

WRIS MAN

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
03-11

2. STATE
Oregon

FOR: HEALTH CARE FINANCING ADMINISTRATION

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
October 1, 2003

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 \$ -0-
b. FFY \$ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
19b, 19c, 20b
Attachment 3.1-A, page 10; Attachment 3.1-B, page 10
Supplement 2 to Attachment 3.1-A, pages 1-6
*Attachment to Supplement 2 to Attachment 3.1A,
pages 1-3*

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):
19b and 20b

10. SUBJECT OF AMENDMENT:

This transmittal is being submitted to establish the Program of All-Inclusive Care for the Elderly (PACE) in the state plan.

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:
Per Attachment 7.3A

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Lynn Read, Jean I. Thorne

14. TITLE: Administrator, OMAP Director, DHS

15. DATE SUBMITTED: 5-16-03

16. RETURN TO:

Office of Medical Assistance Programs
Department of Human Services
500 Summer Street NE, 3rd Floor, E35
Salem, OR 97301

ATTN: Carole Van Eck

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: MAY 21 2003

18. DATE APPROVED: SEP 26 2003

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVAL: OCT 1 2003

20. SIGNATURE OF REGIONAL OFFICIAL: 151

21. TYPED NAME: Karen S. O'Connor

22. TITLE: Associate Regional Administrator
Division of Medicaid &

23. REMARKS: *Per Inc changes authorized by the state on 10/12/03.*

TESTIMONIAL: 5/19 • Salem

*Approved: 09/26/03
effective: 10/01/03*

Revision: HCFA-PM-91-4 (BPD) Transmittal #03-11
 August 1991 OMB No.: 0938-

State/Territory: OREGON

<u>Citation</u> <u>Needy</u>	3.1(a)(1)	<u>Amount, Duration, and Scope of Services: Categorically</u> <u>(Continued)</u>
		(vi) Home health service are provided to individuals entitled to nursing facility services as indicated in item 3.1(b) of this plan.
1902(e)(7) of the Act		(vii) Inpatient services that are being furnished to infants and children described in section 1902(l)(1)(B) through (D), or Section 1905(n)(2) of the Act on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished.
1902(e)(9) of the Act	—	(viii) Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.
1902(a)(52) section and 1925 of the Act		(ix) Services are provided to families eligible under 1925 of the Act as indicated in item 3.5 of this plan.

TN No. 03-11
 Supersedes TN No. 91-25

Approval Date

Effective Date 10/1/03

HCFA ID: 7982E

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

State/Territory: OREGON

Citation 3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)

1902(e)(9) of Act _____ (ix) Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.

1905(a)(26) and 1934 _____ Program of all-inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-B identifies services provided to each covered group of the medically needy. (NOTE: Other programs to be offered to Medically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Medically Needy beneficiaries would also list the additional coverage - that is in excess of established service limits - for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

TN No. 03-11
Supersedes TN No. 91-25

Approval Date

Effective Date 10/1/03

HCFA ID: 7982E

Revision: HCFA-PM-94-9 (MB)
DECEMBER 1994

Transmittal #03-11
Attachment 3.1-A
Page 10

State OREGON

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

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

 provided X not provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (c) furnished in a home.

X Provided: X State Approved (Not Physician) Service Plan Allowed
 X Services outside the Home Also Allowed
 X Limitations Described on Attachment

 Not Provided.

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 2 to Attachment 3.1-A.

X Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

 No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

TN No. 03-11
Supersedes TN No. 91-25

Approval Date

Effective Date 10/1/03

State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Aged, Blind, Disabled

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

Provided Not Provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home setting.

Provided: State Approved (Not Physician) Service Plan Allowed
 Services Outside the Home Also Allowed
 Limitations Described on Attachment

Not provided.

27. Program of Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 2 to Attachment 3.1-A.

Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

State of Oregon

Name and address of State Administering Agency, if different from the State Medicaid Agency.

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 in regulations). 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:

(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.)

In accordance with Appendix C, page 2, item b. of Oregon's Home and Community Based Waiver (#0185.90 R2), the applicable group is the group of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are those individuals with a special income level equal to 300% of the SSI Federal benefit (FBR).

- 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(s).

TN No. 03-11
Supersedes TN No. 03-04

Approval Date

Effective Date 10/1/03

Regular Post Eligibility

1. SSI State. The State is using the post-eligibility rules at 42 CFR 435.726.
Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

- (a). Sec. 435.726--States which do not use more restrictive eligibility requirements than SSI.

1. Allowances for the needs of the:

(A.) Individual (check one)

1. The following standard included under the State plan (check one):

- (a) SSI
(b) Medically Needy
(c) The special income level for the institutionalized
(d) Percent of the Federal Poverty Level: _____ %
(e) Other (specify): SSI + state supplement

2. The following dollar amount: \$ _____
Note: If this amount changes, this item will be revised.

3. The following formula is used to determine the needs allowance:

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B.) Spouse only (check one):

1. SSI Standard
2. Optional State Supplement Standard
3. Medically Needy Income Standard
4. The following dollar amount: \$ _____
Note: If this amount changes, this item will be revised.

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6. The amount is determined using the following formula:
The amount allowed in Sec. 1924 of the Act _____
-
7. Not applicable (N/A)

(C.) Family (check one):

1. AFDC need standard
2. Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. The following dollar amount: \$ _____
Note: If this amount changes, this item will be revised.
4. The following percentage of the following standard that is not greater than the standards above: _____ % of _____ standard.
5. The amount is determined using the following formula:

6. Other _____
7. Not applicable (N/A)

(2). Medical and remedial care expenses in 42 CFR 435.726.

Regular Post Eligibility

2. 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) 42 CFR 435.735--States using more restrictive requirements than SSI.

1. Allowances for the needs of the:
(A.) Individual (check one)

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TN No. 03-11
Supersedes TN No.

Approval Date

Effective Date 10/1/03

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B.) Spouse only (check one):

1. The following standard under 42 CFR 435.121:

2. The Medically needy income standard

3. The following dollar amount: \$ _____

Note: If this amount changes, this item will be revised.

4. The following percentage of the following standard that is not greater than the standards above: _____ % of _____ standard.

5. The amount is determined using the following formula:

6. Not applicable (N/A)

(C.) Family (check one):

1. AFDC need standard

2. Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. The following dollar amount: \$ _____

Note: If this amount changes, this item will be revised.

4. The following percentage of the following standard that is not greater than the standards above: _____ % of _____ standard.

5. The amount is determined using the following formula:

6. Other

7. Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.