Table of Contents

State/Territory Name: Oregon

State Plan Amendment (SPA) #: 23-0007

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

April 20, 2023

David Baden, Interim Director
Oregon Health Authority
500 Summer Street Northeast, E-15
Salem, OR 97301-1079

RE: Oregon State Plan Amendment (SPA) Transmittal Number OR-23-0007

Dear Mr. Baden:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) OR-23-0007. This amendment was submitted to align the state plan with current law and clinical practice related to transplants and to streamline, minimizing duplicative content.

We conducted our review of your submittal according to statutory requirements at 1903(i)(1) of the Social Security Act and implementing regulations at 42 CFR 441.35. This letter is to inform you that OR-23-0007 was approved on April 20, 2023, with an effective date of January 1, 2023.

If there are any questions concerning this approval, please contact me or you may contact Nikki Lemmon at Nicole.Lemmon@cms.hhs.gov or at 303-844-2641.

Sincerely,

[redacted]
Digitally signed by James G. Scott -S
Date: 2023.04.20 14:22:48 -05'00'

James G. Scott, Director
Division of Program Operations

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: 23-0007

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: 1/1/23

5. FEDERAL STATUTE/REGULATION CITATION
1903(i)(1) of the Act, 42 CFR 441.35

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ 0
b. FFY 2024 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-E, page 1 through 4

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-E, page 1 through 4

9. SUBJECT OF AMENDMENT
This transmittal is being submitted to align the HERC List, and SPA with current law and clinical practice related to transplants and to streamline, minimizing duplicative content.

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
Medicaid Director

14. DATE SUBMITTED
2/28/23

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
2/28/23

17. DATE APPROVED
April 20, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
1/1/23

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]
Digitally signed by James G. Scott -S
Date: 2023.04.20 14:23:27 -05'00'

20. TYPED NAME OF APPROVING OFFICIAL
James G. Scott

21. TITLE OF APPROVING OFFICIAL
Director, Division of Program Operations

22. REMARKS

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

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

General Coverage standards:

Transplant services, including inpatient and outpatient pre-and post-operative medical, surgical hospital, and related transportation services are covered for eligible beneficiaries when medically necessary.

The following standards apply to all transplant services:

a. The recipient must be enrolled in the Oregon Health Plan at the time the service is provided and must have the OHP Plus (full Medicaid) benefit Package;
b. Services are reasonable in amount, duration, and scope to achieve their purpose;
c. Similarly situated individuals are treated alike;
d. Provided in a Medicare approved transplant center and be an enrolled provider with Oregon's Medical Assistance Program;
e. Transplants must be medically necessary and meet the requirements for physician and hospital services. No payment is made for any transplant not specifically listed below, except for the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) population of Medicaid eligible children under the age of 21, for whom services are furnished based on medical necessity.

The following types of transplants and transplant-related procedures are covered under Oregon's Medical Assistance program subject to the standards and criteria determined by the Health Evidence Review Commission (HERC) Prioritized List of Health Services guideline notes:

(a) Bone Marrow;
(b) Cord blood;
(c) Cornea;
(d) Heart or combination Heart-Lung;
(e) Intestine;
(f) Kidney;
(g) Liver or combination Liver-Kidney;
(h) Lung single or bilateral
(i) Pancreas or combination Pancreas- Kidney;
(j) Peripheral Stem Cell, Autologous and Allogeneic,
(k) Any other transplants the Health Evidence Review Commission (HERC) determine are to be added to the HERC Prioritized List of Health Services guideline notes.

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

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

When services are available in the state of Oregon, reimbursement will not be made to out-of-state transplant centers unless any of the conditions at 42 CFR 431.52(b) are met and all other criteria for a transplant are met.

Out-of-state centers will be considered if one of the following criteria exists:

(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) An in-state transplant center requests the out-of-state transplant referral;

(3) A contiguous out-of-state transplant center has a contract or special agreement with Oregon;

(4) It would be cost effective as determined by OHA. 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.

Donor services:

Donor expenses incurred directly in connection with a covered transplant are payable. Expenses incurred for complications that arise with respect to the donor are covered only if they are directly and immediately attributed to the surgery.

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

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

Non-Covered Transplant Services:

The following types of transplants are not covered by the Oregon Medical Assistance program:

a) Any transplants not listed in this state plan;
b) Transplants that are considered experimental or investigational, or which are performed on an experimental or investigational basis, as determined by the Health Evidence Review Commission (HERC) and/or Oregon's Medical Assistance program.

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

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

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