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State/Territory Name: **Oregon**

State Plan Amendment (SPA) #: **OR-25-0023**

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Service
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

December 17, 2025

Dr. Emma Sandoe
Medicaid Director
Oregon Health Authority
500 Summer Street Northeast, E-65
Salem, OR 97301-1079

RE: Oregon §1915(k) Community First Choice State Plan Amendment (SPA) OR-25-0023 and 1915(b)(4) Waiver Amendment for OR-0011.R02.01

Dear Dr. Sandoe:

The Centers for Medicare and Medicaid Services (CMS) is approving Oregon's request to amend its 1915(k) Community First Choice (CFC) state plan benefit submitted under transmittal number OR-25-0023. This amendment updates State Plan language regarding the Community First Choice program to add Agency with Choice as a service delivery model. CMS conducted a review of the state's submittal according to statutory requirements in Title XIX of the Social Security Act and relevant federal regulations. Enclosed is a copy of the approved state plan amendment (SPA).

This SPA is approved with a January 1, 2026, effective date.

It is important to note that CMS' approval of this 1915(k) CFC amendment solely addresses the state's compliance with the applicable Medicaid authorities. CMS' approval does not address the state's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, §504 of the Rehabilitation Act, or the Supreme Court's Olmstead decision. Guidance from the Department of Justice concerning compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

Concurrently, CMS is approving Oregon's request to amend its 1915(b)(4) Fee-for-Service (FFS) Selective Contracting Waiver, CMS control number OR-0011.R02.01, titled APD Case Management and Agency with Choice Freedom of Choice. This waiver allows Oregon to limit contracting with two Agency with Choice providers. This 1915(b) waiver is authorized under section 1915(b)(4) of the Social Security Act.

Our decision is based on the evidence submitted to CMS demonstrating that the state's proposal is consistent with the purposes of the Medicaid program, will meet all the statutory and regulatory requirements for assuring beneficiaries' access to and quality of services, and will be a cost-effective means of providing services to enrollees under this waiver.

The 1915(b)(4) waiver, OR-0011.R02, is effective for one year beginning January 1, 2026 through December 31, 2026. The state may request renewal of this waiver authority by providing evidence and documentation of satisfactory performance and oversight. Oregon's request that this waiver authority be renewed should be submitted to CMS no later than October 2, 2026.

We appreciate the cooperation and effort provided by you and your staff during the review of these concurrent actions. If you have any questions concerning this information, please contact Carshena Harvin at (206) 615-2400 or via email at Carshena.Harvin@cms.hhs.gov for the 1915(k) or Chandni Patel at 410-786-4970 or via email at Chandni.Patel@cms.hhs.gov for the 1915(b)(4).

Sincerely,

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

Division of Managed Care Operations

Cc:
Jesse Anderson, OHA
Donny Jardine, OHA
Beth Jackson, OHA
Dominique Mathurin, CMS
Stephanie Sale, CMS
Matt Rodriguez, CMS
Rebecca Nehrt-Flores, CMS
James Moreth, CMS
Bill Vehrs, CMS
Kevin Patterson, 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: 25-0023

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: 1/1/26

5. FEDERAL STATUTE/REGULATION CITATION
1915(k), 42 CFR 441.500-590

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2026 $ 2,645,685
b. FFY 2027 $ 3,527,580

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-k, page 3, 3.a (NEW) (P&I), and 32
Attachment 4.19-B, page 20, 21, 22 (P&I) ~~through~~ 22a (NEW)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-k, page 32
Attachment 4.19-B, page 20, 21, 22 (P&I) ~~through 22a~~

9. SUBJECT OF AMENDMENT
This transmittal is being submitted to revise the 1915(k) Community First Choice to include Agency with Choice model.

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

12. TYPED NAME
Emma Sandoe, PhD

13. TITLE
Medicaid Director

14. DATE SUBMITTED
9/29/25

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
9/29/25

17. DATE APPROVED
12/17/2025

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
01/01/2026

19. SIGNATURE OF APPROVING OFFICIAL
Digitally signed by George

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

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

22. REMARKS
12/2/25: P&I change to block 7 and 8 authorized
12/3/25: P&I change to block 7 and 8 authorized
12/12/25: P&I change to block 7 authorized

Instructions on Back

INSTRUCTIONS FOR COMPLETING FORM CMS-179

Use Form CMS-179 to transmit State plan material to the Center for Medicaid & CHIP Services for approval. Submit a separate typed transmittal form with each plan/amendment.

Block 1 - Transmittal Number - Enter the State Plan Amendment transmittal number. Assign consecutive numbers on a **calendar year** basis with the first two digits being the two-digit year (e.g., 21-0001, 21-0002, etc.). Because states have different state fiscal years, a calendar year is required for consistency.

Block 2 - State - Enter the two-letter abbreviation code of the State/District/Territory submitting the plan material.

Block 3 - Program Identification - Enter the applicable Title of the Social Security Act (Title XIX Medicaid or Title XXI CHIP).

Block 4 - Proposed Effective Date - Enter the proposed effective date of material. The effective date of a new plan may not be earlier than the first day of the calendar quarter in which an approvable plan is submitted. With respect to expenditures for assistance under such plan, the effective date may not be earlier than the first day on which the plan is in operation on a statewide basis or earlier than the day following publication of notice of changes.

Block 5 - Federal Statute/Regulation Citation - Enter the appropriate statutory/regulatory citation.

Block 6 - Federal Budget Impact - 6(a) - IN WHOLE DOLLARS, NOT IN THOUSANDS, Enter 1st **Federal Fiscal Year** (FFY) impacted by the SPA & estimated Federal share of the cost of the SPA for 1st FFY. The first FFY should be the FFY inclusive of the earliest effective date of any amended payment language; **6 (b) -** Enter 2nd FFY impacted by the SPA & estimated Federal share of the cost for 2nd FFY. In general, the estimates should include any amount not currently approved in the state's plan for assistance.

Block 7 - Page No.(s) of Plan Section or Attachment - Enter the page number(s) of plan material amended and transmitted. If additional space is needed, use bond paper. **New pages** should be included in Block 7, but not in Block 8.

Block 8 - Page No.(s) of the Superseded Plan Section or Attachment (if Applicable) - Enter the page number(s) (including the transmittal number) that is being superseded. If additional space is needed, use bond paper. **Deleted pages** should be included in Block 8, but not in Block 7.

Block 9 - Subject of Amendment - Briefly describe plan material being transmitted.

Block 10 - Governor's Review - Check the appropriate box. See SMM section 13026 A.

Block 11 - Signature of State Agency Official - Authorized State official signs this block.

Block 12 - Typed Name - Type name of State official who signed block 11.

Block 13 - Title - Type title of State official who signed block 11.

Block 14 - Date Submitted - Enter the date that the state transmits plan material to CMCS. Unless the state officially withdraws this SPA and then resubmits it, this date should not be revised. Documentation of version revisions will be maintained in the CMCS administrative record.

Block 15 - Return To - Type the name and address of State official to whom this form should be returned.

Block 16–22 (FOR CMS USE ONLY).

Block 16 - Date Received - Enter the date plan material is received by CMCS. This is the date that the submission is received by CMCS via the subscribed submission process.

Block 17 - Date Approved - Enter the date CMCS approved the plan material.

Block 18 - Effective Date of Approved Material - Enter the date the plan material becomes effective. If more than one effective date, list each provision and its effective date in Block 22 or attach a sheet.

Block 19 - Signature of Approving Official - Approving official signs this block.

Block 20 - Typed Name of Approving Official - Type approving official's name.

Block 21 - Title of Approving Official - Type approving official's title.

Block 22 - Remarks - Use this block to reference and explain agreed to changes and strike-throughs to the original CMS-179 as submitted, a partial approval, more than one effective date, etc. If additional space is needed, use bond paper.

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

Community First Choice State Plan Option

For Individuals eligible under section 1902(a) (10)(A)(ii)(VI) of the Act who continue to meet all of the 1915(c) waiver requirements and who are receiving at least one 1915(c) waiver service a month, excess income determined under 42 C.F.R. 435.726 is applied, in addition to the cost of 1915(c) waiver services, to the cost of 1915(k) services. Therefore, excess income is applied to both 1915(c) waiver and 1915(k) services.

The LOC assessment is just one step in the planning process. Another step is the functional needs assessment that identifies the needs of the individual that must be addressed to ensure their safety and well-being and to ensure that individuals do not become unnecessarily institutionalized. The person-centered service plan (PCSP) that is individualized to address the individual's strengths, supports, goals and ensures their independence, dignity and well-being, is also completed.

ii. Service Delivery Models

☒ Agency Model - The Agency Model is based on the person-centered assessment of need. The Agency Model is a delivery method in which the services and supports are provided by entities under a contract. Individuals may select either a traditional agency-provider service delivery model or an agency-provider with choice service delivery model.

☐ Self-Directed Model with service budget – This Model is one in which the individual has both a service plan and service budget based on the person-centered assessment of need.

____ Direct Cash
____ Vouchers
____ Financial Management Services in accordance with 441.545(b) (1).
____ Other Service Delivery Model as described below:

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

Community First Choice State Plan Option

iii. Service Package

A. The following are included CFC services (including service limitations):

Attendant services and supports assist in accomplishing activities of daily living, instrumental activities of daily living and health related tasks through hands-on assistance, supervision, or cueing.

Services may be provided in the individual's home through enrolled homecare workers, personal support workers, in-home agencies or in a licensed, certified or endorsed community programs/settings of their choice.

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

Community First Choice State Plan Option

viii. Qualifications of Providers of CFCO Services

Adult Day Providers- Licensing and certification requirements are OAR 411-066-0000 through 411-066-0015. Adult Day Service (ADS) programs that contract with the Department to provide services must be certified.

Adult Foster Care- - Licensing requirements at OAR 411-050-0600 – 0690 OAR 309-040-0030 through 309-040-0330; and 411-360-0010 through 411-360-0310. Local CDDPs, Branch offices, DHS Central Office, and OHA/HSD are responsible for verification of provider qualifications upon initial license and annual renewal.

Adult Group Home- Contracted and State Operated Licensing requirements at OAR 411-325-0010 through 411-325-0480 and agency certification requirements at OAR 411-323-0010 through 411-323-0070. DHS Central Office is responsible for verification of provider qualifications biennially.

Agency with Choice (AwC) Providers- Licensing requirements at OAR 411-039-0000 through 411-039-0270. AwC providers that contract with the Department to provide services must be licensed by the Department.

Assisted Living Facility- Licensing requirements at OAR 411-054-0000-0300. The DHS Client Care Monitoring Unit is responsible for verification of provider qualifications at initial license and renewal (every 2 years).

Behavior Support Service Providers- Behavior consultants are certified by the state or approved by a Department Designee. The Department is responsible for verification of provider qualifications initially and at least every 5 years.

Children's Developmental Disability Foster Care- Certification requirements at OAR 411-346-0100 through 411-346-0230 or 413-200-0300 through 413-200-0396. DHS, Office of Developmental Disabilities Services (ODDS) or Child.

Children's Developmental Disability Host Home—Children's Developmental Disability Host Homes Programs are certified and endorsed by the state. DHS Central Office is responsible for verification of provider qualifications initially and biennially thereafter.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Community First Choice State Plan Option

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of services provided under the Community First Choice Option. The agency's fee schedule rate was set as of January 1, 2026 and is effective for services provided on or after that date. All rates are published on the agency website:
Aging and People with Disabilities (APD) Rates are published at:
https://www.oregon.gov/odhs/providers-partners/seniors-disabilities/Documents/rate-schedule.pdf

Office of Developmental Disabilities Services (ODDS) rate are published at
https://www.oregon.gov/odhs/providers-partners/idd/Documents/odds-expenditure-guidelines.pdf

The following 1915(k) provider types are reimbursed in the manner described:

Assisted Living Facility- Assisted Living Facility rates are established based upon market conditions designed to assure adequate access to services for beneficiaries. Assisted Living Facilities rates are paid based on the individual's assessed needs. The individual's needs result in a reimbursement in one of 5 payment levels. The different payment levels reflect the individual's acuity and ADL needs as follows:

Level 1 -- All individuals qualify for Level 1 or greater.

Level 2 -- Individual requires assistance in cognition/behavior AND elimination or mobility or eating.

Level 3 -- Individual requires assistance in four to six activities of daily living OR requires assistance in elimination, eating and cognition/behavior.

Level 4 -- Individual is full assist in one or two activities of daily living OR requires assistance in four to six activities of daily living plus assistance in cognition/behavior.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Community First Choice State Plan Option

Home Accessibility Adaptations Providers- A scope of work is created for the adaptation. From the scope of work, bids or estimates of the cost of the adaptation are received from multiple qualified providers. The provider who submits the most cost-effective bid or estimate is chosen to complete the home adaptation.

Home Delivered Meal Providers- Home Delivered Meal rates are established utilizing detailed cost reports. The Department conducts an analysis of the cost reports. A weighted average is used to determine a statewide reimbursement rate.

Homecare and Personal Support Workers- Reimbursement rates for Home Care Workers and Personal Support Workers that provide In-Home services are collectively bargained through the Department of Administrative Services on behalf of the Department of Human Services with the Service Employees International Union. These rates are set based on a bargaining agreement at 2-year intervals. Mileage reimbursement is collectively bargained, as well.

Community Transportation Providers- Contract rates for transportation brokerages are individually negotiated with the provider. The rates are based on a cost allocation model supplied by each transportation brokerage.

APD Adult Foster Care- Medicaid reimbursement rates for APD Adult Foster Home providers are collectively bargained through the Department of Administrative Services on behalf of the Department of Human Services with the Service Employees International Union. These rates are set based on a bargaining agreement at two-year intervals. The collective bargaining process is a public process.

APD Adult Foster Homes and Residential Care Facilities- will be paid based upon the assessed acuity of the individual. Based on the individual's assessment, the individual will receive points for Activities of Daily Living, Instrumental Activities of Daily Living and Health Related Tasks.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Community First Choice State Plan Option

APD Adult Foster Homes and Residential Care Facilities (Cont)- Individuals with the lowest need will receive one (1) point, while those with the highest need will receive five (5) points per each assessed ADL, IADL and Health Related Task. Additional points will be provided for individuals with high needs driven by cognitive impairments.

- Points will be converted to Tiers based on the sum of all needs.
- Providers will receive a payment based on the individual's corresponding Tier needs.

Transferring Scores to Rates

Assessed Levels	**Score Ranges**	**Level**
Low	0 – 40	Tier 1
Moderate	41 – 55	Tier 2
Medium High	56 – 82	Tier 3
High	83 – 106	Tier 4
Very High	107 +	Tier 5

DD Children's Foster Care- A functional needs assessment is used to measure the support needs of an individual and determine rates for Adult FC and CDDFC based on those assessed needs.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Community First Choice State Plan Option

DD Children's Foster Care (Cont)
Based on the answer selection, the functional needs assessment will then calculate a rate for the individual commensurate with the level of identified need. The rates from the various support needs area categories are then totaled to get an overall FC service rate. The rate structure is designed to fall within rate ranges based on groupings of level of need. There is a process for specific rate increases by exception if there is an identified need that is outside the standard assessment parameters, such as 2:1 support for a specific support task.

DD Children's Host Home- Each individual's support needs are assessed using a functional needs assessment. Changes in an individual's support needs may be identified during regularly scheduled monitoring visits, annual LOC redeterminations, annual ISP meetings, and when changes are brought to the person-centered plan coordinator's attention, an individual's provider of service, family member, friend or member of the community. The rate setting methodology incorporates other payroll expenditures (OPE), allowable administration percentages, and other costs associated with operating this service.

DD Adult Foster Care- The functional needs assessment is used to measure the support needs of an individual and determine rates for Adult FC and CDDFC based on those assessed needs.

Based on the answer selection, the functional needs assessment will then calculate a rate for the individual commensurate with the level of identified need. The rates from the various support needs area categories are then totaled to get an overall FC service rate. The rate structure is designed to fall within rate ranges based on groupings of level of need. There is a process for specific rate increases by exception if there is an identified need that is outside the standard assessment parameters, such as 2:1 support for a specific support task.