

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>	1. TRANSMITTAL NUMBER: <b>01-06</b>	2. STATE <b>Oregon</b>
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) <b>Medical Assistance</b>	
FOR: <b>HEALTH CARE FINANCING ADMINISTRATION</b>		
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE <b>April 1, 2001</b> <i>January 1, 2001 (PFI)</i>	

FILE COPY APR - 2 2001

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: <b>Medicare, Medicaid, and SCHIP Benefits Improvement &amp; Protection Act of 2000 (BIPA)</b>	7. FEDERAL BUDGET IMPACT: a. FFY 2001 \$ <del>250,000</del> <b>125,000</b> (PFI) b. FFY 2002 \$ <del>0</del> <b>125,000</b>
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>Section 3.1-A, pages 1-b and 1-c (PFI)</b>	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  <b>Section 3.1-A, page 1-b</b>

10. SUBJECT OF AMENDMENT:  
**This transmittal is submitted to implement the new Medicaid prospective payment system for RHCs to accommodate the BIPA requirements.**

11. GOVERNOR'S REVIEW (Check One):

GOVERNOR'S OFFICE REPORTED NO COMMENT       OTHER, AS SPECIFIED:  
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL      **Per Attachment 7.3A**

12. SIGNATURE OF STATE AGENCY OFFICIAL: <i>Hersh Crawford</i> <i>Bobby Mink</i>	16. RETURN TO:  Office of Medical Assistance Programs Department of Human Services 500 Summer Street NE, 3rd Floor Salem, OR 97310  ATTN: Carole Van Eck
13. TYPED NAME: <b>Hersh Crawford</b> <b>Bobby Mink</b>	
14. TITLE: <b>Administrator, OMAP</b> <b>Director, DHS</b>	
15. DATE SUBMITTED: <b>3-29-01</b>	

FOR REGIONAL OFFICE USE ONLY	
17. DATE RECEIVED: <b>APR - 2 2001</b>	18. DATE APPROVED: <b>APR 29 2001</b>
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>JAN 1 2001</b>	20. SIGNATURE OF REGIONAL OFFICIAL: <i>[Signature]</i>
21. TYPED NAME: <b>JERRA H. TRUBLE</b>	22. REGIONAL OFFICE: <b>REGION OF MEDICAL ASSISTANCE</b>
23. REMARKS: <b>PFI changes authorized by the state</b> <b>3/30/01</b> <b>Salem</b> <b>(DATE)</b> <b>(CITY)</b>	

LIMITATIONS OF SERVICES (Continued)

b. Rural Health Clinic Services

Rural Health Clinic Services (RHC) is limited to otherwise covered services provided by licensed physicians and/or certified nurse practitioners in Rural Health Clinics certified by the Department of Health and Human Services. In addition to the above provider types, Maternity Case Management (MCM) services provided through a Rural Health Clinic may be provided by physician assistant, certified nurse midwife, direct entry midwife, social worker, or a registered nurse with a minimum of two years related and relevant work experience employed by the Rural Health Clinic. Specific services not within the recognized scope of practice of the provider of MCM services must be referred to an appropriate discipline.

c. Federally Qualified Health Center (FQHC) Services

Limited to ambulatory services.

3. Clinical laboratory and pathology services and procedures\*

\*performed by any provider are reimbursable only after the provider is certified by HCFA as meeting the requirements of the Clinical Laboratory Improvement Amendments of 1988 (CLIA) and HCFA has notified OMAP of the assignment of a ten-digit CLIA number. Enforcement of compliance with CLIA requirements will occur only after notification in writing from HCFA.

\*are provided subject to the rules and procedures set forth in the Medical-Surgical Services Administrative Rules and Billing Instructions for Oregon Medical Assistance Programs

TN # 01-06  
SUPERSEDES  
TN # 92-18

DATE APPROVED 6-29-01  
EFFECTIVE DATE April 1, 2001  
January 1, 2001 (P+D)