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State/Territory Name: Oregon

State Plan Amendment (SPA) #: 22-0029

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

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

Medicaid and CHIP Operations Group

March 6, 2023

James Schroeder, Interim Director
Oregon Health Authority
500 Summer Street Northeast, E15
Salem, OR 97301-1097

RE: Approval of Oregon State Plan Amendment (SPA) Transmittal Number 22-0029

Dear Mr. Schroeder:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of Oregon State Plan Amendment (SPA) Transmittal Number OR-22-0029. This amendment proposes to continue flexibilities granted in the Oregon 1915(j) Self-Directed Personal Assistance Services beyond the end of the COVID-19 Public Health Emergency (PHE).

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations. This letter is to inform you that Oregon Medicaid SPA Transmittal Number 22-0029 is approved. The Self-Directed Personal Assistance Services flexibilities were initially authorized through Disaster Relief SPA OR-20-0009 effective March 1, 2020. Therefore, the effective date of this SPA, that is permanently waiving the three consecutive months of tenancy as a condition of eligibility, adding any changes to the service plan that include a change in the care setting must have the review of a case manager and including when the state may utilize the risk assessment and monitoring instrument by telehealth, will be the day after the COVID-19 Public Health Emergency (PHE) ends on May 12, 2023. A copy of the approved State Plan pages and the signed CMS-179 form are enclosed.

If you have any additional questions concerning this information, please contact me or your staff may contact Carshena Harvin at (206) 615-2400 or by email at Carshena.Harvin@cms.hhs.gov. We appreciate the efforts of you and your staff in responding to the needs of the residents of the State of Oregon and the health care community.

Sincerely,

[redacted]

George P. Failla, Jr., Director
Division of HCBS Operations and Oversight

cc: Dana Hittle, OHA
Chris Pascual, OHA
Jesse Anderson, OHA
Annese Abdullah-Mclaughlin, CMS
Nikki Lemmon, CMS
Bill Vehrs, CMS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 22-0029

2. STATE: OR

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
One day after the end of PHE

5. FEDERAL STATUTE/REGULATION CITATION
1915(j) Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ 0
b. FFY _____ $ _____

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Supplement 3 to Attachment 3.1-A, pages 5, 10, 20~~-22~~ (P&I)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Supplement 3 to Attachment 3.1-A, pages 5, 10, 20~~-22~~ (P&I)

9. SUBJECT OF AMENDMENT
This transmittal is being submitted to continue some provisions submitted for the COVID-19 PHE period, this will continue those past the PHE period.

10. 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Dana Hittle

13. TITLE
Interim Medicaid Director

14. DATE SUBMITTED
12/30/22

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

ATTN: Jesse Anderson, State Plan Manager

FOR CMS USE ONLY

16. DATE RECEIVED
12/30/22

17. DATE APPROVED
3/6/2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
5/12/2023

19. SIGNATURE OF APPROVIN
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
George P. Failla, Jr.

21. TITLE OF APPROVING OFFICIAL
Director, Division of HCBS Operations and Oversight

22. REMARKS
2/23/2023 - State authorized P&I change to blocks 7 and 8

FORM CMS-179 (09/24)

Instructions on Back

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

1915(j) Self-Directed Personal Assistance Services

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 State plan attendant care services 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

Please list 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.

Consumers must demonstrate the ability to assess and plan for care by maintaining a stable living situation, defined as continuous tenancy at a given residence for the past three months. If health issues or a no-fault situation has prompted a move within the past three months, proof of any three consecutive months of tenancy during the past year is acceptable. The state may waive the three consecutive months of tenancy as a condition of eligibility for the IC program.

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 IC Program, disenrolled and transitioned to another program that may better meet his or her care needs.

The provider of services may be related by blood or marriage.

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

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

Please describe safeguards in place, when States 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. Any changes to the service plan that include a change in the care setting must have the review of a case manager.

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

xi. Quality Assurance and Improvement Plan

Please describe the State's quality assurance and improvement plan, 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

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

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

D. Please describe how the State will ensure 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.

Local APD and AAA case managers have the responsibility for assessing the individual's level of care and developing a plan of care in accordance with the individual's choice of services to be provided. The case manager must address all of the met or unmet needs of the participant through the assessment and provide the participant with a copy of the service plan for signature by all parties for the authorized services. The case manager will consult with the participant every six months to reassess, review and verify 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 requests.

The state may utilize the risk assessment and monitoring instrument by telehealth if:

- o The participant agrees to participate in this manner; and
- o The case manager will determine if An in-person evaluation is not considered necessary in order to properly assess or monitor.

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.