service priority level (SPL) 1 - 13, and are Medicaid eligible (which excludes Medicare Savings Plan only individuals who are not Medicaid eligible, MAGI beneficiaries who are not receiving long-term services and supports, and individuals who are assessed for the first time with SPL 14 - 18).

Acute Care:

The methods, assumptions, and benefits considered in calculating the PACE acute care AWOPs are generally the same as those used to develop the Oregon Health Plan CCO capitation rates. The PACE methods also 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 are modified for the PACE-eligible population and contract period.

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

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

Program of All-inclusive Care for the Elderly (PACE) Rate Methodology and Amount That Would Have Otherwise Been Paid (AWOP) Calculation (cont.)

Acute Care (Cont):

1. The appropriate Long Term Services and Supports (LTSS) eligible population excluding PACE enrollees and their acute costs are extracted from member databases and summarized by relevant factors, such as service category and service priority level. Appropriate adjustments are made for account for data completion. Supplemental data from outside the PACE service area may be used if needed to improve credibility of results. The eligibility member months by delivery system are used in the calculation of unadjusted acute per member per month amount.
2. Trend rates are developed and applied for various service categories, eligibility groups, and delivery systems.
3. Total projected costs per member per month are calculated for selected rate groups.

Long Term Care:
The Long-Term Care (LTC) component of the PACE AWOP is developed in a similar manner to the acute care AWOP. However, the LTC services for the PACE-eligible population are only paid on a fee-for service basis. Additionally, certain services appropriate for inclusion in the AWOP, but not included in the MMIS system, were identified and their costs were included in the calculation. These included client contributions paid directly by the individuals to providers, including payments to nursing homes, assisted living, residential care facilities, memory care and adult foster homes.

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

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

Program of All-inclusive Care for the Elderly (PACE) Rate Methodology and Amount That Would Have Otherwise Been Paid (AWOP) Calculation (cont.)

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

1. The appropriate LTSS eligible population, excluding PACE enrollees and their LTSS costs, are extracted from member databases and summarized by relevant factors, such as service category and service priority level. Appropriate adjustments are made to account for data completion. Supplemental data from outside the PACE service area may be used, if needed, to improve credibility of results. The LTSS eligibility member months are used in the calculation of unadjusted LTSS per member per month amount.
2. Trend rates are developed and applied for various service categories. For certain cost categories and time periods, scheduled changes to reimbursement levels are applied in lieu of trend.
3. Total projected LTSS costs per member per month are calculated for selected groups

Final Amount That Would Have Otherwise Been Paid (AWOP):

The per member per month costs reflect the expected acute plus LTSS claims costs per person per month, plus an administrative allowance. The Administrative allowance is calculated based on the cost of processing LTSS and acute claims for the comparable population, not PACE organization administrative costs. Since PACE enrollees can come from either fee-for-service or CCOs, costs are blended based on the distribution of PACE eligible member months between the delivery systems. Smoothing or credibility enhancement techniques, including development of rate cells, may be applied to mitigate the effects of small populations in certain cohorts. The rate cells for which an AWOP is calculated match the rate cells for which capitation payments are developed. AWOPs are then calculated from a blend of actual or projected PACE enrollment by rate cell. A percentage of the resulting AWOPs is used to calculate the PACE capitation rates. The PACE rates may vary by Medicare eligible status to account for the difference in cost due to Medicare coverage.

In addition to the prospective monthly capitation payment, the state may make a retrospective supplemental per member per month payment to a PACE organization if it meets specified performance measures for the reporting period. The State ensures the combined per member per month PACE capitation rate and the supplemental per member per month performance incentive payment will be less than the AWOP for each eligibility category.