Table of Contents

Section 1 –

- Single State Agency Organization
  - Designation and Authority
    - *Single State Agency*
    - *Attorney General Certificate*
    - *Administration of the Medicaid Program*
  - Intergovernmental Cooperation Act Waivers
  - Eligibility Determinations and Fair Hearings
    - *Eligibility*
    - *Fair Hearings*
    - *Evidentiary Hearings*
  - Organization and Administration
    - *Description of the Organization and Functions of the Single State Agency*
    - *Entities that Determine Eligibility or Conduct Fair Hearings Other than the Medicaid Agency*
    - *Coordination with Other Executive Agencies*
  - Single State Agency Assurances
- Tribal Consultation Requirements
- **1.5** - Pediatric Immunization Program
- S10 Modified Adjusted Gross Income (MAGI) - Based Income Methodologies
  - S14 Aid to Families with Dependent Children (AFDC) Income Standards
    - *MAGI-Equivalent AFDC Payment Standard in Effect As of May 1, 1988*
      - *S13a Income Standard Entry – Dollar Amount – Automatic Increase Option*
    - *MAGI-Equivalent AFDC Payment Standard in Effect As of May 1, 1996*
      - *S13a Income Standard Entry – Dollar Amount – Automatic Increase Option*
    - *AFDC Need Standard in Effect As Of July 16, 1996*
      - *S13a Income Standard Entry – Dollar Amount – Automatic Increase Option*
- S21 Hospital Presumptive Eligibility
- Eligibility Groups – Mandatory Coverage
  - S25 Parents and other Caretaker Relatives
  - S28 Pregnant Women
  - S30 Infants and Children Under Age 19
  - Adult Group
- Eligibility Groups – Options for Coverage
  - S33 Former Foster Care Children
  - S50 Individuals Above 133% FPL
  - S51 Optional Coverage of Parents and Other Caretaker Relatives
  - S52 Reasonable Classification of Individuals Under Age 21
    - S11 Reasonable Classification of Children
      - *Individuals in state custody*
      - *Individuals in public psychiatric facilities or programs*
  - S53 Children with Non IV-E Adoption Assistance
  - S54 Optional Targeted Low Income Children
  - S55 Individuals with Tuberculosis
  - S57 Independent Foster Care Adolescents

    - S59 Individuals Eligible for Family Planning Services
- Non-Financial Eligibility
    - S88 State Residency
    - S89 Citizenship and Non-Citizen Eligibility
- General Eligibility Requirements
    - S94 Eligibility Process
    - Eligibility Determinations of Individuals Age 65 or Older Who Have Blindness or a Disability

Section 2 – Coverage and Eligibility

- **2.1** - Application, Determination of Eligibility and Furnishing Medicaid
- **2.2** - Coverage and Conditions of Eligibility
    - Eligibility Groups - Mandatory Coverage
- **2.4** - Blindness
- **2.5** - Disability
- **2.6** - Financial Eligibility
- **2.7** - Medicaid Furnished Out of State

Section 3 – Services: General Provisions

- **3.1** - Amount, Duration, and Scope of Services
    - *3.1(a)*
        - *(1) Categorically Needy*
        - *(2) Medically Needy*
        - *(3-4) Other Required Special Groups: Qualified Medicare Beneficiaries, Qualified Disabled and Working Individuals, Specified Low-Income Medicare Beneficiaries, Qualifying Individuals*
        - *(5) Families Receiving Extended Medicaid Benefits*
        - *(6-10) Certain Aliens, Homeless Individuals, Ambulatory Prenatal Care, EPSDT, and Comparability of Services*
    - *3.1(b-c)* - Home Health Services, Assurance of Transportation, and Payment for Nursing Facility Services
    - *3.1(d)* - Methods and Standards to Assure Quality of Services
    - *3.1(e)* - Family Planning Services
    - *3.1(f)* - Optometric Services, Organ Transplant Procedures
    - *3.1(g-h)* - Participation by Indian Health Service Facilities, Respiratory Care Services for Ventilator-Dependent Individuals
- **3.2** - Coordination of Medicaid with Medicare and Other Insurance
    - *3.2(a)* Premiums - Medicare Part A and Part B
    - *3.2(b)* Deductibles/Coinsurance - Medicare Part A and Part B
- **3.3** - Medicaid for Individuals Age 65 or Over in Institutions for Mental Diseases
- **3.4** - Special Requirements Applicable to Sterilization Procedures
- **3.5** - Families Receiving Extended Medicaid Benefits
- **3.8** - Additional Amounts for Nursing Facility Residents

Section 4 – General Program Administration

- **4.1** - Methods of Administration
- **4.2** - Hearings for Applicants and Recipients
- **4.3** - Safeguarding Information on Applicants and Recipients
- **4.4** - Medicaid Quality Control

- **4.5** - Medicaid Agency Fraud Detection and Investigation Program
- **4.6** - Reports
- **4.7** - Maintenance of Records
- **4.8** - Availability of Agency Program Manuals
- **4.9** - Reporting Provider Payments to the Internal Revenue Service
- **4.10** - Free Choice of Providers
- **4.11** - Relations with Standard-Setting and Survey Agencies
- **4.12** - Consultation to Medical Facilities
- **4.13** - Required Provider Agreement
    - Provider Screening and Enrollment
- **4.14** - Utilization/Quality Control
- **4.15** - Inspections of Care in Skilled Nursing and Intermediate Care Facilities and Institutions for Mental Diseases
- **4.16** - Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees
- **4.17** - Liens and Adjustments or Recoveries
    - Long Term Care Insurance Partnership
- **4.18** - Recipient Cost Sharing and Similar Charges
- **4.19** - Payment for Services
    - *4.19(a):* Inpatient hospital services
    - *4.19(b):* Federally qualified health centers (FQHCs); rural health clinics (RHCs); services except for inpatient hospital, nursing and intermediate care facility services
    - *4.19(c):* Reserve a bed during a recipient's temporary absence from an inpatient facility
    - *4.19(d):* Nursing facility services and intermediate care facility services
    - *4.19(e):* Timely payment of claims
    - *4.19(f):* Acceptance of State payment as payment in full
    - *4.19(g):* Audits
    - *4.19(h):* Documentation of access to care and service payment rates
    - *4.19(i):* Medicaid provider participation and public process to inform access to care
    - *4.19(j):* Public notice of changes in Statewide methods and standards for setting payment rates
    - *4.19(k):* Medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law
    - *4.19(m):* Medicaid Reimbursement for Administration of Vaccines under the Pediatric Immunization Program
- **4.20** - Direct Payments to Certain Recipients for Physicians' or Dentists' Services
- **4.21** - Prohibition Against Reassignment of Provider Claims
- **4.22** - Third Party Liability
- **4.23** - Use of Contracts
- **4.24** - Standards for Payments for Nursing Facility and Intermediate Care Facility
- **4.25** - Program for Licensing Administrators of Nursing Homes
- **4.26** - Drug Utilization Review Program
- **4.27** - Disclosure of Survey Information and Provider or Contractor Evaluation
- **4.28** - Appeals Process for Skilled Nursing and Intermediate Care Facilities
- **4.29** - Conflict of Interest Provisions
- **4.30** - Exclusion of Providers and Suspension of Practitioners and Other Individuals

- **4.31** - Disclosure of information by Providers and Fiscal Agents
- **4.32** - Income and Eligibility Verification System
- **4.33** - Medicaid Eligibility Cards for Homeless Individuals
- **4.34** - Systematic Alien Verification for Entitlements
- **4.35** - Remedies for Skilled Nursing and Intermediate Care Facilities that Do Not Meet Requirements of Participation
- **4.36** - Required Coordination Between the Medicaid and Women, Infants, and Children (WIC) Programs
- **4.38** - Nurse Aide Training and Competency Evaluation for Nursing Facilities
- **4.39** - Pre-admission Screening and Annual Resident Review (PASRR) in Nursing Facilities
- **4.43** - Cooperation with Medicaid Integrity Program Efforts

Section 5 – Personnel Administration

- **5.1** - Standards of Personnel Administration
- **5.2** - [Reserved]
- **5.3** - Training Programs; Subprofessional and Volunteer Programs

Section 6 – Financial Administration

- **6.1** - Fiscal Policies and Accountability
- **6.2** - Cost Allocation
- **6.3** - State Financial Participation

Section 7 – General Provisions

- **7.1** - Plan Amendments
- **7.2** - Nondiscrimination
- **7.3** - Maintenance of AFDC Efforts
- **7.4** - State Governor's Review
- **7.4** - Medicaid Disaster Relief for the Covid-19 National Emergency

Attachments

- **2.1-A**: State Plan Definition of HMO
- **2.2-A**: Mandatory Coverage
    - A. Categorically Needy and Other Required Special Groups
        - 2. Deemed Recipients of AFDC (Families and Children)
            - *2.a. Individuals denied a title IV-A cash payment*
            - *2.b. Families with Medicaid eligibility extended because of increased collection of spousal support*
            - *2.c. Children with adoption assistance, foster care, or guardianship care under title IV-E*
        - Pregnant Women, Children Under 19, and Newborn Children
            - *11.a– b. Pregnant women; Postpartum Period*
            - *12. Deemed Newborn Children*
        - 13. Aged, Blind and Disabled Individuals Receiving Cash Assistance
            - *13.a. Individuals receiving SSI*
            - *13.b. Individuals in States using more restrictive requirements for Medicaid than the SSI requirements [Page Sunset]*

- 14. Qualified severely impaired blind and disabled individuals under age 65 (Individuals with income between ages 16 and 65 with a disability)
- Individuals in States using more restrictive requirements for Medicaid than the SSI requirements [Page Sunset]
- 15-17. Individuals in States using more restrictive requirements for Medicaid than the SSI requirements; Individuals who are ineligible for SSI or optional State supplements because of requirements that do not apply under title XIX of the Act; Individuals receiving mandatory State supplements [Page Sunset]
- 18. Individuals eligible as essential spouses in December 1973
- 19-20. Institutionalized individuals, blind, and disabled individuals who were eligible in December 1973
- 21. Individuals who would be eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972)
- 22. Individuals who become ineligible for cash assistance as a result of OASDI cost-of-living increases received after April 1977 [Page Sunset]
- 22. Individuals who become ineligible for cash assistance as a result of OASDI cost-of-living increases received after April 1977
- 23. Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction [Page Sunset]
- 23. Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction
- 24. Disabled widows and widowers who would be eligible for SSI except for the increase in disability benefits resulting from elimination of the reduction factor under Pub. L. 98-21 [Page Sunset]
- 24. Disabled widows and widowers who would be eligible for SSI except for the increase in disability benefits resulting from elimination of the reduction factor under Pub. L. 98-21
- 25-26. Aged, Blind, and Disabled Qualified Medicare Beneficiaries; Qualified Disabled and Working Individuals
- 27-28. Aged, Blind, and Disabled Special Low-income Medicare Beneficiaries; Qualifying Individuals
- 29. Individuals who are ineligible for SSI or optional State supplements because of requirements that do not apply under title XIX of the Act [Page Sunset]
- 29. Individuals who are ineligible for SSI or optional State supplements because of requirements that do not apply under title XIX of the Act

- B. Optional Groups Other Than the Medically Needy
  - Options for Coverage of Families and Children and the Aged, Blind, and Disabled
  - 1-2. Optional eligibility for individuals who meet the income and resource requirements of the cash assistance programs; Optional eligibility for individuals who would be eligible for cash assistance if they were not in medical institutions.
  - 3. Individuals who would be ineligible if they were not enrolled in an MCO or PCCM
  - 4. Individuals receiving home and community-based services
  - 5. [Placeholder]
  - 10. Aged, blind, and disabled individuals in States that use more restrictive requirements for Medicaid than SSI requirements: Optional coverage
  - 11. Aged, blind, and disabled individuals in States that use more restrictive requirements for Medicaid than SSI requirements: Optional coverage
  - 12. Individuals in institutions who are eligible under a special income level
  - 13. Individuals under age 19 who would be eligible for Medicaid if they were in a medical institution
  - 16. [Placeholder]

        - 20-21. Optional eligibility for individuals needing treatment for breast or cervical cancer
    - C. Optional Coverage Of the Medically Needy

- **2.2-A**: Medicare Prescription Drug Low Income Subsidy Determination

- **2.6-A**: Eligibility Conditions and Requirements
    - General Conditions of Eligibility
        - 1-2. General Financial Eligibility Requirements and Options; Categorical Requirements for Eligibility
        - 3. Citizenship and non-citizen eligibility
        - 4. State residence
        - 5-7. Institutionalized individuals; Assignment of rights to benefits - State plan requirements; Use of social security number
    - Post Eligibility Treatment of Institutionalized Individuals
    - Financial Eligibility – Categorically and Medically Needy and Qualified Medicare Beneficiaries
    - Methods for Determining Resources
    - Effective Date of Eligibility for the Prospective Period and for the Retroactive Period
    - Pre-OBRA 93 Transfer of Resources, Transfer of Assets, and Treatment of Trusts

    Supplements to Attachment 2.6-A

        - 1: Optional Categorically Needy Groups with Incomes Related to the Supplemental Security Income (SSI) Federal Benefit Rate
            - *1: Individuals in Institutions Who Are Eligible under a Special Income Level*
            - *3: Income Eligibility Levels for Aged and Disabled Individuals*
            - *C. - CA. Income Eligibility Levels Qualified Medicare Beneficiaries with Incomes Related to Federal Poverty Level; Qualified Disabled Working Individuals with Incomes Related to Federal Poverty Level*
            - *D. Income Eligibility Levels Medically Needy*
        - 2: Aged and Disabled Individuals; Medically Needy Resource Levels [Page Sunset]
        - 2: Aged and Disabled Individuals; Medically Needy Resource Levels
        - 3: Method for Determining Cost Effectiveness of Caring for Certain Disabled Children at Home
        - 4: Section 1902(f) Methodologies for Treatment of Income that Differ from Those of the SSI Program [Page Sunset]
        - 5: More Restrictive Methods of Treating Resources than Those of the SSI Program (Section 1902(f) States Only) - Irrevocable Burial Contracts [Page Sunset]
            - *5a: Methods for Treatment of Resources for Individuals with Income Related to Federal Poverty Levels*
        - 6: Standards for Optional State Supplementary Payments for Aged, Blind, and Disabled
        - 7: Income Levels for 1902(f) States – Categorically Needy Who Are Covered Under Requirements More Restrictive than SSI [Page Sunset]
        - 8: Resource Standards for 1902(f) States – Categorically Needy [Page Sunset]
        - 8: Resource Standards for 1902(f) States – Categorically Needy
            - *8a: More Liberal Methods of Treating Income Under Section 1902(r)(2) of the Act*
            - *8b: More Liberal Methods of Treating Resources Under Section 1902(r)(2) of the Act [Page Sunset]*
            - *8b: More Liberal Methods of Treating Resources Under Section 1902(r)(2) of the Act*
            - *8c: State Long-Term Care Insurance Partnership*
        - 9: Transfer of Resources

        - *9a: Transfer of Assets*
        - *9b: Transfer of Assets (after Feb 8, 2006)*
    - 10, Corrected: Transfer of Assets: Undue Hardship
    - 13: Section 1924 Provisions
    - 16: Asset Verification System
    - 17: Disqualification for Long-Term Care Assistance for Individuals with Substantial Home Equity
    - 18: Methodology for Identification of Applicable FMAP Rates - Adult Group
        - Attachment A: Most Recent Updated Summary Information for Part 2 of Modified Adjusted Gross Income (MAGI) Conversion Plan
        - Attachment E: Adult Population Reprocess Plan

- **3.1-A**: Amount, Duration, and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy
    - 1. Inpatient Hospital Services Other Than Those Provided in an Institution for Mental Diseases
    - 2a. Outpatient Hospital Services
    - 2b. Rural Health Clinic Services and Other Ambulatory Services Furnished by Rural Health Clinics
    - 2c. Federally qualified health center (FQHC) services and other ambulatory services furnished by an FQHC
    - 3. Other Laboratory and X-ray Services
    - 4.a. Nursing Facility Services (other than services in an institution for mental diseases) for Individuals 21 years of Age or Older
    - 4b. Early and Periodic Screening, Diagnosis, and Treatment of Conditions Found (EPSDT)
        - A. Screening Services
        - B. Diagnosis and Treatment
            - 1. Medical or Other Remedial Care by Licensed Practitioners: Optometric, Podiatrists, Podiatrists, Licensed Behavioral Health Practitioner Services, Applied Behavior Analysis (ABA)
            - 2. Medical supplies, equipment, appliances and prosthetic devices
            - 3. Diagnostic Services
            - 4. Clinic Services
            - 5. - 7. Dental Services, Physical Therapy, Occupational Therapy, and Services for Individuals with Speech, Hearing, and Language Disorders, Prescribed Drugs
            - 8. Rehabilitative Services: Outpatient Behavioral Health
                - *Individual Provider Qualifications*
                - *Covered Services*
                - *Exclusions and Limitations and Non-Covered Services*
            - 9-13. Preventative Services: Outpatient Substance Abuse Prevention Counseling; Inpatient Psychiatric Services; Personal Care Services; School-Based Health Services; Private Duty Nursing Services
        - C–E. Other Necessary Health Care, Transportation and Scheduling Assistance, and Continuing Care
    - Nursing Facility Benefits, Early and Periodic Screening, Diagnosis, and Treatment Services for Individuals under 21 years of age, and Treatment of Conditions Found, Family Planning Services and Supplies, Physicians' Services, Medical and Surgical Services furnished by a Dentist, Medical care and any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law, podiatrists' services (with limitations) (July 1, 1993)
        - 4.c. Family Planning Benefits
            - *4.c. Family Planning Service Limitations*
        - 5. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere

- 6a. Podiatrists' services

- Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law:
  - *Optometrists' services and Chiropractors' services*; home health: *a. Intermittent or part time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area, b. home health aide services provided by a home health agency, c. Medical supplies, equipment, and appliances suitable for use in any setting in which normal life activities take place, other than a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.*
  - 6.d. Other practitioners' services (see attachment)
    - *A. -F.: Psychological Services, Psychological Services, Anesthesiologist Assistants, Physician Assistants, Nutritional Services, Health Education and counseling services (including genetic) for pregnant women*
    - *G. Licensed Behavioral Health Practitioner Services*
    - *H. – I.: Genetic Counseling Services; Diabetes Self-Management Education and Support (DSMES) Services*
  - 7. Home Health services (see attachment)
    - *7.d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility, 8. Private duty nursing services*
- Clinic, dental, and physical therapy and related services
  - Free-Standing Ambulatory Surgery Center
  - 9. Renal Dialysis Facilities
  - Clinic Services
  - Public Health Clinic Services
  - 10. Dental Services
- Prescribed Drugs, Dentures, Prosthetic Devices, and Eyeglasses Prescribed by a Physician Skilled in Diseases of the Eye or by an Optometrist, Other diagnostic, screening, preventative, and rehabilitative services, i.e. other than those provided elsewhere in this plan: *Diagnostic services.*
  - 12.a. Prescription Drugs
    - *Tiered Drug List, Supplemental Drug Rebate*
  - 12.c. Prosthetics and Orthotics
    - *For Children*
  - Eyeglasses
    - *See EPSDT*
- Other diagnostic, screening, preventative, and rehabilitative services, i.e. other than those provided elsewhere in this plan: *Screening, preventive, rehabilitation;* Services for individuals age 65 or older in institutions for mental disease*: inpatient hospital services, nursing facility services*
  - 13.b. Screening Services
    - *See Att. 3.1-A, Page 1a-4*
  - 13.d. Rehabilitative Services: Outpatient Behavioral Health Services
    - Eligible Providers, Provider Specialties
    - Covered Services

        - ¬ *Mental Health Assessment by a Non-Physician, Behavioral Health Services Plan Development by a Non-Physician, Individual/Interactive Psychotherapy, Family Psychotherapy, Group Psychotherapy*
        - ¬ *Community Recovery Support*
        - ¬ *Psychosocial Rehabilitation Services, Crisis Intervention Services, Psychological Testing, Meditation Training and Support, Crisis Intervention Services (family based stabilization), Alcohol and Drug Assessment, Alcohol and/or Substance Abuse Services Treatment Plan Development, Alcohol and/or Substance Abuse Services Skill Development*
        - ¬ *Individual Provider Qualifications*
        - ¬ *Limitation on Services*
    - Program of Assertive Community Treatment (PACT)
        - ¬ *Eligible Organizations, Multidisciplinary Team*
        - ¬ *Covered Service Components and Descriptions (Service Contacts)*
        - ¬ *Limitation on Services*
    - Certified Community Behavioral Health (CCBH) Services
        - ¬ Eligible Organizations
        - ¬ Interdisciplinary Treatment Team
        - ¬ Interdisciplinary Treatment Team Qualifications
        - ¬ Covered Service Components and Descriptions
            - *Limitations*
    - Residential Substance Use Disorder Services
        - ¬ Eligible Providers, Service Descriptions: Levels of Care
        - ¬ Covered Services & Provider Qualifications
        - ¬ Excluded Services
  - Services for individuals age 65 or older in institutions for mental diseases: inpatient hospital service
- Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care; Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions; Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions; Inpatient psychiatric facility services for individuals under 21 years of age; Nurse-midwife services, Hospice care for individuals under 21 years of age (in accordance with section 1905(o) of the Act)
  - 15. Services in an intermediate care facility for the mentally retarded (other than such services in an institution for mental diseases) for individuals who are determined, in accordance with Section 1902(a)(31)(A), to be in need of such care
  - 16. Inpatient Psychiatric Services for Individuals Under Age 21
- Case management services and Tuberculosis related services; Extended services for pregnant women
  - Special tuberculosis (TB) related services under Section 1902(z)(2) of the Act
  - Extended services for pregnant women
    - Pregnancy-related and postpartum services
    - High risk pregnant women
        - ¬ *Nutritional Assessment/Counseling*
        - ¬ *Health Education*
        - ¬ *Psychosocial Assessment/Counseling*
        - ¬ *Genetics Assessment Counseling*

- Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an qualified provider (in accordance with section 1920 of the Act); Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act); Pediatric or family nurse practitioners' services
    - 21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an qualified provider (in accordance with section 1920 of the Act)
    - 23. Pediatric or family nurse practitioners' services

- Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary: *transportation; Services of Christian Science nurses; Care and services provided in Christian Science sanitoria; Nursing facility services for patients under 21 years of age, Emergency hospital services; Personal care services in recipient's home prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse; Birthing Center Services; Critical Access Hospital*
    - 24.a. Non-emergency Transportation (NEMT)
    - 24.d. Nursing facility services provided for patients under 21 years of age
    - 24.f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and rendered by qualified person under supervision of a R.N.
    - 24.g. Birthing Center Services
    - 24.h. Critical Access Hospital

- Program of All-Inclusive Care for the Elderly (PACE) services; Medication Assisted Treatment
    - Medication Assisted Treatment

Supplements to Attachment 3.1-A

- 1: Targeted Case Management (TCM) Services
    - *Chronically and/or severely mentally ill age 18 years and older or children who are at imminent risk of out-of-home placement due to psychiatric or substance abuse reasons*
    - *High Risk Pregnant Women, First Time Pregnant Women and Their Infants, Developmentally Disabled Children 0-3 Years of Age*
    - *Persons under age 21 who are in imminent risk of out-of-home placement for psychiatric or substance abuse reasons or are in out-of-home placement due to psychiatric or substance abuse reasons*
    - *Children under age 18 who are assessed as at risk of abuse or neglect as defined in Title 10A §1-1-105 of the Oklahoma Statutes and who are in emergency, temporary, or permanent custody of the Department of Human Services or in voluntary status who are placed in out-of-home care or trial adoption*
    - *Eligible individuals under age 21 who are assessed as at risk of abuse or neglect as defined in title 10A §1-1-105 of the Oklahoma Statutes and who are involved in, or at serious risk of involvement with the juvenile justice system—group does not include those who are involuntarily in secure custody of law enforcement or judicial systems, except individuals who meet Medicaid criteria for inpatient care as defined in 42 CFR §435.1009; 42 CFR §435.1010*
    - *Persons with mental retardation and/or related conditions who are served by the Home and Community Based Services (HBCS) Waiver; or individuals who reside in institutions and have requested HBCS and receive TCM prior to entering the waiver; or who are being assessed for admission to the HBCS Waivers*
- 3: Pace Services

- **3.1**
  - **A.1**: Requirements Relating to Payment for Covered Outpatient Drugs for the Categorically Needy
  - **B**: Amount, Duration, and Scope of Services Provided: Medically Needy Group(s), Ambulatory Services
  - **C**: Standards and Methods to Assure Care and Services of High Quality, Executive Order, and Submittal and Report of Action of Public Assistance Plan Materials
  - **D**: Methods of Providing Transportation
  - **E**: Standards for the Coverage of Organ Transplant Services
  - **H**: Health Home State Plan Amendment
  - **L**: Adult Expansion Alternative Benefit Plan (ABP)
    Populations, Voluntary Benefit Package Selection Assurances, Selection of Benchmark Benefit Package or Benchmark Equivalent Benefit Package, Cost Sharing, Benefits Description, Benefit Assurances, Service Delivery Systems, Employer Sponsored Insurance and Payment Premiums, General Assurances, Payment Methodology
- **3.2-A**: Coordination of Title XIX with Part A and Part B of Title XVII
- **4.5-A**: Medicaid Recovery Audit Contractor Program
- **4.11-A**: Standards for Institutions
  - Outpatient Mental Health Clinics
  - Community Mental Health Clinics (CMHC)
- **4.14-A**: Single Utilization Review Methods for Intermediate Care Facilities
- **4.16-A**: Cooperative Arrangements with State Department of Health and State Vocational Rehabilitation Agencies and with Title V Grantees
- **4.17-A**: Amount, Duration, and Scope of Medical and Remedial Care and Services provided – Categorically Needy – Liens
- **4.18**: Pages Sunsetted
- **Medicaid Premiums & Cost Sharing**:
  - Cost Sharing Requirements
  - Cost Sharing Amounts **-** Categorically Needy Individuals**,** Medically Needy Individuals, Targeting, Limitations
- **4.19:** Methods and Standards for Establishing Payment Rates
  - **4.19-A**: Inpatient Hospital Services
    - General Reimbursement Policy
    - Payment Methodology for Freestanding Rehabilitation, and Freestanding Psychiatric Hospitals
    - Payment Methodology for Long Term Care Hospitals Serving Children (LTCHs)
    - Appeals – Per Diem Payments
    - Per Discharge Prospective Payment Methodology for Hospitals
      - *A. Services included in or Excluded from the Prospective Rate*
      - *B. Computation of DRG Relative Weights*
      - *C. – E. Computation of Hospital Base Rates; Updates; Special Prospective Payment Provisions*

        - *F. Appeals*
    - Graduate Medical Education Activities
    - Supplemental Payments for Hospitals with Level 1 Trauma Centers
    - Hospitals Deemed Disproportionate Share
    - Supplemental Payments for Hospitals Participating in the Supplemental Hospital Offset Payment Program (SHOPP)
    - Inpatient Facility Services for Individuals Under Age 21
        - *Inpatient Psychiatric Services for Individuals under Age 21 (Acute 1)*
        - *Residential Level of Care in a Psychiatric Residential Treatment Facility (PRTF) (Acute 2)*
- **4.19-A(1)**: Letter to Regional Administration – Re: Skilled Nursing and Intermediate Care Facilities
- **4.19-B**: Other Types of Care – Frontispiece
    - Outpatient Hospital Reimbursement
        - *A: Emergency Room Services*
        - *B: Outpatient Surgery*
        - *C: Dialysis Services*
        - *D: Ancillary Services, Imaging, and Other Diagnostic Services*
        - *E: Therapeutic Services*
        - *F: Clinic Services and Observation/Treatment Room*
        - *G: Hospital-based Community Mental Health Centers (CMHCs) Operated by Units of Government*
        - *H: Partial Hospitalization Program (PHP) Services*
    - Supplemental Hospital Offset Payment Program
    - Supplemental Payments for Hospitals with Level 1 Trauma Centers
    - Indian Health Service and Tribal Health Facilities
    - Rural Health Clinics and Ambulatory Services Furnished by Rural Health Clinics
    - Federally Qualified Health Center Services
    - Clinical Laboratory Services
    - Physician Services
    - Payment for Durable Medical Equipment, Supplies, and Appliances
    - Free-Standing Ambulatory Surgery Center-Clinic
    - Dentists for General Dental, Orthodontic Services, and Dentists Working at a Governmental Hospital Based Children's Dental Clinic
    - Ground Ambulance, Air Ambulance, and Non-Emergency Transportation (NEMT) and Meals and Lodging
    - Prescribed Drugs
    - Licensed Behavioral Health Practitioner (LBHPs) Services)
    - Blood and Blood Fractions
    - Prosthetics, Orthotics, and Eyeglasses
    - Personal Care Services
    - Nurse-Midwives
    - Family Planning Services
    - Early And Periodic Screening, Diagnosis, and Treatment of Conditions Found (EPSDT) of Individuals Under 21 Years of Age
    - EPSDT
        - *Outpatient Behavioral Health Services*
        - *Multi-systemic Therapy*
        - *Partial Hospitalization Program*
        - *Emergency Hospital Services*
        - *Speech and Audiologist Therapy Services*
        - *Chiropractors*
        - *Hospice*
        - *Christian Science Nurses*
        - *Dentures*

- *Respiratory Care*
- *Private Duty Nursing*
- *Physical Therapist*
- *Occupational Therapist*
- *Speech Language Pathologist*
- *Christian Science Sanatoria*
- *Other Practitioners-Licensed Clinical Social Workers*
- *ABA*
    - *See Att. 3.1-A Page 1a-6.1*
- *Outpatient Behavioral Health Services in Licensed, Private Residential Group Homes*

▫ Renal Dialysis Facilities
▫ Anesthesiologists
▫ Physician Assistants
▫ Nutritional Services
▫ Case Management Services
▫ Clinic Services
▫ Rehabilitative Services
- *Outpatient Behavioral Health and Substance Use Disorder (SUD) Treatment Services*
- *Reimbursement for PACT Services*
- *Reimbursement for CCBH Rehabilitative Services*
- *Residential Substance Use Disorder (SUD) Reimbursement*

▫ Certified Pediatric Nurse Practitioners Services
▫ Targeted Case Management Services for High-Risk Pregnant Women, First Time Pregnant Women and Their Infants, and Developmentally Disabled Children 0-3 Years of Age
▫ Birthing Center Services
▫ Critical Access Hospitals (CAHs)
▫ Government Providers, Private Providers, and Non-Duplication of Services for Children Under Age 18 Who are Assessed as at Risk of Abuse or Neglect and Who are Involved in Emergency, Temporary, or Permanent Custody of the Department of Human Services (DHS) or in Voluntary Status Who are Placed in Out-of-Home Care or Trial Adoption
▫ Government Providers, Private Providers, and Non-Duplication of Services for Children Under Age 18 Who are Assessed as at Risk of Abuse or Neglect and Who are Involved in, or at Serious Risk of Involvement with the Juvenile Justice System
▫ Developmental Disabilities Services Division Targeted Case Management (DDSD TCM) for Persons with Mental Retardation and/or Related Conditions Who are Served by the Home and Community Based Services (HCBS) Waiver; or Individuals Who Reside in Institutions and have Requested HCBS and Receive TCM Prior to Entering the Waiver; or Who are being Assessed for Admission to the HCBS Waivers
▫ Residential Behavior Management Services (RBMS) – Group Service
▫ Covered Outpatient Drugs

Supplements to Attachment 4.19-B

▫ Methods and Standards for Establishing Payment Rates for Medicare Part A and Part B Deductible/Coinsurance and Claims

- **4.19-C**: Payment for Reserved Beds in Long-Term Care Facilities
- **4.19-D**: Methods and Standards for Establishing Payment Rates for Nursing Facilities
    - ▫ Standard Nursing Facility Serving Adults
    - ▫ Standard Nursing Facility Serving AIDS Patients
    - ▫ Standard Nursing Facility Serving Ventilator-Dependent Patients
    - ▫ Public and Standard Private Intermediate Care Facilities for the Mentally Retarded
    - ▫ Specialized Private ICF/MR Facilities 16 Bed or Less
- **4.19-E**: Timely-Claims Payment – Definition of Claim

- **4.22**: Requirements for Third Party Liability
    - **A**: Identifying Liable Sources
    - **B**: Requirements for Third Party Liability

Supplements to Attachment 4.22

- State Laws Requiring Third Parties to Provide Coverage, Eligibility, and Claims Data

- **4.30**: Sanctions for MCOs and PCCMs

- **4.32-A**: Income and Eligibility Verification System Procedures: Requests to Other State Agencies
- **4.33-A**: Method for Issuance of Medicaid Eligibility Cards to Homeless Individuals

- **4.34-A**: Requirements for Advance Directives Under State Plans for Medical Assistance

- **4.35-A**: Enforcement of Compliance for Nursing Facilities
  - **B**: Termination of Provider Agreement
  - **C**: Temporary Management
  - **D**: Denial of Payment for New Admissions
  - **E**: Civil Money Penalty
  - **F**: State Monitoring
  - **G**: Transfer of residents, Transfer of Residents with Closure of Facility
  - **H**: Additional Remedies

- **4.38-A**: Disclosure and Collection of Additional Registry Information

- **4.39-A**: Categorical Determinations Regarding Need of Nursing Facility and Specialized Services

- **4.42**: Employee Education About False Claims Recoveries
- **4.42-A**: Employee Education About False Claims Recoveries

- **7.2-A**: Methods of Administration – Civil Rights

OMB No. 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: Oklahoma

TABLE OF CONTENTS

SECTION	PAGE NUMBERS
State Plan Submittal Statement	1
SECTION 1 - SINGLE STATE AGENCY ORGANIZATION	2
1.1 Designation and Authority	2
1.2 Organization for Administration	7
1.3 Statewide Operation	8
1.4 State Medical Care Advisory Committee	9
1.5 Pediatric Immunization Program	9a

STATE OK
DATE REC'D JUN 2 8 1987
DATE APPV'D JAN 11 1988
DATE EFF APR 1 1987
HCFA 179 90-8
A

SECTION PAGE NUMBERS

SECTION 2 - COVERAGE AND ELIGIBILITY 10

2.1 Application, Determination of Eligibility and Furnishing Medicaid 10

2.2 Coverage and Conditions of Eligibility 12

2.3 Residence 13

2.4 Blindness 14

2.5 Disability 15

2.6 Financial Eligibility 16

2.7 Medicaid Furnished Out of State 18

STATE OK
DATE REC'D JUN 29 1987
DATE APPV'D JAN 11 1988
DATE EFF APR 1 1987
HCFA 179 87-9
A

SECTION	PAGE NUMBERS
SECTION 3 - SERVICES: GENERAL PROVISIONS	19
3.1 Amount, Duration, and Scope of Services	19
3.2 Coordination of Medicaid with Medicare Part B	29
3.3 Medicaid for Individuals Age 65 or Over in Institutions for Mental Diseases	30
3.4 Special Requirements Applicable to Sterilization Procedures	31
3.5 Medicaid for Medicare Cost Sharing for Qualified Medicare Beneficiaries	31a
3.6 Ambulatory Prenatal Care for Pregnant Women during Presumptive Eligibility Period	31b

STATE OK
DATE REC'D JUN 29 1987
DATE APP'D JAN 11 1988
DATE EFF APR 1 1987
HCFA 179 87-9
A

SECTION PAGE NUMBERS

SECTION 4 - GENERAL PROGRAM ADMINISTRATION 32

4.1 Methods of Administration 32

4.2 Hearings for Applicants and Recipients 33

4.3 Safeguarding Information on Applicants and Recipients 34

4.4 Medicaid Quality Control 35

4.5 Medicaid Agency Fraud Detection and Investigation Program 36

4.6 Reports 37

4.7 Maintenance of Records 38

4.8 Availability of Agency Program Manuals 39

4.9 Reporting Provider Payments to the Internal Revenue Service 40

4.10 Free Choice of Providers 41

4.11 Relations with Standard-Setting and Survey Agencies 42

4.12 Consultation to Medical Facilities 44

4.13 Required Provider Agreement 45

4.14 Utilization Control 46

4.15 Inspections of Care in Skilled Nursing and Intermediate Care Facilities and Institutions for Mental Diseases 51

4.16 Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees 52

4.17 Liens and Recoveries 53

4.18 Cost Sharing and Similar Charges 54

4.19 Payment for Services 57

TN No. 87-9
Supersedes
TN No. —

Approval Date JAN 11 1988 Effective Date APR 1 1987

STATE OK
DATE REC'D JUN 29 1987
DATE APPV'D JAN 11 1988 APR 1 1987
DATE EFF 87-9
A

HCFA ID: 1002P/0010P

SECTION PAGE NUMBERS

4.20 Direct Payments to Certain Recipients for Physicians' or Dentists' Services 67

4.21 Prohibition Against Reassignment of Provider Claims 68

4.22 Third Party Liability 69

4.23 Use of Contracts 71

4.24 Standards for Payments for Skilled Nursing and Intermediate Care Facility Services 72

4.25 Program for Licensing Administrators of Nursing Homes 73

4.26 RESERVED 74

4.27 Disclosure of Survey Information and Provider or Contractor Evaluation 75

4.28 Appeals Process for Skilled Nursing and Intermediate Care Facilities 76

4.29 Conflict of Interest Provisions 77

4.30 Exclusion of Providers and Suspension of Practitioners Convicted and Other Individuals 78

4.31 Disclosure of Information by Providers and Fiscal Agents 79

4.32 Income and Eligibility Verification System 79

4.33 Medicaid Eligibility Cards for Homeless Individuals 79a

4.34 Systematic Alien Verification for Entitlements 79b

4.35 Remedies for Skilled Nursing and Intermediate Care Facilities that Do Not Meet Requirements of Participation 79c

SECTION PAGE NUMBERS

SECTION 5 - PERSONNEL ADMINISTRATION 80

5.1 Standards of Personnel Administration 80

5.2 RESERVED 81

5.3 Training Programs; Subprofessional and Volunteer Programs 82

STATE OK
DATE REC'D JUN 29 1987
DATE APPV'D JAN 11 1988
DATE EFF APR 1 1987
HCFA 179 87-9
A

SECTION PAGE NUMBERS

SECTION 6 - FINANCIAL ADMINISTRATION 83

6.1 Fiscal Policies and Accountability 83

6.2 Cost Allocation 84

6.3 State Financial Participation 85

STATE OK
DATE RECD JUN 29 1987
DATE APP'D JAN 11 1988
DATE EFF APR 1 1987
HCFA 179 87-9
A

SECTION PAGE NUMBERS

SECTION 7 - GENERAL PROVISIONS 86

7.1 Plan Amendments 86

7.2 Nondiscrimination 87

7.3 Maintenance of AFDC Effort 88

7.4 State Governor's Review 89

Revised 10-01-91

TN No. 92-01 Approval Date FEB 28 1992 Effective Date OCT 01 1991
Supersedes TN No. 87-9

HCFA ID: 7982E

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APP'D FEB 28 1992
DATE EFF OCT 01 1991
HCFA TN 92-01

A

LIST OF ATTACHMENTS

No.	Title of Attachments
*1.1-A	Attorney General's Certification
*1.1-B	Waivers under the Intergovernmental Cooperation Act
1.2-A	Organization and Function of State Agency
1.2-B	Organization and Function of Medical Assistance Unit
1.2-C	Professional Medical and Supporting Staff
1.2-D	Description of Staff Making Eligibility Determination
*2.2-A	Groups Covered and Agencies Responsible for Eligibility Determinations
	* Supplement 1 - Reasonable Classifications of Individuals under the Age of 21, 20, 19 and 18
	* Supplement 2 - Definitions of Blindness and Disability (Territories only)
	* Supplement 3 - Method of Determining Cost Effectiveness of Caring for Certain Disabled Children at Home
*2.6-A	Eligibility Conditions and Requirements (States only)
	* Supplement 1 - Income Eligibility Levels – Categorically Needy, Medically Needy and Qualified Medicare Beneficiaries
	* Supplement 2 - Resource Levels – Categorically Needy, Including Groups with Incomes Up to a Percentage of the Federal Poverty Level, Medically Needy, and other Optional Groups
	* Supplement 3 - Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered under Medicaid
	* Supplement 4 - Section 1902(f) Methodologies for Treatment of Income that Differ from those of the SSI Program

*Forms Provided

A

STATE Oklahoma
DATE RECD 9-23-03
DATE APPV'D 12-9-03
DATE EFF 8-13-03
HCFA 179 03-12

SUPERSEDES: TN- 92-01

Revised 08-13-03

No.	Title of Attachment
* Supplement 5 -	Section 1902(f) Methodologies for Treatment of Resources that Differ from those of the SSI Program
* Supplement 5a-	Methodologies for Treatment of Resources for Individuals With Incomes Up to a Percentage of the Federal Poverty Level
* Supplement 6 -	Standards for Optional State Supplementary Payments
* Supplement 7 -	Income Levels for 1902(f) States - Categorically Needy Who Are Covered under Requirements More Restrictive than SSI
* Supplement 8 -	Resource Standards for 1902(f) States - Categorically Needy
* Supplement 8a-	More Liberal Methods of Treating Income Under Section 1902(r)(2) of the Act
* Supplement 8b-	More Liberal Methods of Treating Resources Under Section 1902(r)(2) of the Act
* Supplement 9 -	Transfer of Resources
* Supplement 10-	Consideration of Medicaid Qualifying Trusts--Undue Hardship
*2.6-A	Eligibility Conditions and Requirements (Territories only)
* Supplement 1 -	Income Eligibility Levels - Categorically Needy, Medically Needy, and Qualified Medicare Beneficiaries
* Supplement 2 -	Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered under Medicaid
* Supplement 3 -	Resource Levels for Optional Groups with Incomes Up to a Percentage of the Federal Poverty Level and Medically Needy
* Supplement 4 -	Consideration of Medicaid Qualifying Trusts--Undue Hardship
* Supplement 5 -	More Liberal Methods of Treating Income under Section 1902(r)(2) of the Act
* Supplement 6 -	More Liberal Methods of Treating Resources under Section 1902(r)(2) of the Act

*Forms Provided

Revised 10-01-91

TN No. 92-01
Supersedes TN No. 87-9 Approval Date FEB 2 8 1992 Effective Date OCT 0 1 1991

HCFA ID: 7982E

STATE Oklahoma
DATE RECD JAN 2 9 1992
DATE APP'D FEB 2 8 1992
DATE EFF OCT 0 1 1991
HCFA 179 92-01
A

No.	Title of Attachment
*3.1-A	Amount, Duration, and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy
	* Supplement 1 - Case Management Services Supplement 2 - Alternative Health Care Plans for Families Covered Under Section 1925 of the Act
*3.1-B	Amount, Duration, and Scope of Services Provided Medically Needy Groups
3.1-C	Standards and Methods of Assuring High Quality Care
3.1-D	Methods of Providing Transportation
*3.1-E	Standards for the Coverage of Organ Transplant Procedures
4.11-A	Standards for Institutions
4.14-A	Single Utilization Review Methods for Intermediate Care Facilities
4.14-B	Multiple Utilization Review Methods for Intermediate Care Facilities
4.16-A	Cooperative Arrangements with State Health and State Vocational Rehabilitation Agencies and with Title V Grantees
4.17-A	Determining that an Institutionalized Individual Cannot Be Discharged and Returned Home
*4.18-A	Charges Imposed on Categorically Needy
*4.18-B	Medically Needy - Premium
*4.18-C	Charges Imposed on Medically Needy and other Optional Groups
*4.18-D	Premiums Imposed on Low Income Pregnant Women and Infants
*4.18-E	Premiums Imposed on Qualified Disabled and Working Individuals
4.19-A	Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

*Forms Provided

Revised 10-01-91

TN No. 92-01
Supersedes TN No. 90-08
Approval Date FEB 28 1992
Effective Date ~~OCT 01 1991~~
HCFA ID: 7982E

STATE OKlahoma
DATE RECD JAN 29 1992
DATE APP'D FEB 28 1992
DATE EFF OCT 01 1991
HCFA ID 92-01
A

No.	Title of Attachment
4.19-B	Methods and Standards for Establishing Payment Rates - Other Types of Care
	* Supplement 1 - Methods and Standards for Establishing Payment Rates for Title XVIII Deductible/Coinsurance
4.19-C	Payments for Reserved Beds
4.19-D	Methods and Standards for Establishing Payment Rates - Skilled Nursing and Intermediate Care Facility Services
4.19-E	Timely-Claims Payment - Definition of Claim
4.20-A	Conditions for Direct Payment for Physicians' and Dentists' Services
4.22-A	Requirements for Third Party Liability--Identifying Liable Resources
*4.22-B	Requirements for Third Party Liability--Payment of Claims
*4.32-A	Income and Eligibility Verification System Procedures: Requests to Other State Agencies
*4.33-A	Method for Issuance of Medicaid Eligibility Cards to Homeless Individuals
7.2-A	Methods of Administration - Civil Rights (Title VI)
4.35-A	Criteria for the Application of Specified Remedies for Skilled Nursing and Intermediate Care Facilities
4.35-B	Alternative Remedies to Specified Remedies for Skilled Nursing and Intermediate Care Facilities

*Forms Provided

New 10-01-91

TN No. 92-01
Supersedes TN No. ____
Approval Date FEB 28 1992
Effective Date OCT 01 1991
HCFA ID: 7982E

STATE Oklahoma
DATE RECD JAN 29 1992
DATE APPD FEB 28 1992
DATE EFF OCT 01 1991
HCFA # 92-01
A

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

OMB No. 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: OKLAHOMA

Citation

42 CFR
430.10

As a condition for receipt of Federal funds under title XIX of the Social Security Act, the

Oklahoma Health Care Authority
(Single State Agency)

submits the following State plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this State plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

STATE Oklahoma
DATE REC'D 03-31-95
DATE APPV'D 04-22-95
DATE EFF 01-01-95
HCFA 179 95-06

A

Revised 01-01-95

TN No. 95-06
Supersedes TN No. 92-01
Approval Date 4/22/95
Effective Date 1/1/95

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State: Oklahoma
Date Received: 27 November, 2013
Date Approved: 19 September, 2016
Effective Date: 1 October, 2013
Transmittal Number: 13-19

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State: Oklahoma
Date Received: 27 November, 2013
Date Approved: 19 September, 2016
Effective Date: 1 October, 2013
Transmittal Number: 13-19

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State: Oklahoma
Date Received: 27 November, 2013
Date Approved: 19 September, 2016
Effective Date: 1 October, 2013
Transmittal Number: 13-19

Medicaid State Plan Administration

Organization

Designation and Authority

MEDICAID | Medicaid State Plan | Administration | OK2019MS0005O | OK-19-0015

Package Header

Package ID	OK2019MS0005O	**SPA ID**	OK-19-0015
Submission Type	Official	**Initial Submission Date**	3/29/2019
Approval Date	6/21/2019	**Effective Date**	1/1/2019
Superseded SPA ID	OK-13-0019		
	User-Entered		

A. Single State Agency

1. State Name: Oklahoma

☑ 2. As a condition for receipt of Federal funds under title XIX of the Social Security Act, the single state agency named here agrees to administer the Medicaid program in accordance with the provisions of this state plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Centers for Medicare and Medicaid Services (CMS).

3. Name of single state agency:

Oklahoma Health Care Authority (OHCA)

4. This agency is the single state agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named as the single state agency.)

B. Attorney General Certification:

☑ The certification signed by the state Attorney General identifying the single state agency and citing the legal authority under which it administers or supervises administration of the program has been provided.

Name	Date Created	
OK SPA 19-0015 Administration Organization Update Attorney General Cert	3/29/2019 3:30 PM EDT	PDF

C. Administration of the Medicaid Program

The state plan may be administered solely by the single state agency, or some portions may be administered by other agencies.

○ 1. The single state agency is the sole administrator of the state plan (i.e. no other state or local agency administers any part of it). The agency administers the state plan directly, not through local government entities.

◉ 2. The single state agency administers portions of the state plan directly and other governmental entity or entities administer a portion of the state plan.

☐ a. The single state agency supervises the administration through counties or local government entities.

☐ b. The single state agency supervises the administration through other state agencies. The other state agency implements the state plan through counties and local government entities.

☑ c. Another state agency administers a portion of the state plan through a waiver under the Intergovernmental Cooperation Act of 1968.

Designation and Authority

MEDICAID | Medicaid State Plan | Administration | OK2019MS0005O | OK-19-0015

Package Header

Package ID	OK2019MS0005O	**SPA ID**	OK-19-0015
Submission Type	Official	**Initial Submission Date**	3/29/2019
Approval Date	6/21/2019	**Effective Date**	1/1/2019
Superseded SPA ID	OK-13-0019		
	User-Entered		

D. Additional information (optional)

Medicaid State Plan Administration

Organization

Intergovernmental Cooperation Act Waivers

MEDICAID | Medicaid State Plan | Administration | OK2019MS0005O | OK-19-0015

Package Header

Package ID	OK2019MS0005O	**SPA ID**	OK-19-0015
Submission Type	Official	**Initial Submission Date**	3/29/2019
Approval Date	6/21/2019	**Effective Date**	1/1/2019
Superseded SPA ID	OK-13-0019		
	User-Entered		

A. Intergovernmental Cooperation Act Waivers

The state has the following Intergovernmental Cooperation Act Waivers:

View Waiver - Oklahoma Department of Human Services (DHS)

1. Name of state agency to which responsibility is delegated:

Oklahoma Department of Human Services (DHS)

2. Date waiver granted:

6/13/2016

3. The type of responsibility delegated is (check all that apply):

☑ a. Conducting fair hearings

☐ b. Other

4. The scope of the delegation (i.e. all fair hearings) includes:

Oklahoma Health Care Authority (OHCA) delegates the authority to conduct fair hearings and issue final hearing decisions related to eligibility of non-MAGI individuals to Oklahoma Department of Human Services (DHS). Hearings are conducted by Administrative Law Judges who are employees of DHS. Fair hearing decisions by the DHS Administrative Law Judges may be appealed to the DHS agency director for a final decision. The Medicaid beneficiary can then file suit in district court for a review of the record.

The parties to this waiver acknowledge that the OHCA delegates the authority to make final decisions regarding designated applicants and beneficiaries as defined in the Interagency Agreement between the OHCA and the DHS. The agreement also defines the respective relationships between the OHCA and the DHS including implementation of 42 C.F.R. section 431, subpart E, and any quality control and oversight that is planned.

The DHS acknowledges and agrees in writing that it will act as a neutral and impartial decision-maker on behalf of the Medicaid agency in adjudicating all Medicaid cases and that it will comply with all applicable federal and state laws, rules, regulations, policies, and guidance governing the Medicaid program.

5. Methods for coordinating responsibilities between the agencies include:

☑ a. The Medicaid agency retains oversight of the state plan, as well as the development and issuance of all policies, rules and regulations on all program matters.

☑ b. The Medicaid agency has established a process to monitor the entire appeals process, including the quality and accuracy of the hearing decisions made by the delegated entity.

☑ c. The Medicaid agency informs every applicant and beneficiary in writing of the fair hearing process and how to directly contact and obtain information from the Medicaid agency.

☑ d. The Medicaid agency ensures that the delegated entity complies with all applicable federal and state laws, rules, regulations, policies and guidance governing the Medicaid program.

☑ e.The Medicaid agency has written authorization specifying the scope of the delegated authority and description of roles and responsibilities between itself and the delegated entity through:

☑ i. A written agreement between the agencies.

☐ ii. State statutory and/or regulatory provisions.

6. The single state agency has established a review process whereby the agency reviews fair hearing decisions made by the delegated entity.

○ Yes

◉ No

7. Additional methods for coordinating responsibilities among the agencies (optional):

Intergovernmental Cooperation Act Waivers

MEDICAID | Medicaid State Plan | Administration | OK2019MS0005O | OK-19-0015

Package Header

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Submission Type	Official	**Initial Submission Date**	3/29/2019
Approval Date	6/21/2019	**Effective Date**	1/1/2019
Superseded SPA ID	OK-13-0019		
	User-Entered		

B. Additional information (optional)

Medicaid State Plan Administration

Organization

Eligibility Determinations and Fair Hearings

MEDICAID | Medicaid State Plan | Administration | OK2019MS0005O | OK-19-0015

Package Header

Package ID	OK2019MS0005O	**SPA ID**	OK-19-0015
Submission Type	Official	**Initial Submission Date**	3/29/2019
Approval Date	6/21/2019	**Effective Date**	1/1/2019
Superseded SPA ID	OK-13-0019		
	User-Entered		

A. Eligibility Determinations (including any delegations)

1. The entity or entities that conduct determinations of eligibility for families, adults, and individuals under 21 are:

- ☑ a. The Medicaid agency
- ☐ b. Delegated governmental agency

2. The entity or entities that conduct determinations of eligibility based on age (65 or older), or having blindness or a disability are:

- ☐ a. The Medicaid agency
- ☑ b. Delegated governmental agency
  - ☑ i. Single state agency under Title IV-A (TANF) (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
  - ☐ ii. An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
  - ☐ iii. The Social Security Administration determines Medicaid eligibility for:
    - ☐ (1) SSI beneficiaries
    - ☐ (2) Optional state supplement recipients
  - ☐ iv. Other

3. Assurances:

- ☑ a. The Medicaid agency is responsible for all Medicaid eligibility determinations.
- ☑ b. There is a written agreement between the Medicaid agency and the Exchange or any other state or local agency that has been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).
- ☑ c. The Medicaid agency does not delegate authority to make eligibility determinations to entities other than government agencies which maintain personnel standards on a merit basis.
- ☑ d. The delegated entity is capable of performing the delegated functions.

Eligibility Determinations and Fair Hearings

MEDICAID | Medicaid State Plan | Administration | OK2019MS0005O | OK-19-0015

Package Header

Package ID	OK2019MS0005O	**SPA ID**	OK-19-0015
Submission Type	Official	**Initial Submission Date**	3/29/2019
Approval Date	6/21/2019	**Effective Date**	1/1/2019
Superseded SPA ID	OK-13-0019		
	User-Entered		

B. Fair Hearings (including any delegations)

☑ The Medicaid agency has a system of hearings that meets all of the requirements of 42 CFR Part 431, Subpart E.

☑ The Medicaid agency is responsible for all Medicaid fair hearings.

1. The entity or entities that conduct fair hearings with respect to eligibility based on applicable modified adjusted gross income (MAGI) are:

☑ a. Medicaid agency

☐ b. State agency to which fair hearing authority is delegated under an Intergovernmental Cooperation Act waiver.

☐ c. Local governmental entities

☐ d. Delegated governmental agency

3. For all other Medicaid fair hearings (not related to an eligibility determination based on MAGI):

☑ All other Medicaid fair hearings are conducted at the Medicaid agency or at another state agency authorized under an ICA waiver.

Eligibility Determinations and Fair Hearings

MEDICAID | Medicaid State Plan | Administration | OK2019MS0005O | OK-19-0015

Package Header

Package ID	OK2019MS0005O	**SPA ID**	OK-19-0015
Submission Type	Official	**Initial Submission Date**	3/29/2019
Approval Date	6/21/2019	**Effective Date**	1/1/2019
Superseded SPA ID	OK-13-0019		
	User-Entered		

C. Evidentiary Hearings

The Medicaid agency uses local governmental entities to conduct local evidentiary hearings.

- ○ Yes
- ◉ No

D. Additional information (optional)

Medicaid State Plan Administration

Organization

Organization and Administration

MEDICAID | Medicaid State Plan | Administration | OK2019MS0005O | OK-19-0015

Package Header

Package ID	OK2019MS0005O	**SPA ID**	OK-19-0015
Submission Type	Official	**Initial Submission Date**	3/29/2019
Approval Date	6/21/2019	**Effective Date**	1/1/2019
Superseded SPA ID	OK-13-0019		
	User-Entered		

A. Description of the Organization and Functions of the Single State Agency

1. The single state agency is:

- (●) a. A stand-alone agency, separate from every other state agency
- ( ) b. Also the Title IV-A (TANF) agency
- ( ) c. Also the state health department
- ( ) d. Other:

2. The main functions of the Medicaid agency and where these functions are located within the agency are described below. This description should be consistent with the accompanying organizational chart attachment. (If the function is not performed by the Medicaid agency, indicate in the description which other agency performs the function.)

a. Eligibility Determinations

The OHCA operates the state's Medicaid program. The OHCA is organized in seven different divisions with specified responsibilities. Each division reports to a specific chief, deputy, or director. Eligibility rules are written and maintained by the agency's Federal and State Authorities department, a subset of the Legal & Federal and State Authorities division. Changes to eligibility policy must be approved by OHCA's Board of Directors and the State Legislature. The OHCA is responsible for all eligibility determinations, except Aged, Blind, and Disabled (ABD) and long term care applicants. Oklahoma since 2010, has offered an online eligibility system, which presently serves MAGI populations. The OHCA Enrollment Automation and Data Integrity group have responsibility for online enrollment as well as the Eligibility and Recipient subsystems of the Medicaid Management Information System (MMIS). This group ensures that eligibility policy is the basis for systematic application processing and eligibility determinations, and is housed in the Business Operations department, which reports to the Chief Executive Officer. Additionally, the Member Services department, located in the SoonerCare Operations division under the direction of the Deputy State Medicaid Director, is in constant contact with members, providers, and other stakeholders such as the legislature, and the Oklahoma Department of Human Services (DHS). The DHS is responsible for ABD eligibility determinations and any fair hearings regarding these determinations. The OHCA eligibility fair hearings functions reside with the Administrative Law Judge (ALJ) of the Business and Resource Services division. In summary, four different unrelated departments (Federal and State Authorities, Enrollment Automation and Data Integrity, Member Services, and Business and Resource Services) within the agency are involved in the eligibility determination and fair hearing process.

b. Fair Hearings (including expedited fair hearings)

Within the OHCA, fair hearings are conducted by the ALJ, an OHCA employee located in Business and Resource Services, apart from the Legal & Federal and State Authorities division. The ALJ independently renders a decision based on the preponderance of the evidence as governed by the written agreements. The OHCA fair hearing system does not provide for an agency hearing prior to review by an Administrative Law Judge. The scope of the hearings conducted by the ALJ includes hearings related to benefits and services, fair hearing of MAGI-based eligibility determinations in addition to fair hearing of eligibility and services for the ADvantage home and community-based waiver population. An additional appeal with the OHCA Executive Officer is available.

Per the ICA waiver, the DHS is responsible for any fair hearings regarding aged, blind, disabled (ABD) eligibility determinations.

c. Health Care Delivery, including benefits and services, managed care (if applicable)

The Deputy State Medicaid Director establishes and maintains day-to-day operations of the Medicaid program. The position directs and supervises certain operational divisions of the agency. These include the following units: Population Care Management, Health Care Systems Innovations, Provider/Medical Home Services, Member Services, Provider Services, Insure Oklahoma, Pharmacy Services, and Behavioral Health Services.

d. Program and policy support including state plan, waivers, and demonstrations (if applicable)

The General Counsel/Chief of Legal & Federal and State Authorities is responsible for the direction, coordination and management of all phases of Legal Services and policy development of the agency. The division includes the following units: Provider Enrollment, Legal Services, and Federal and State Authorities (policy development and federal authorities).

e. Administration, including budget, legal counsel

The Deputy CEO is responsible for multiple departments in a division called Business and Resource Services. The division includes the following departments: Communications, Planning and Project Management Office, Program Integrity and Accountability, and Quality Assurance (Q/A) and Community Living Services, and the Administrative Law Judge.

The Chief Financial Officer (CFO) is responsible for directing, coordinating and managing all phases of the multi-functional Finance division of the agency. The CFO directly oversees the operations, adequacy and soundness of the agency's fiscal structure. The Finance division includes the following units: Purchasing and Contracts Development, Financial Management, General Accounting/Budget and Fiscal Planning, Financial Resources, Financial Accountability and Compliance, Provider Rates and Analysis.

The Director of Human Resources and Administrative Services for the Human Resources division including employee training as well as the direction, coordination, and management of Administrative Services including the front desk, mail room, maintenance, and records.

f. Financial management, including processing of provider claims and other health care financing

The Chief Financial Officer (CFO) is responsible for directing, coordinating and managing all phases of the multi-functional Finance division of the agency. The CFO directly oversees the operations, adequacy and soundness of the agency's fiscal structure. The Finance division includes the following units: Purchasing and Contracts Development, Financial Management, General Accounting/Budget and Fiscal Planning, Financial Resources, Financial Accountability and Compliance, Provider Rates and Analysis.

The Chief Medical Officer is responsible the direction, coordination, and management of all phases of the following units: Quality Assurance and Quality Improvement (QA/QI) SoonerCare Compliance, Medical Support Services, Medical Authorization and Review, Coding Integrity and Reporting, Medical, and Dental.

g. Systems administration, including MMIS, eligibility systems

The Chief of Business Operations is responsible for the direction, coordination, and management of the OHCA's information systems. The division includes the following units: Technical Support, Enrollment Automation and Data Integrity, Electronic Customer Relations, Performance and Electronic Processes, Electronic Health Operations, Security Governance, and the Privacy Officer.

h. Other functions, e.g., TPL, utilization management (optional)

3. An organizational chart of the Medicaid agency has been uploaded:

Name	Date Created	
OK SPA 19-0015 Administration Organization Update - Org Chart 5.29.19	5/29/2019 6:45 PM EDT	

Organization and Administration

MEDICAID | Medicaid State Plan | Administration | OK2019MS0005O | OK-19-0015

Package Header

Package ID	OK2019MS0005O	**SPA ID**	OK-19-0015
Submission Type	Official	**Initial Submission Date**	3/29/2019
Approval Date	6/21/2019	**Effective Date**	1/1/2019
Superseded SPA ID	OK-13-0019		
	User-Entered		

B. Entities that Determine Eligibility or Conduct Fair Hearings Other than the Medicaid Agency

Title

Single state agency under Title IV-A (TANF)

Description of the functions the delegated entity performs in carrying out its responsibilities:

The Oklahoma Department of Human Services (DHS) is responsible for ABD eligibility determinations and any fair hearings regarding these determinations

Organization and Administration

MEDICAID | Medicaid State Plan | Administration | OK2019MS0005O | OK-19-0015

Package Header

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Superseded SPA ID	OK-13-0019		
	User-Entered		

E. Coordination with Other Executive Agencies

The Medicaid agency coordinates with any other Executive agency related to any Medicaid functions or activities not described elsewhere in the Organization and Administration portion of the state plan (e.g. public health, aging, substance abuse, developmental disability agencies):.

(•) Yes

( ) No

Name of agency:	Description of the Medicaid functions or activities conducted or coordinated with another executive agency:
Oklahoma Department of Mental Health and Substance Abuse Services	The Oklahoma Department of Mental Health and Substance Abuse Services is responsible for providing public health services relating to mental illness and substance abuse. ODMHSAS supports a continuum of programs from community-based treatment and case management to acute inpatient care.
Oklahoma Department of Rehabilitative Services	The Oklahoma Department of Rehabilitative Services expands opportunities for employment, independent life and economic self-sufficiency by helping Oklahomans with disabilities bridge barriers to success in the workplace, school and at home. ODRS is comprised of five program divisions: Vocational Rehabilitation Division, Visual Services Division, Disability Determination Division, Oklahoma School for the Deaf, and Oklahoma School for the Blind.
Oklahoma Office of Juvenile Affairs	The Oklahoma Office of Juvenile Affairs is responsible for planning and coordinating statewide juvenile justice and delinquency prevention services. OJA is also responsible for operating juvenile correctional facilities in the State.

Name of agency:	Description of the Medicaid functions or activities conducted or coordinated with another executive agency:
Oklahoma State Department of Health	The Oklahoma State Department of Health leads the state in strategic planning to become a healthier state. This agency is also a public health provider. OHCA and OSDH collaborate and interact on matters related to family planning, child wellness, and performance improvement initiatives.

Organization and Administration

MEDICAID | Medicaid State Plan | Administration | OK2019MS0005O | OK-19-0015

Package Header

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Superseded SPA ID	OK-13-0019		
	User-Entered		

F. Additional information (optional)

The Governor is the Chief Executive Officer of the State of Oklahoma. Within 45 days of taking office, the governor is allowed to create his/her own cabinet, with anywhere from no less than 10 but no more than 15 Secretaries representing all the branches of state government.

The OHCA is under the Governor's Cabinet Secretary for Health and Human Services and has extensive working relationships with the other state agencies that provide health, human services, and public assistance. In addition to the OHCA, this includes the Oklahoma State Department of Health, the Oklahoma Department of Human Services, the Oklahoma Department of Mental Health and Substance Abuse Services, the Oklahoma Department of Rehabilitative Services, and Oklahoma Office of Juvenile Affairs.

Medicaid State Plan Administration

Organization

Single State Agency Assurances

MEDICAID | Medicaid State Plan | Administration | OK2019MS0005O | OK-19-0015

Package Header

Package ID	OK2019MS0005O	**SPA ID**	OK-19-0015
Submission Type	Official	**Initial Submission Date**	3/29/2019
Approval Date	6/21/2019	**Effective Date**	1/1/2019
Superseded SPA ID	OK-13-0019		
	User-Entered		

A. Assurances

☑ 1. The state plan is in operation on a statewide basis, in accordance with all the requirements of 42 CFR 431.50.

☑ 2. All requirements of 42 CFR 431.10 are met.

☑ 3. There is a Medical Care Advisory Committee to the agency director on health and medical services established in accordance with 42 CFR 431.12. All requirements of 42 CFR 431.12 are met.

☑ 4. The Medicaid agency does not delegate, other than to its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.

☑ 5. The Medicaid agency has established and maintains methods of personnel administration on a merit basis in accordance with the standards described at 5 USC 2301, and regulations at 5 CFR Part 900, Subpart F. All requirements of 42 CFR 432.10 are met.

☑ 6. All requirements of 42 CFR Part 432, Subpart B are met, with respect to a training program for Medicaid agency personnel and the training and use of sub-professional staff and volunteers.

B. Additional information (optional)

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

This view was generated on 6/27/2019 1:45 PM EDT

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: OKLAHOMA

Tribal Consultation Requirements

Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

Please describe the process the State uses to seek advice on a regular, ongoing basis from federally-recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Please include information about the frequency, inclusiveness and process for seeking such advice.

Oklahoma has three different tribal provider types including 638 tribal facilities, facilities operated by the Indian Health Service, and Urban Indian clinics (This collective group is referred to as Indian Tribal Units I/T/Us). The agency has quarterly meetings with all of the Indian Health Service business office managers, and meets on an as needed basis with any of the three tribal provider types, as well as conducts site visits and trainings as needed. Additionally, the agency hosts an annual tribal consultation meeting each year in which all tribal provider types are invited.

In regard to rule, waiver implementations or renewals, state plan changes, and demonstrations projects, the agency issues an I/T/U Public Notice provider letter to each I/T/U provider(s) advising them of all proposed rule, waiver implementations or renewals, state plan changes, and demonstrations projects, and/or state plan changes. The I/T/Us are encouraged to offer feedback on proposed changes. The letter is also posted to our public website under I/T/U Public Notification which is a designated place for I/T/Us updates and information. The agency also has a proposed rule change page on our public website that allows public comment on proposed rule changes and offers web alerts for future updates and comment opportunities. Notification to tribes for consultation under normal circumstances is provided at least 60 days prior to a rule change or waiver/SPA submission. In the event of abnormal circumstances (such as, but not exclusive to Federal Regulatory changes, judgments from lawsuits, etc.), I/T/Us are given as much notice for consultation as possible; if such an abnormal process has been identified, notification to tribes for consultation could be as short as 14 days prior to submission of the waiver implementations or renewals, state plan changes, and/or demonstrations projects, in conjunction with email notification to the I/T/Us of the proposed changes.

Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

The agency developed and issued a survey and letter to I/T/Us to ascertain if the tribes were satisfied with the current process and to offer suggestions for improvement. Of the respondents, approximately 80% indicated that they were satisfied or very satisfied with the current process.

Revised 12-01-10

State: Oklahoma
Date Received: 27 November, 2013
Date Approved: 19 September, 2016
Effective Date: 1 October, 2013
Transmittal Number: 13-19

TN 13-19 Approval Date 9/19/16 Effective Date 10/1/13
Supersedes TN 10-38

Revision: HCFA-PM-94-3 (MB)
APRIL 1994
State/Territory: OKLAHOMA

Citation

1.5 Pediatric Immunization Program

1928 of the Act

1. The State has implemented a program for the distribution of pediatric vaccines to program-registered providers for the immunization of federally vaccine-eligible children in accordance with section 1928 as indicated below.

   a. The State program will provide each vaccine-eligible child with medically appropriate vaccines according to the schedule developed by the Advisory Committee on Immunization Practices and without charge for the vaccines.

   b. The State will outreach and encourage a variety of providers to participate in the program and to administer vaccines in multiple settings, e.g., private health care providers, providers that receive funds under Title V of the Indian Health Care Improvement Act, health programs or facilities operated by Indian tribes, and maintain a list of program-registered providers.

   c. With respect to any population of vaccine-eligible children a substantial portion of whose parents have limited ability to speak the English language, the State will identify program-registered providers who are able to communicate with this vaccine-eligible population in the language and cultural context which is most appropriate.

   d. The State will instruct program-registered providers to determine eligibility in accordance with section 1928(b) and (h) of the Social Security Act.

   e. The State will assure that no program-registered provider will charge more for the administration of the vaccine than the regional maximum established by the Secretary. The State will inform program-registered providers of the maximum fee for the administration of vaccines.

   f. The State will assure that no vaccine-eligible child is denied vaccines because of an inability to pay an administration fee.

   g. Except as authorized under section 1915(b) of the Social Security Act or as permitted by the Secretary to prevent fraud or abuse, the State will not impose any additional qualifications or conditions, in addition to those indicated above, in order for a provider to qualify as a program-registered provider.

New 10-01-94

STATE Oklahoma
DATE RECD DEC 29 1994
DATE APPVD JAN 17 1995
DATE EFF DEC 01 1994
HCFA 179 94-24
A

TN No. 94-24
Supersedes
TN No SUPERSEDES: NONE - NEW PAGE

Approval Date JAN 17 1995 Effective Date DEC 01 1994

Revision: HCFA-PM-94-3 (MB)
APRIL 1994
State/Territory: OKLAHOMA

Citation

1928 of the Act

2. The State has not modified or repealed any Immunization Law in effect as of May 1, 1993 to reduce the amount of health insurance coverage of pediatric vaccines.

3. The State Medicaid Agency has coordinated with the State Public Health Agency in the completion of this preprint page.

4. The State agency with overall responsibility for the implementation and enforcement of the provisions of section 1928 is:

___ State Medicaid Agency

X State Public Health Agency

STATE Oklahoma
DATE RCVD DEC 29 1994
DATE APPVD JAN 17 1995
DATE EFF DEC 01 1994
HCFA 179 94-24

A

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

MAGI-Based Income Methodologies — S10

1902(e)(14)
42 CFR 435.603

☑ The state will apply Modified Adjusted Gross Income (MAGI)-based methodologies as described below, and consistent with 42 CFR 435.603.

In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid on or before December 31, 2013, MAGI-based income methodologies will not be applied until March 31, 2014, or the next regularly-scheduled renewal of eligibility, whichever is later, if application of such methods results in a determination of ineligibility prior to such date.

In determining family size for the eligibility determination of a pregnant woman, she is counted as herself plus each of the children she is expected to deliver.

In determining family size for the eligibility determination of the other individuals in a household that includes a pregnant woman:

- ○ The pregnant woman is counted just as herself.
- ○ The pregnant woman is counted as herself, plus one.
- ◉ The pregnant woman is counted as herself, plus the number of children she is expected to deliver.

Financial eligibility is determined consistent with the following provisions:

When determining eligibility for new applicants, financial eligibility is based on current monthly income and family size.

When determining eligibility for current beneficiaries, financial eligibility is based on:

- ◉ Current monthly household income and family size
- ○ Projected annual household income and family size for the remaining months of the current calendar year

In determining current monthly or projected annual household income, the state will use reasonable methods to:

- ☒ Include a prorated portion of a reasonably predictable increase in future income and/or family size.
- ☒ Account for a reasonably predictable decrease in future income and/or family size.

Except as provided at 42 CFR 435.603(d)(2) through (d)(4), household income is the sum of the MAGI-based income of every individual included in the individual's household.

In determining eligibility for Medicaid, an amount equivalent to 5 percentage points of the FPL for the applicable family size will be deducted from household income in accordance with 42 CFR 435.603(d).

Household income includes actually available cash support, exceeding nominal amounts, provided by the person claiming an individual described at §435.603(f)(2)(i) as a tax dependent

○ Yes ◉ No

State: Oklahoma
Date Received: 11/27/2013
Date Approved: 02/21/2014
Date Effective: 1/1/2014
Transmittal Number: 13-0018

Medicaid Eligibility

☑ The age used for children with respect to 42 CFR 435.603(f)(3)(iv) is:

◉ Age 19

○ Age 19, or in the case of full-time students, age 21

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State: Oklahoma
Date Received: 11/27/2013
Date Approved: 02/21/2014
Date Effective: 1/1/2014
Transmittal Number: 13-0018

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

AFDC Income Standards — S14

Enter the AFDC Standards below. All states must enter:

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988 and
AFDC Payment Standard in Effect As of July 16, 1996

Entry of other standards is optional.

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988

Income Standard Entry - Dollar Amount - Automatic Increase Option — S13a

The standard is as follows:

- (•) Statewide standard
- ( ) Standard varies by region
- ( ) Standard varies by living arrangement
- ( ) Standard varies in some other way

Enter the statewide standard

	Household size	Standard ($)	
+	1	200	X
+	2	251	X
+	3	325	X
+	4	401	X
+	5	469	X
+	6	537	X
+	7	604	X
+	8	665	X
+	9	724	X

Additional incremental amount
( ) Yes (•) No

Increment amount $

The dollar amounts increase automatically each year
( ) Yes (•) No

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

Medicaid Eligibility

AFDC Payment Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- (•) Statewide standard
- ( ) Standard varies by region
- ( ) Standard varies by living arrangement
- ( ) Standard varies in some other way

Enter the statewide standard

	Household size	Standard ($)	
+	1	190	X
+	2	238	X
+	3	307	X
+	4	380	X
+	5	445	X
+	6	509	X
+	7	574	X
+	8	631	X
+	9	685	X

Additional incremental amount

( ) Yes (•) No

Increment amount $

The dollar amounts increase automatically each year

( ) Yes (•) No

MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- (•) Statewide standard
- ( ) Standard varies by region
- ( ) Standard varies by living arrangement

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

○ Standard varies in some other way

Enter the statewide standard

	Household size	Standard ($)	
+	1	210	X
+	2	265	X
+	3	341	X
+	4	421	X
+	5	493	X
+	6	564	X
+	7	636	X
+	8	700	X
+	9	760	X

Additional incremental amount

○ Yes ◉ No

Increment amount $

The dollar amounts increase automatically each year

○ Yes ◉ No

AFDC Need Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

◉ Statewide standard

○ Standard varies by region

○ Standard varies by living arrangement

○ Standard varies in some other way

Enter the statewide standard

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

Medicaid Eligibility

	Household size	Standard ($)	
+	1	398	X
+	2	499	X
+	3	645	X
+	4	798	X
+	5	933	X
+	6	1,068	X
+	7	1,203	X
+	8	1,323	X
+	9	1,436	X

Additional incremental amount

○ Yes ◉ No

Increment amount $

The dollar amounts increase automatically each year

○ Yes ◉ No

AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date.

Income Standard Entry - Dollar Amount - Automatic Increase Option **S13a**

The standard is as follows:

○ Statewide standard

○ Standard varies by region

○ Standard varies by living arrangement

○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- ○ Statewide standard
- ○ Standard varies by region
- ○ Standard varies by living arrangement
- ○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

TANF payment standard

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- ○ Statewide standard
- ○ Standard varies by region
- ○ Standard varies by living arrangement
- ○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

MAGI-equivalent TANF payment standard

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- ○ Statewide standard
- ○ Standard varies by region
- ○ Standard varies by living arrangement
- ○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

Medicaid Eligibility

PRA Disclosure Statement

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State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

OK - Submission Package - OK2021MS0005O - (OK-21-0038) - Eligibility

CMS-10434 OMB 0938-1188

Medicaid State Plan Eligibility

Presumptive Eligibility

Presumptive Eligibility by Hospitals

MEDICAID | Medicaid State Plan | Eligibility | OK2021MS0005O | OK-21-0038

Package Header

Package ID	OK2021MS0005O	**SPA ID**	OK-21-0038
Submission Type	Official	**Initial Submission Date**	9/16/2021
Approval Date	07/25/2023	**Effective Date**	10/1/2021
Superseded SPA ID	16-0015		
	User-Entered		

☐ The state provides an assurance that it has policies and procedures in place to enable qualified hospitals to determine presumptive eligibility under 42 CFR 435.1110, and the state is providing Medicaid coverage for individuals determined presumptively eligible under this provision.

☐ The state attests that presumptive eligibility by hospitals is administered in accordance with the following provisions:

A. Qualifications of Hospitals

A qualified hospital is a hospital that:

1. Participates as a provider under the state plan or a Medicaid 1115 Demonstration, notifies the Medicaid agency of its election to make presumptive eligibility determinations and agrees to make presumptive eligibility determinations consistent with state policies and procedures.

2. Has not been disqualified by the Medicaid agency for failure to make presumptive eligibility determinations in accordance with applicable state policies and procedures or for failure to meet any standards that may have been established by the Medicaid agency.

3. Assists individuals in completing and submitting the full application and understanding any documentation requirements.

◉ Yes ○ No

Presumptive Eligibility by Hospitals

MEDICAID | Medicaid State Plan | Eligibility | OK2021MS0005O | OK-21-0038

Package Header

Package ID	OK2021MS0005O	**SPA ID**	OK-21-0038
Submission Type	Official	**Initial Submission Date**	9/16/2021
Approval Date	07/25/2023	**Effective Date**	10/1/2021
Superseded SPA ID	16-0015		
	User-Entered		

B. Eligibility Groups or Populations Included

The eligibility groups or populations for which hospitals determine eligibility presumptively are:

1. Pregnant Women
2. Infants and Children under Age 19
3. Parents and Other Caretaker Relatives
4. Adult Group, if covered by the state
5. Individuals above 133% FPL under Age 65, if covered by the state
6. Individuals Eligible for Family Planning Services, if covered by the state
7. Former Foster Care Children
8. Certain Individuals Needing Treatment for Breast or Cervical Cancer, if covered by the state

The state limits qualified hospitals for this group to providers who conduct screenings for breast and cervical cancer under the state's Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program.

○ Yes ◉ No

☐ 9. Other Medicaid state plan eligibility groups:

☐ 10. Demonstration populations covered under section 1115

Presumptive Eligibility by Hospitals

MEDICAID | Medicaid State Plan | Eligibility | OK2021MS0005O | OK-21-0038

Package Header

Package ID	OK2021MS0005O	**SPA ID**	OK-21-0038
Submission Type	Official	**Initial Submission Date**	9/16/2021
Approval Date	07/25/2023	**Effective Date**	10/1/2021
Superseded SPA ID	16-0015		
	User-Entered		

C. Standards for Participating Hospitals

The state establishes reasonable standards for qualified hospitals making presumptive eligibility determinations.

(•) Yes ( ) No

[ ] The state has a standard requiring that a percentage of individuals who are determined presumptively eligible submit a regular application, as described at 42 CFR 435.907, before the end of the presumptive eligibility period.

Percentage of individuals submitting a regular application:

95.00%

[ ] The state has a standard requiring that a percentage of individuals who are determined presumptively eligible be determined eligible for Medicaid based on the submission of an application before the end of the presumptive eligibility period.

Percentage of individuals found eligible for Medicaid

95.00%

[ ] The state has elected one or more other reasonable standard(s).

D. Presumptive Eligibility Period

1. The presumptive period begins on the date the determination is made.
2. The end date of the presumptive period is the earlier of:
   - The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or
   - The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.
3. Periods of presumptive eligibility are limited as follows:

( ) a. No more than one period within a calendar year.

( ) b. No more than one period within two calendar years.

( ) c. No more than one period within a six-month period, starting with the effective date of the initial presumptive eligibility period.

( ) d. No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

(•) e. Other reasonable limitation:

Name of limitation	Description
Number of non-pregnancy-related PE periods allowed	The number of PE periods that may be authorized is one (1) period within 12 calendar months.
Number of pregnancy-related PE periods allowed	Individuals applying for pregnancy-related PE are limited to one PE period per pregnancy.

Presumptive Eligibility by Hospitals

MEDICAID | Medicaid State Plan | Eligibility | OK2021MS0005O | OK-21-0038

Package Header

Package ID	OK2021MS0005O	**SPA ID**	OK-21-0038
Submission Type	Official	**Initial Submission Date**	9/16/2021
Approval Date	07/25/2023	**Effective Date**	10/1/2021
Superseded SPA ID	16-0015		
	User-Entered		

E. Application for Presumptive Eligibility

☐ 1. The state uses a standardized screening process for determining presumptive eligibility.

☐ 2. The state uses the single streamlined paper and/or online application form for Medicaid and Presumptive Eligibility, approved by CMS. A copy of the single streamlined paper and/or online application with questions necessary for a PE determination highlighted or denoted is included.

☐ 3. The state uses a separate paper application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

Name	Date Created	
HPE Application 12.12.22	4/27/2023 8:05 PM EDT	

☐ 4. The state uses an online portal or electronic screening tool for presumptive eligibility approved by CMS. Screenshots of the tool included.

5. Describe the presumptive eligibility screening process:

At the individual's initial visit to a Hospital Presumptive Eligibility (HPE) Qualified Entity, an Authorized Hospital Employee takes the following steps to screen a participants enrollment:
1. Verifies the applicant is not currently enrolled in Medicaid through the Provider Portal Eligibility Verification System (EVS).
2. Assists the individual in completing all the required questions of the HPE application.
3. Determine if individual meets the reasonable estimate of Modified Adjusted Gross Income (MAGI) methodology.
4. Provide the eligibility notice to the member.
5. Summarize benefits and answer any questions.
6. Email the individual's application and benefits eligibility to the State Medicaid Agency within 5 days of the application date .
7. Assist the individual with completing the full Medicaid application within 15 days of the start of the HPE determination date.

F. Presumptive Eligibility Determination

The presumptive eligibility determination is based on the following factors:

1. The individual's categorical or non-financial eligibility for the group for which the individual's presumptive eligibility is being determined (e.g., based on age, pregnancy status, status as a parent/caretaker relative, disability, or other requirements specified in the Medicaid state plan or a Medicaid 1115 demonstration for that group)

2. Household income must not exceed the applicable income standard for the group for which the individual's presumptive eligibility is being determined, if an income standard is applicable for this group.

◉ a. A reasonable estimate of MAGI-based income is used to determine household income.

○ b. Gross income is used to determine household size.

○ c. Other income methodology

☐ 3. State residency

☐ 4. Citizenship, status as a national, or satisfactory immigration status

Presumptive Eligibility by Hospitals

MEDICAID | Medicaid State Plan | Eligibility | OK2021MS0005O | OK-21-0038

Package Header

Package ID OK2021MS0005O
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Superseded SPA ID 16-0015
User-Entered

G. Qualified Entity Requirements

☐ 1. The state assures that it has communicated the requirements for qualified hospitals, and has provided adequate training to the hospitals.

2. A copy of the training materials has been uploaded for review during the submission process.

Name	Date Created	
HPE Attestation	5/27/2022 11:36 AM EDT	
HPE MAGI Training	4/27/2023 8:09 PM EDT	
HPE Training	4/27/2023 8:09 PM EDT	
HPE Application 12.12.22	4/27/2023 8:09 PM EDT	
HPE Applicant Approval Notice 11.09.22	4/27/2023 8:09 PM EDT	
HPE Applicant Denial Notice 11.09.22	4/27/2023 8:09 PM EDT	

1 – 6 of 6

H. Additional Information (optional)

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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OK - Submission Package - OK2021MS0005O - (OK-21-0038) - Eligibility

CMS-10434 OMB 0938-1188

Medicaid State Plan Eligibility

Eligibility and Enrollment Processes

Presumptive Eligibility

MEDICAID | Medicaid State Plan | Eligibility | OK2021MS0005O | OK-21-0038

Package Header

Package ID OK2021MS0005O
SPA ID OK-21-0038
Submission Type Official
Initial Submission Date 9/16/2021
Approval Date 07/25/2023
Effective Date 10/1/2021
Superseded SPA ID N/A

User-Entered

The state provides Medicaid services to individuals during a presumptive eligibility period following a determination by a qualified entity.

Presumptive eligibility covered in the state plan includes:

Eligibility Groups

Eligibility Group Name	Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Presumptive Eligibility for Children under Age 19	☐	☐	○	NEW
Parents and Other Caretaker Relatives - Presumptive Eligibility	☐	☐	○	NEW
Presumptive Eligibility for Pregnant Women	☐	☐	○	NEW
Adult Group - Presumptive Eligibility	☐	☐	○	NEW
Individuals above 133% FPL under Age 65 - Presumptive Eligibility	☐	☐	○	NEW
Individuals Eligible for Family Planning Services - Presumptive Eligibility	☐	☐	○	NEW
Former Foster Care Children - Presumptive Eligibility	☐	☐	○	NEW
Individuals Needing Treatment for Breast or Cervical Cancer - Presumptive Eligibility	☐	☐	○	NEW

Hospitals

Eligibility Group Name	Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Presumptive Eligibility by Hospitals	☐	☐	○	APPROVED

Presumptive Eligibility

MEDICAID | Medicaid State Plan | Eligibility | OK2021MS0005O | OK-21-0038

Package Header

Package ID	OK2021MS0005O	**SPA ID**	OK-21-0038
Submission Type	Official	**Initial Submission Date**	9/16/2021
Approval Date	07/25/2023	**Effective Date**	10/1/2021
Superseded SPA ID	N/A		
	User-Entered		

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Medicaid State Plan Eligibility

Mandatory Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | OK2020MS0008O | OK-21-0001

Package Header

Package ID OK2020MS0008O
SPA ID OK-21-0001
Submission Type Official
Initial Submission Date 9/8/2020
Approval Date 12/4/2020
Effective Date 7/1/2021
Superseded SPA ID OK-13-0017
System-Derived

Mandatory Coverage

A. The state provides Medicaid to mandatory groups of individuals. The mandatory groups covered are:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Infants and Children under Age 19		☑	☐	○	CONVERTED
Parents and Other Caretaker Relatives		☑	☐	○	CONVERTED
Pregnant Women		☑	☐	○	CONVERTED
Deemed Newborns		☑	☐	○	NEW
Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care		☑	☐	○	NEW
Former Foster Care Children		☑	☐	○	NEW
Transitional Medical Assistance		☑	☐	○	NEW
Extended Medicaid due to Spousal Support Collections		☑	☐	○	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
SSI Beneficiaries		☑	☐	○	NEW
Closed Eligibility Groups		☑	☐	○	NEW
Individuals Deemed To Be Receiving SSI		☑	☐	○	NEW
Working Individuals under 1619(b)		☑	☐	○	NEW
Qualified Medicare Beneficiaries		☑	☐	○	NEW
Qualified Disabled and Working Individuals		☑	☐	○	NEW
Specified Low Income Medicare Beneficiaries		☑	☐	○	NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Qualifying Individuals		☑	☐	◯	NEW

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage
Parents and Other Caretaker Relatives S25

42 CFR 435.110
1902(a)(10)(A)(i)(I)
1931(b) and (d)

■ **Parents and Other Caretaker Relatives** - Parents and other caretaker relatives of dependent children with household income at or below a standard established by the state.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Individuals qualifying under this eligibility group must meet the following criteria:

■ Are parents or other caretaker relatives (defined at 42 CFR 435.4), including pregnant women, of dependent children (defined at 42 CFR 435.4) under age 18. Spouses of parents and other caretaker relatives are also included.

The state elects the following options:

☐ This eligibility group includes individuals who are parents or other caretakers of children who are 18 years old, provided the children are full-time students in a secondary school or the equivalent level of vocational or technical training.

☐ Options relating to the definition of caretaker relative (select any that apply):

☒ Options relating to the definition of dependent child (select the one that applies):

◉ The state elects to eliminate the requirement that a dependent child must be deprived of parental support or care by reason of the death, physical or mental incapacity, or absence from the home or unemployment of at least one parent.

○ The child must be deprived of parental support or care, but a less restrictive standard is used to measure unemployment of the parent (select the one that applies):

■ Have household income at or below the standard established by the state.

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

■ Income standard used for this group

■ Minimum income standard

The minimum income standard used for this group is the state's AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in S14 AFDC Income Standards.

☑ The state certifies that it has submitted and received approval for its converted May 1, 1988 AFDC payment standard.

An attachment is submitted.

■ Maximum income standard

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

Medicaid Eligibility

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for parents and other caretaker relatives to MAGI-equivalent standards and the determination of the maximum income standard to be used for parents and other caretaker relatives under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is:

◉ The state's effective income level for section 1931 families under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for section 1931 families under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

○ A percentage of the federal poverty level: [ ] %

○ The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

○ The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

○ The state's TANF payment standard, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

◉ Other dollar amount

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

◉ Statewide standard

○ Standard varies by region

○ Standard varies by living arrangement

○ Standard varies in some other way

Enter the statewide standard

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

Medicaid Eligibility

	Household size	Standard ($)	
+	1	407	X
+	2	521	X
+	3	668	X
+	4	820	X
+	5	958	X
+	6	1,098	X
+	7	1,236	X
+	8	1,364	X
+	9	1,486	X

Additional incremental amount

○ Yes ◉ No

Increment amount $

The dollar amounts increase automatically each year

○ Yes ◉ No

☑ Income standard chosen:

Indicate the state's income standard used for this eligibility group:

○ The minimum income standard

◉ The maximum income standard

○ The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date. The standard is described in S14 AFDC Income Standards.

○ Another income standard in-between the minimum and maximum standards allowed

☑ There is no resource test for this eligibility group.

☑ Presumptive Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

○ Yes ◉ No

PRA Disclosure Statement

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

Medicaid Eligibility

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Pregnant Women

MEDICAID | Medicaid State Plan | Eligibility | OK2022MS0011O | OK-22-0042

Women who are pregnant or post-partum, with household income at or below a standard established by the state.

Package Header

Package ID	OK2022MS0011O	**SPA ID**	OK-22-0042
Submission Type	Official	**Initial Submission Date**	12/30/2022
Approval Date	3/23/2023	**Effective Date**	1/1/2023
Superseded SPA ID	OK-13-0017		
	System-Derived		

The state covers the mandatory pregnant women group in accordance with the following provisions:

A. Characteristics

1. Individuals qualifying under this eligibility group must be pregnant or post-partum, as defined in 42 CFR 435.4.

2. Pregnant women in the last trimester of their pregnancy without dependent children are eligible for full benefits under this group in accordance with section 1931 of the Act, if they meet the income standard for state plan Parents and Other Caretaker Relatives at 42 C.F.R. 435.110.

○ Yes

◉ No

B. Financial Methodologies

MAGI-based methodologies are used in calculating household income. Please refer as necessary to MAGI-Based Methodologies, completed by the state.

C. Income Standard Used

The state uses the following income standard for this group:

FPL 205.00%

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

Pregnant Women

MEDICAID | Medicaid State Plan | Eligibility | OK2022MS0011O | OK-22-0042

Package Header

Package ID	OK2022MS0011O	**SPA ID**	OK-22-0042
Submission Type	Official	**Initial Submission Date**	12/30/2022
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Superseded SPA ID	OK-13-0017		
	System-Derived		

D. Benefits for Pregnant Women

Benefits for individuals in this eligibility group consist of the following:

(•) 1. All pregnant women eligible under this group receive full Medicaid coverage under this state plan.

( ) 2. Pregnant women whose income exceeds the income limit specified for full coverage of pregnant women receive only pregnancy-related services.

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

Pregnant Women

MEDICAID | Medicaid State Plan | Eligibility | OK2022MS0011O | OK-22-0042

Package Header

Package ID	OK2022MS0011O	**SPA ID**	OK-22-0042
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Superseded SPA ID	OK-13-0017		
	System-Derived		

E. Basis for Pregnant Women Income Standard

1. Minimum income standard

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for pregnant women, or as of July 1, 1989, had authorizing legislation to do so.

- ○ Yes
- ◉ No

b. The minimum income standard for this eligibility group is 133% FPL.

2. Maximum income standard

☑ a. The state certifies that it has submitted and received approval for its converted income standard(s) for pregnant women to MAGI-equivalent standards and the determination of the maximum income standard to be used for pregnant women under this eligibility group.

b. The state's maximum income standard for this eligibility group is:

- ◉ i. The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- ○ ii. The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- ○ iii. The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- ○ iv. The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- ○ v. 185% FPL

c. The amount of the maximum income standard is: **FPL** 205.00%

G. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility and Enrollment Processes

Continuous Eligibility for Pregnant Women and Extended Postpartum Coverage

MEDICAID | Medicaid State Plan | Eligibility | OK2022MS0011O | OK-22-0042

Package Header

Package ID	OK2022MS0011O	**SPA ID**	OK-22-0042
Submission Type	Official	**Initial Submission Date**	12/30/2022
Approval Date	3/23/2023	**Effective Date**	1/1/2023
Superseded SPA ID	New		
	User-Entered		

The state provides continuous eligibility for pregnant individuals and extended postpartum coverage in accordance with the following provisions:

A. Mandatory Continuous Eligibility for Pregnant Women

The state provides continuous eligibility to pregnant individuals who were eligible and enrolled under the state plan, without regard to any changes in income that otherwise would result in ineligibility, through the last day of the month in which a 60-day postpartum period (beginning on the last day of the pregnancy) ends. This extension does not apply to pregnant individuals eligible only during a period of presumptive eligibility.

B. Optional 12-Month Postpartum Continuous Eligibility for Pregnant Women

The state provides continuous eligibility to pregnant individuals who were eligible and enrolled under the state plan while pregnant (including during a period of retroactive eligibility) through the last day of the month in which a 12-month postpartum period (beginning on the last day of the pregnancy) ends. The 12-month postpartum continuous eligibility option applies for the period beginning on the effective date of this reviewable unit and is available through March 31, 2027 (or other date as specified by law).

(•) Yes

( ) No

1. This extension does not apply to pregnant individuals eligible only during a period of presumptive eligibility.
2. Full benefits are provided for a pregnant or postpartum individual under this option. This includes all items and services covered under the state plan (or waiver) that are not less in amount, duration, or scope than, or are determined by the Secretary to be substantially equivalent to, the medical assistance available for an individual described in subsection 1902 (a)(10)(A)(i) of the Act.
3. Continuous eligibility is provided to pregnant individuals eligible and enrolled under the state plan through the end of the 12-month postpartum period who would otherwise lose eligibility because of a change in circumstances, unless:

    a. The individual requests voluntary termination of eligibility;

    b. The individual ceases to be a resident of the state;

    c. The Medicaid agency determines that eligibility was determined incorrectly at the most recent determination or redetermination of eligibility because of agency error or fraud, abuse or perjury attributed to the individual; or

    d. The individual dies.

C. Additional Information (optional)

Section 5113 of the Consolidated Appropriations Act, 2023 eliminated, without replacement, the March 31, 2027, sunset date of the 12-month postpartum continuous eligibility option. Therefore, the durational limit of the option that is described in section B. does not apply.

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage
Infants and Children under Age 19 **S30**

42 CFR 435.118
1902(a)(10)(A)(i)(III), (IV), (VI) and (VII)
1902(a)(10)(A)(ii)(IV) and (IX)
1931(b) and (d)

■ **Infants and Children under Age 19** - Infants and children under age 19 with household income at or below standards established by the state based on age group.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Children qualifying under this eligibility group must meet the following criteria:

■ Are under age 19

■ Have household income at or below the standard established by the state.

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

■ Income standard used for infants under age one

■ Minimum income standard

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for infants under age one, or as of July 1, 1989, had authorizing legislation to do so.

○ Yes ◉ No

The minimum income standard for infants under age one is 133% FPL.

■ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for infants under age one to MAGI-equivalent standards and the determination of the maximum income standard to be used for infants under age one.

An attachment is submitted.

The state's maximum income standard for this age group is:

◉ The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

Medicaid Eligibility

The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

185% FPL

Enter the amount of the maximum income standard: 205 % FPL

☑ Income standard chosen

The state's income standard used for infants under age one is:

◉ The maximum income standard

If not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

☑ Income standard for children age one through age five, inclusive

☑ Minimum income standard

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

The minimum income standard used for this age group is 133% FPL.

☑ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for children age one through five to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age one through five.

An attachment is submitted.

The state's maximum income standard for children age one through five is:

◉ The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

Enter the amount of the maximum income standard: 205 % FPL

☑ Income standard chosen

The state's income standard used for children age one through five is:

◉ The maximum income standard

○ If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

Medicaid Eligibility

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

■ Income standard for children age six through age eighteen, inclusive

■ Minimum income standard

The minimum income standard used for this age group is 133% FPL.

■ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for children age six through eighteen to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age six through age eighteen.

An attachment is submitted.

The state's maximum income standard for children age six through eighteen is:

◉ The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ 133% FPL

Enter the amount of the maximum income standard: 205 % FPL

■ Income standard chosen

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

Medicaid Eligibility

The state's income standard used for children age six through eighteen is:

(•) The maximum income standard

( ) If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

( ) If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

( ) If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

( ) If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

( ) Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

[■] There is no resource test for this eligibility group.

[■] Presumptive Eligibility

The state covers children when determined presumptively eligible by a qualified entity.

( ) Yes (•) No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

Mandatory Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | OK2020MS0008O | OK-21-0001

Package Header

Package ID	OK2020MS0008O	**SPA ID**	OK-21-0001
Submission Type	Official	**Initial Submission Date**	9/8/2020
Approval Date	12/4/2020	**Effective Date**	7/1/2021
Superseded SPA ID	OK-13-0017		
	System-Derived		

B. The state elects the Adult Group, described at 42 CFR 435.119.

(•) Yes ( ) No

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Adult Group		☑	☑	◯	APPROVED

C. Additional Information (optional)

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Former Foster Care Children

MEDICAID | Medicaid State Plan | Eligibility | OK2022MS0010O | OK-22-0031

Individuals under the age of 26, who were in foster care and on Medicaid when they turned age 18 or aged out of foster care.

Package Header

Package ID	OK2022MS0010O	**SPA ID**	OK-22-0031
Submission Type	Official	**Initial Submission Date**	12/30/2022
Approval Date	3/22/2023	**Effective Date**	1/1/2023
Superseded SPA ID	OK-13-17		
	User-Entered		

The state covers the mandatory former foster care children group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are under age 26

2. Were in foster care upon attaining age 18 or a higher age at which the state's or Tribe's foster care assistance ends under title IV-E of the Act (up to age 21).

3. Are described under either Section B. or C.

B. Individuals Covered

For individuals who turn 18 before January 1, 2023:

1. The state covers individuals who:

a. Upon attaining age 18 or a higher age at which the state's or Tribe's foster care assistance ends under title IV-E of the Act (up to age 21) were:

i. In foster care under the responsibility of the state or a Tribe within the state (including children who were cared for through a grant to the state under the unaccompanied refugee minor program); and

ii. Enrolled in Medicaid under the state's Medicaid state plan or 1115 demonstration; and

b. Are not otherwise eligible for and enrolled for mandatory coverage under the state plan, except that eligibility under this group takes precedence over eligibility under the Adult Group.

2. In addition to B.1., the state elects to cover individuals who were in foster care under the responsibility of the state or a Tribe within the state (including children who were cared for through a grant to the state under the unaccompanied refugee minor program) when they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends under title IV-E of the Act, and meet the following criteria:

☐ a. They were enrolled in Medicaid under the state's Medicaid state plan or 1115 demonstration at any time during the foster care period in which they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends.

☐ b. They were placed by the state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project when they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends.

☐ c. They were placed by the state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project at any time during the foster care period in which they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends.

C. Individuals Covered

For individuals who turn 18 on or after January 1, 2023:

1. The state covers individuals who:

a. Upon attaining age 18 or a higher age at which the state's or Tribe's foster care assistance ends under title IV-E of the Act (up to age 21) were:

i. In foster care under the responsibility of any state or a Tribe within any stat to the state under the unaccompanied refugee minor program); and

ii. Enrolled in Medicaid under a state's Medicaid state plan or 1115 demonstra

b. Are not enrolled in mandatory coverage under the state plan, except that eligibility under this group takes preced

2. In addition to C.1., the state elects to cover individuals who were in foster care under the responsibility of children who were cared for through a grant to a state under the unaccompanied refugee minor program) w state's or Tribe's foster care assistance ends under title IV-E of the Act, and meet the following criteria:

☐ a. They were enrolled in Medicaid under a state's Medicaid state plan or 1115 demonstration at any time during the foster care period in which they turned 18 or a higher age at which a state's or Tribe's foster care assistance ends.

☐ b. They were placed by a state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project when they turned 18 or a higher age at which a state's or Tribe's foster care assistance ends.

☐ c. They were placed by a state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project at any time during the foster care period in which they turned 18 or a higher age at which a state's or Tribe's foster care assistance ends.

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

Former Foster Care Children

MEDICAID | Medicaid State Plan | Eligibility | OK2022MS0010O | OK-22-0031

Package Header

Package ID	OK2022MS0010O	**SPA ID**	OK-22-0031
Submission Type	Official	**Initial Submission Date**	12/30/2022
Approval Date	3/22/2023	**Effective Date**	1/1/2023
Superseded SPA ID	OK-13-17		
	User-Entered		

D. Additional Information (optional)

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage Individuals above 133% FPL	S50

1902(a)(10)(A)(ii)(XX)
1902(hh)
42 CFR 435.218

Individuals above 133% FPL - The state elects to cover individuals under 65, not otherwise mandatorily or optionally eligible, with income above 133% FPL and at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.218.

○ Yes ◉ No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Optional Coverage of Parents and Other Caretaker Relatives **S51**

42 CFR 435.220
1902(a)(10)(A)(ii)(I)

Optional Coverage of Parents and Other Caretaker Relatives - The state elects to cover individuals qualifying as parents or other caretaker relatives who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.220.

○ Yes ◉ No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Reasonable Classification of Individuals under Age 21 **S52**

42 CFR 435.222
1902(a)(10)(A)(ii)(I)
1902(a)(10)(A)(ii)(IV)

Reasonable Classification of Individuals under Age 21 - The state elects to cover one or more reasonable classifications of individuals under age 21 who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.222.

(•) Yes ( ) No

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Individuals qualifying under this eligibility group must qualify under a reasonable classification by meeting the following criteria:

■ Be under age 21, or a lower age, as defined within the reasonable classification.

■ Have household income at or below the standard established by the state, if the state has an income standard for the reasonable classification.

■ Not be eligible and enrolled for mandatory coverage under the state plan.

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered at least one reasonable classification under this eligibility group under its Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013, with income standards higher (including disregarding all income) than the current mandatory income standards for the individual's age.

(•) Yes ( ) No

The state also covered at least one reasonable classification under this group in the Medicaid state plan as of March 23, 2010 with income standards higher (including disregarding all income) than the current mandatory income standards for the individual's age.

(•) Yes ( ) No

Reasonable Classifications Covered in the Medicaid State Plan as of March 23, 2010

☑ The state attaches the approved pages from the Medicaid state plan as of March 23, 2010 to indicate the age groups, reasonable classifications, and income standards used at that time for this eligibility group.

An attachment is submitted.

Current Coverage of All Children under a Specified Age

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

The state covers all children under a specified age limit, equal to or higher than the age limit and/or income standard used in the Medicaid state plan as of March 23, 2010, provided the income standard is higher than the current mandatory income standard for the individual's age. The age limit and/or income standard used must be no higher than any age limit and/or income standard covered in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013. Higher income standards may include the disregard of all income.

○ Yes ◉ No

Current Coverage of Reasonable Classifications Covered in the Medicaid State Plan as of March 23, 2010

The state covers reasonable classifications of children previously covered in the Medicaid state plan as of March 23, 2010, with income standards higher than the current mandatory income standard for the age group. Age limits and income standards are equal to or higher than the Medicaid state plan as of March 23, 2010, but no higher than any age limit and/or income standard for this classification covered in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013. Higher income standards may include the disregard of all income.

◉ Yes ○ No

Indicate the reasonable classifications of children that were covered in the state plan in effect as of March 23, 2010 with income standards higher than the mandatory standards used for the child's age, using age limits and income standards that are not more restrictive than used in the state plan as of as March 23, 2010 and are not less restrictive than used in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Current Coverage of Reasonable Classifications Covered in the Medicaid State Plan as of March 23, 2010

Reasonable Classifications of Children **S11**

☐ Individuals for whom public agencies are assuming full or partial financial responsibility.

☒ Individuals in adoptions subsidized in full or part by a public agency

Indicate the age which applies:

◉ Under age 21 ○ Under age 20 ○ Under age 19 ○ Under age 18

☐ Individuals in nursing facilities, if nursing facility services are provided under this plan

☐ Individuals receiving active treatment as inpatients in psychiatric facilities or programs, if such services are provided under this plan

☒ Other reasonable classifications

	Name of classification	Description	Age Limit	
+	Individuals in state custody	Individuals in state custody in foster homes, private institutions, or public facilities as reported by the Department of Human Services	Under age 21	X

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

Medicaid Eligibility

	Name of classification	Description	Age Limit	
+	Individuals in public psychiatric facilities or programs	Individuals receiving active treatment as inpatients in public psychiatric facilities or programs	Under age 21	X

Enter the income standard used for these classifications. The income standard must be higher than the mandatory standard for the child's age. It may be no lower than the income standard used in the state plan as of March 23, 2010 and no higher than the highest standard used in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Click here once S11 form above is complete to view the income standards form.

Individuals in adoptions subsidized in full or part by a public agency

■ Income standard used

■ Minimum income standard

The minimum income standard for this classification of children is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

■ Maximum income standard

No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

○ Yes ◉ No

☑ The state certifies that it has submitted and received approval for its converted income standards for this classification of children to MAGI-equivalent standards and the determination of the maximum income standard to be used for this classification of children under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this classification of children (which must exceed the minimum for the classification) is:

◉ The state's effective income level for this classification of children under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

○ The state's effective income level for this classification of children under a Medicaid 1115 Demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under a Medicaid 1115 Demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

○ A percentage of the federal poverty level: [ ] %

◉ The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should only be selected for children 19 and older, and only if the state has not elected to cover the Adult Group.

○ The state's TANF payment standard, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should only be selected for children 19 and older, and only if the state has not elected to cover the Adult Group.

○ Other dollar amount

■ Income standard chosen

Individuals qualify under this classification under the following income standard:

○ The minimum standard.

◉ The maximum income standard.

○ If not chosen as the maximum income standard, the state's effective income level for this classification under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under a Medicaid 1115 Demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under a Medicaid 1115 Demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income level for this classification in the state plan as of March 23, 2010, converted to a MAGI equivalent.

Individuals in state custody

■ Income standard used

■ Minimum income standard

The minimum income standard for this classification of children is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

■ Maximum income standard

No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

○ Yes ◉ No

☑ The state certifies that it has submitted and received approval for its converted income standards for this classification of children to MAGI-equivalent standards and the determination of the maximum income standard to be used for this classification of children under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this classification of children (which must exceed the minimum for the classification) is:

◉ The state's effective income level for this classification of children under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under a Medicaid 1115 Demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under a Medicaid 1115 Demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

○ A percentage of the federal poverty level: [ ] %

◉ The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should only be selected for children 19 and older, and only if the state has not elected to cover the Adult Group.

○ The state's TANF payment standard, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should only be selected for children 19 and older, and only if the state has not elected to cover the Adult Group.

○ Other dollar amount

■ Income standard chosen

Individuals qualify under this classification under the following income standard:

○ The minimum standard.

◉ The maximum income standard.

○ If not chosen as the maximum income standard, the state's effective income level for this classification under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under a Medicaid 1115 Demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under a Medicaid 1115 Demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income level for this classification in the state plan as of March 23, 2010, converted to a MAGI equivalent.

Individuals in public psychiatric facilities or programs

■ Income standard used

■ Minimum income standard

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

The minimum income standard for this classification of children is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

☑ Maximum income standard

No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

○ Yes ◉ No

☑ The state certifies that it has submitted and received approval for its converted income standards for this classification of children to MAGI-equivalent standards and the determination of the maximum income standard to be used for this classification of children under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this classification of children (which must exceed the minimum for the classification) is:

◉ The state's effective income level for this classification of children under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under a Medicaid 1115 Demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under a Medicaid 1115 Demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

○ A percentage of the federal poverty level: [ ] %

◉ The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should only be selected for children 19 and older, and only if the state has not elected to cover the Adult Group.

○ The state's TANF payment standard, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should only be selected for children 19 and older, and only if the state has not elected to cover the Adult Group.

○ Other dollar amount

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

Medicaid Eligibility

☑ Income standard chosen

Individuals qualify under this classification under the following income standard:

- ○ The minimum standard.
- ◉ The maximum income standard.
- ○ If not chosen as the maximum income standard, the state's effective income level for this classification under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.
- ○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.
- ○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under a Medicaid 1115 Demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.
- ○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under a Medicaid 1115 Demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.
- ○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income level for this classification in the state plan as of March 23, 2010, converted to a MAGI equivalent.

Other Reasonable Classifications Previously Covered

The state covers reasonable classifications of children not covered in the Medicaid state plan as of March 23, 2010, but covered under the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013 with an income standard higher than the current mandatory income standard for the age group.

○ Yes ◉ No

Additional new age groups or reasonable classifications covered

If the state has not elected to cover the Adult Group (42 CFR 435.119), it may elect to cover additional new age groups or reasonable classifications that have not been covered previously. If the state covers the Adult Group, this additional option is not available, as the standard for the new age groups or classifications is lower than that used for mandatory coverage.

The state does not cover the Adult Group and elects the option to include in this eligibility group additional age groups or reasonable classifications that have not been covered previously in the state plan or under a Medicaid 1115 Demonstration. Any additional age groups or reasonable classifications not previously covered are restricted to the AFDC income standard from July 16, 1996, not converted to a MAGI-equivalent standard.

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

Medicaid Eligibility

○ Yes ◉ No

■ There is no resource test for this eligibility group.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Children with Non IV-E Adoption Assistance **S53**

42 CFR 435.227
1902(a)(10)(A)(ii)(VIII)

Children with Non IV-E Adoption Assistance - The state elects to cover children with special needs for whom there is a non IV-E adoption assistance agreement in effect with a state, who were eligible for Medicaid, or who had income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.227.

(•) Yes ( ) No

[✓] The state attests that it operates this eligibility group in accordance with the following provisions:

[■] Individuals qualifying under this eligibility group must meet the following criteria:

[■] The state adoption agency has determined that they cannot be placed without Medicaid coverage because of special needs for medical or rehabilitative care;

[■] Are under the following age (see the Guidance for restrictions on the selection of an age):

(•) Under age 21
( ) Under age 20
( ) Under age 19
( ) Under age 18

[■] MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered this eligibility group in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

(•) Yes ( ) No

The state also covered this eligibility group in the Medicaid state plan as of March 23, 2010.

(•) Yes ( ) No

[■] Individuals qualify under this eligibility group if they were eligible under the state's approved state plan prior to the execution of the adoption agreement.

The state used an income standard or disregarded all income for this eligibility group either in the Medicaid state plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

(•) Yes ( ) No

[■] Income standard used for this eligibility group

[■] Minimum income standard

The minimum income standard for this eligibility group is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

[■] Maximum income standard

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

Medicaid Eligibility

No income test was used (all income was disregarded) for this eligibility group either in the Medicaid state plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

○ Yes ◉ No

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for this eligibility group to MAGI-equivalent standards and the determination of the maximum income standard to be used for individuals under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group (which must exceed the minimum) is:

◉ The state's effective income level for this eligibility group under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this eligibility group under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this eligibility group under a Medicaid 1115 Demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this eligibility group under a Medicaid 1115 Demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

◉ A percentage of the federal poverty level: 212 %

○ The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should be selected only if Under age 21 or Under age 20 was selected, **and** if the state has not elected to cover the Adult Group.

○ The state's TANF payment standard, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should be selected only if Under age 21 or Under age 20 was selected, **and** if the state has not elected to cover the Adult Group.

○ Other dollar amount

■ Income standard chosen

Individuals qualify under this eligibility group under the following income standard, which must be higher than the minimum for this child's age:

○ The minimum standard.

◉ The maximum income standard.

○ If not chosen as the maximum income standard, the state's effective income level for this eligibility group under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this eligibility group under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL, or amounts by household size.

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

Medicaid Eligibility

- ○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this eligibility group under a Medicaid 1115 Demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.
- ○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this eligibility group under a Medicaid 1115 Demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.
- ○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income level for this eligibility group in the state plan as of March 23, 2010, converted to a MAGI-equivalent.

■ There is no resource test for this eligibility group.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Optional Targeted Low Income Children **S54**

1902(a)(10)(A)(ii)(XIV)
42 CFR 435.229 and 435.4
1905(u)(2)(B)

Optional Targeted Low Income Children - The state elects to cover uninsured children who meet the definition of optional targeted low income children at 42 CFR 435.4, who have household income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.229.

○ Yes ◉ No

PRA Disclosure Statement

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State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Individuals with Tuberculosis **S55**

1902(a)(10)(A)(ii)(XII)
1902(z)

Individuals with Tuberculosis - The state elects to cover individuals infected with tuberculosis who have income at or below a standard established by the state, limited to tuberculosis-related services.

(•) Yes ( ) No

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Individuals qualifying under this eligibility group must meet the following criteria:

■ Are infected with tuberculosis.

■ Are not otherwise eligible for mandatory coverage under the Medicaid state plan.

■ Have household income under a standard established by the state.

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

■ Income standard used for this group

■ Maximum income standard

First indicate the maximum income standard that could be used for this group and then indicate the income standard the state uses for the group.

The state elects to convert the effective income level for coverage of this eligibility group in effect in the Medicaid state plan as of March 23, 2010 and December 31, 2013 to MAGI-equivalent standards.

( ) Yes (•) No

The state's maximum income standard for this eligibility group is:

(•) The break-even point for earned income under the SSI program.

( ) The effective income level for this eligibility group under the Medicaid state plan in effect as of March 23, 2010, not converted to a MAGI-equivalent standard.

( ) The effective income level for this eligibility group under the Medicaid state plan in effect as of December 31, 2013, not converted to a MAGI-equivalent standard.

■ Income standard chosen

The state's income standard used for this eligibility group is:

(•) The maximum income standard.

( ) If not chosen as the maximum income standard, the break-even point for earned income under the SSI program.

( ) Another income standard less than the maximum standard allowed.

■ Individuals qualifying under this group are eligible only for the following services, provided the service is related to the diagnosis, treatment or management of the individual's tuberculosis.

■ Prescribed drugs, described in 42 CFR 440.120

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

Medicaid Eligibility

- ■ Physician services, described in 42 CFR 440.50
- ■ Outpatient hospital and rural health clinic described in 42 CFR 440.20 and Federally-qualified health center services
- ■ Laboratory and x-ray services (including services to confirm the presence of the infection), described in 42 CFR 440.30
- ■ Clinic services, described in 42 CFR 440.90
- ■ Case management services defined in 42 CFR 440.169
- ■ Services other than room and board designed to encourage completion of regimens of prescribed drugs by out-patients, including services to observe directly the intake of prescription drugs.
- ■ Limitations related to tuberculosis-related services may be found in the Benefits section.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Independent Foster Care Adolescents S57

42 CFR 435.226
1902(a)(10)(A)(ii)(XVII)

Independent Foster Care Adolescents - The state elects to cover individuals under an age specified by the state, less than age 21, who were in state-sponsored foster care on their 18th birthday and who meet the income standard established by the state and in accordance with the provisions described at 42 CFR 435.226.

(•) Yes ( ) No

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Individuals qualifying under this eligibility group must meet the following criteria:

■ Are under the following age

(•) Under age 21

( ) Under age 20

( ) Under age 19

■ Were in foster care under the responsibility of a state on their 18th birthday.

■ Are not eligible and enrolled for mandatory coverage under the Medicaid state plan.

■ Have household income at or below a standard established by the state.

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered this eligibility group under its Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 demonstration as of March 23, 2010 or December 31, 2013.

(•) Yes ( ) No

The state also covered this eligibility group in the Medicaid state plan as of March 23, 2010.

(•) Yes ( ) No

■ The state covers children under this eligibility group, as follows (selection may not be more restrictive than the coverage in the Medicaid state plan as of March 23, 2010 until October 1, 2019, nor more liberal than the most liberal coverage in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 demonstration as of March 23, 2010 or December 31, 2013):

(•) All children under the age selected

( ) A reasonable classification of children under the age selected:

■ Income standard used for this eligibility group

■ Minimum income standard

The minimum income standard for this classification of children is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

Medicaid Eligibility

☑ Maximum income standard

No income test was used (all income was disregarded) for this eligibility group either in the Medicaid state plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

○ Yes ◉ No

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for Independent Foster Care Adolescents to MAGI-equivalent standards and the determination of the maximum income standard to be used for individuals under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group (which must exceed the minimum) is:

◉ The state's effective income level for independent foster care adolescents under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for independent foster care adolescents under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for independent foster care adolescents under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for independent foster care adolescents under the Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

◉ A percentage of the federal poverty level: 212 %

○ The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should be selected only if Under age 21 or Under age 20 was selected, **and** if the state has not elected to cover the Adult Group.

○ The state's TANF payment standard, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should be selected only if Under age 21 or Under age 20 was selected, **and** if the state has not elected to cover the Adult Group.

○ Other dollar amount

☑ Income standard chosen

Individuals qualify under this eligibility group under the following income standard:

○ The minimum standard.

◉ The maximum income standard.

○ If not chosen as the maximum income standard, the state's effective income level for independent foster care adolescents under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

Medicaid Eligibility

- ○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for independent foster care adolescents under a Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL, or amounts by household size.
- ○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for independent foster care adolescents under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.
- ○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for independent foster care adolescents under the Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.
- ○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income level for independent foster care adolescents in the Medicaid state plan as of March 23, 2010, converted to a MAGI equivalent.

■ There is no resource test for this eligibility group.

PRA Disclosure Statement

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State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Individuals Eligible for Family Planning Services **S59**

1902(a)(10)(A)(ii)(XXI)
42 CFR 435.214

Individuals Eligible for Family Planning Services - The state elects to cover individuals who are not pregnant, and have household income at or below a standard established by the state, whose coverage is limited to family planning and related services and in accordance with provisions described at 42 CFR 435.214.

(•) Yes ( ) No

[✓] The state attests that it operates this eligibility group in accordance with the following provisions:

[■] The individual may be a male or a female.

[■] Income standard used for this group

[■] Maximum income standard

[✓] The state certifies that it has submitted and received approval for its converted income standard(s) for pregnant women to MAGI-equivalent standards and the determination of the maximum income standard to be used for this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is the highest of the following:

(•) The state's current effective income level for the Pregnant Women eligibility group (42 CFR 435.116) under the Medicaid state plan.

( ) The state's current effective income level for pregnant women under a Medicaid 1115 demonstration.

( ) The state's current effective income level for Targeted Low-Income Pregnant Women under the CHIP state plan.

( ) The state's current effective income level for pregnant women under a CHIP 1115 demonstration.

The amount of the maximum income standard is: 133 % FPL

[■] Income standard chosen

The state's income standard used for this eligibility group is:

(•) The maximum income standard

( ) Another income standard less than the maximum standard allowed.

[■] MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

Medicaid Eligibility

- [■] In determining eligibility for this group, the state uses the following household size:
  - [☒] All of the members of the family are included in the household
  - [☐] Only the applicant is included in the household
  - [☐] The state increases the household size by one
- [■] In determining eligibility for this group, the state uses the following income methodology:
  - (•) The state considers the income of the applicant and all legally responsible household members (using MAGI-based methodology).
  - ( ) The state considers only the income of the applicant.
- [■] Benefits for this eligibility group are limited to family planning and related services described in the Benefit section.
- [■] Presumptive Eligibility

  The state makes family planning services and supplies available to individuals covered under this group when determined presumptively eligible by a qualified entity.

  ( ) Yes (•) No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State: Oklahoma
Date Received: 11/27/13
Date Approved: 1/16/14
Date Effective: 1/1/14
Transmittal Number: 13-17

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Non-Financial Eligibility State Residency	S88

42 CFR 435.403

State Residency

☑ The state provides Medicaid to otherwise eligible residents of the state, including residents who are absent from the state under certain conditions.

Individuals are considered to be residents of the state under the following conditions:

- ■ Non-institutionalized individuals age 21 and over, or under age 21, capable of indicating intent and who are emancipated or married, if the individual is living in the state and:
  - ■ Intends to reside in the state, including without a fixed address, or
  - ■ Entered the state with a job commitment or seeking employment, whether or not currently employed.
- ■ Individuals age 21 and over, not living in an institution, who are not capable of indicating intent, are residents of the state in which they live.
- ■ Non-institutionalized individuals under 21 not described above and non IV-E beneficiary children:
  - ■ Residing in the state, with or without a fixed address, or
  - ■ The state of residency of the parent or caretaker, in accordance with 42 CFR 435.403(h)(1), with whom the individual resides.
- ■ Individuals living in institutions, as defined in 42 CFR 435.1010, including foster care homes, who became incapable of indicating intent before age 21 and individuals under age 21 who are not emancipated or married:
  - ■ Regardless of which state the individual resides, if the parent or guardian applying for Medicaid on the individual's behalf resides in the state, or
  - ■ Regardless of which state the individual resides, if the parent or guardian resides in the state at the time of the individual's placement, or
  - ■ If the individual applying for Medicaid on the individual's behalf resides in the state and the parental rights of the institutionalized individual's parent(s) were terminated and no guardian has been appointed and the individual is institutionalized in the state.
- ■ Individuals living in institutions who became incapable of indicating intent at or after age 21, if physically present in the state, unless another state made the placement.
- ■ Individuals who have been placed in an out-of-state institution, including foster care homes, by an agency of the state.
- ■ Any other institutionalized individual age 21 or over when living in the state with the intent to reside there, and not placed in the institution by another state.
- ■ IV-E eligible children living in the state, or

State: Oklahoma
Date Received: 11/27/2013
Date Approved: 02/24/2014
Date Effective: 1/1/2014
Transmittal Number: 13-0020

☒ Otherwise meet the requirements of 42 CFR 435.403.

State: Oklahoma
Date Received: 11/27/2013
Date Approved: 02/24/2014
Date Effective: 1/1/2014
Transmittal Number: 13-0020

Medicaid Eligibility

Meet the criteria specified in an interstate agreement.

(•) Yes ( ) No

[■] The state has interstate agreements with the following selected states:

[☒] Alabama	[☒] Illinois	[☒] Montana	[☒] Rhode Island
[☒] Alaska	[☒] Indiana	[☒] Nebraska	[☒] South Carolina
[☒] Arizona	[☒] Iowa	[☒] Nevada	[☒] South Dakota
[☒] Arkansas	[☒] Kansas	[☒] New Hampshire	[☒] Tennessee
[☒] California	[☒] Kentucky	[☒] New Jersey	[☒] Texas
[☒] Colorado	[☒] Louisiana	[☒] New Mexico	[☒] Utah
[☒] Connecticut	[☒] Maine	[ ] New York	[☒] Vermont
[☒] Delaware	[☒] Maryland	[☒] North Carolina	[☒] Virginia
[☒] District of Columbia	[☒] Massachusetts	[☒] North Dakota	[☒] Washington
[☒] Florida	[☒] Michigan	[☒] Ohio	[☒] West Virginia
[☒] Georgia	[☒] Minnesota	[ ] Oklahoma	[☒] Wisconsin
[☒] Hawaii	[☒] Mississippi	[☒] Oregon	[ ] Wyoming
[☒] Idaho	[☒] Missouri	[☒] Pennsylvania	

[■] The interstate agreement contains a procedure for providing Medicaid to individuals pending resolution of their residency status and criteria for resolving disputed residency of individuals who (select all that apply):

- [☒] Are IV-E eligible
- [ ] Are in the state only for the purpose of attending school
- [ ] Are out of the state only for the purpose of attending school
- [ ] Retain addresses in both states
- [ ] Other type of individual

The state has a policy related to individuals in the state only to attend school.

( ) Yes (•) No

[■] Otherwise meet the criteria of resident, but who may be temporarily absent from the state.

The state has a definition of temporary absence, including treatment of individuals who attend school in another state.

(•) Yes ( ) No

State: Oklahoma
Date Received: 11/27/2013
Date Approved: 02/24/2014
Date Effective: 1/1/2014
Transmittal Number: 13-0020

Medicaid Eligibility

Provide a description of the definition:

Temporary absence from the State, with subsequent returns to the State, or intent to return when the purposes of the absence have been accomplished, does not interrupt continuity of Oklahoma residence.

PRA Disclosure Statement

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State: Oklahoma
Date Received: 11/27/2013
Date Approved: 02/24/2014
Date Effective: 1/1/2014
Transmittal Number: 13-0020

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Non-Financial Eligibility Citizenship and Non-Citizen Eligibility	S89

1902(a)(46)(B)
8 U.S.C. 1611, 1612, 1613, and 1641
1903(v)(2),(3) and (4)
42 CFR 435.4
42 CFR 435.406
42 CFR 435.956

Citizenship and Non-Citizen Eligibility

☑ The state provides Medicaid to citizens and nationals of the United States and certain non-citizens consistent with requirements of 42 CFR 435.406, including during a reasonable opportunity period pending verification of their citizenship, national status or satisfactory immigration status.

■ The state provides Medicaid eligibility to otherwise eligible individuals:

■ Who are citizens or nationals of the United States; and

■ Who are qualified non-citizens as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (8 U.S.C. §1641), or whose eligibility is required by section 402(b) of PRWORA (8 U.S.C. §1612(b)) and is not prohibited by section 403 of PRWORA (8 U.S.C. §1613); and

■ Who have declared themselves to be citizens or nationals of the United States, or an individual having satisfactory immigration status, during a reasonable opportunity period pending verification of their citizenship, nationality or satisfactory immigration status consistent with requirements of 1903(x), 1137(d), 1902(ee) of the SSA and 42 CFR 435.406, and 956.

The reasonable opportunity period begins on and extends 90 days from the date the notice of reasonable opportunity is received by the individual.

The agency provides for an extension of the reasonable opportunity period if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency needs more time to complete the verification process.

◉ Yes ○ No

The agency begins to furnish benefits to otherwise eligible individuals during the reasonable opportunity period on a date earlier than the date the notice is received by the individual.

◉ Yes ○ No

The date benefits are furnished is:

◉ The date of application containing the declaration of citizenship or immigration status.

○ The date the reasonable opportunity notice is sent.

○ Other date, as described:

State: Oklahoma
Date Received: 11/27/2013
Date Approved: 02/24/2014
Date Effective: 10/1/2013
Transmittal Number: 13-0021

Medicaid Eligibility

The state provides Medicaid coverage to all Qualified Non-Citizens whose eligibility is not prohibited by section 403 of PRWORA (8 U.S.C. §1613).

◉ Yes ○ No

The state elects the option to provide Medicaid coverage to otherwise eligible individuals under 21 and pregnant women, lawfully residing in the United States, as provided in section 1903(v)(4) of the Act.

○ Yes ◉ No

☑ An individual is considered to be lawfully residing in the United States if he or she is lawfully present and otherwise meets the eligibility requirements in the state plan.

☑ An individual is considered to be lawfully present in the United States if he or she:

1. Is a qualified non-citizen as defined in 8 U.S.C. 1641(b) and (c);

2. Is a non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a)(17));

3. Is a non-citizen who has been paroled into the United States in accordance with 8 U.S.C. 1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;

4. Is a non-citizen who belongs to one of the following classes:

   ☑ Granted temporary resident status in accordance with 8 U.S.C. 1160 or 1255a, respectively;

   ☑ Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. §1254a, and individuals with pending applications for TPS who have been granted employment authorization;

   ☑ Granted employment authorization under 8 CFR 274a.12(c);

   ☑ Family Unity beneficiaries in accordance with section 301 of Pub. L. 101-649, as amended;

   ☑ Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;

   ☑ Granted Deferred Action status;

   ☑ Granted an administrative stay of removal under 8 CFR 241;

   ☑ Beneficiary of approved visa petition who has a pending application for adjustment of status;

5. Is an individual with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C.1231, or under the Convention Against Torture who -

   ☑ Has been granted employment authorization; or

   ☑ Is under the age of 14 and has had an application pending for at least 180 days;

6. Has been granted withholding of removal under the Convention Against Torture;

7. Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C. 1101(a)(27)(J);

8. Is lawfully present in American Samoa under the immigration laws of American Samoa; or

9. Is a victim of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, as amended (22 U.S.C. 7105(b));

State: Oklahoma
Date Received: 11/27/2013
Date Approved: 02/24/2014
Date Effective: 10/1/2013
Transmittal Number: 13-0021

Medicaid Eligibility

10. Exception: An individual with deferred action under the Department of Homeland Security's deferred action for the childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (1) through (9) of this definition.

☐ Other

☑ The state assures that it provides limited Medicaid services for treatment of an emergency medical condition, not related to an organ transplant procedure, as defined in 1903(v)(3) of the SSA and implemented at 42 CFR 440.255, to the following individuals who meet all Medicaid eligibility requirements, except documentation of citizenship or satisfactory immigration status and/or present an SSN:

- ■ Qualified non-citizens subject to the 5 year waiting period described in 8 U.S.C. 1613;
- ■ Non-qualified non-citizens, unless covered as a lawfully residing child or pregnant woman by the state under the option in accordance with 1903(v)(4) and implemented at 435.406(b).

PRA Disclosure Statement

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State: Oklahoma
Date Received: 11/27/2013
Date Approved: 02/24/2014
Date Effective: 10/1/2013
Transmittal Number: 13-0021

Medicaid State Plan Eligibility

Income/Resource Methodologies

Eligibility Determinations of Individuals Age 65 or Older or Who Have Blindness or a Disability

MEDICAID | Medicaid State Plan | Eligibility | OK2020MS0008O | OK-21-0001

Package Header

Package ID	OK2020MS0008O	**SPA ID**	OK-21-0001
Submission Type	Official	**Initial Submission Date**	9/8/2020
Approval Date	12/4/2020	**Effective Date**	7/1/2021
Superseded SPA ID	N/A		
	User-Entered		

A. Eligibility Determinations of Individuals Who Are Age 65 or Older or Who Have Blindness or a Disability

Eligibility determinations of individuals who are age 65 or older or who have blindness or a disability are based on one of the following:

○ 1. SSA Eligibility Determination State (1634 State)

The state has an agreement under section 1634 of the Social Security Act for the Social Security Administration to determine Medicaid eligibility of SSI beneficiaries. For all other individuals who seek Medicaid eligibility on the basis of being age 65 or older or having blindness or a disability, the state requires a separate Medicaid application and determines financial eligibility based on SSI income and resource methodologies.

◉ 2. State Eligibility Determination (SSI Criteria State)

The state requires all individuals who seek Medicaid eligibility on the basis of being age 65 or older or having blindness or a disability, including SSI beneficiaries, to file a separate Medicaid application, and determines financial eligibility based on SSI income and resource methodologies.

○ 3. State Eligibility Determination (209(b) State)

The state requires all individuals who seek Medicaid eligibility on the basis of being age 65 or older or having blindness or a disability, including SSI beneficiaries, to file a separate Medicaid application, and determines financial eligibility using income and resource methodologies more restrictive than SSI.

B. Additional information (optional)

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

General Eligibility Requirements
Eligibility Process **S94**

State: Oklahoma
Date Received: 11/27/2013
Date Approved: 02/21/2014
Date Effective: 10/1/2013
Transmittal Number: 13-0016

42 CFR 435, Subpart J and Subpart M

Eligibility Process

☑ The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

☒ The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

☒ An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

An attachment is submitted.

☐ An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

☐ The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

☒ An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

○ Yes ● No

Medicaid Eligibility

☑ The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

Redetermination Processing

☑ Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:

- ■ Once every 12 months
- ■ Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency
- ■ If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

■ Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

- ☒ Once every 12 months
- ☐ Once every 6 months
- ☐ Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

☑ The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

PRA Disclosure Statement

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State: Oklahoma
Date Received: 11/27/2013
Date Approved: 02/21/2014
Date Effective: 10/1/2013
Transmittal Number: 13-0016

Revision: HCFA-PM-91-4 (BPD) AUGUST 1991 OMB No.: 0938-

State: OKLAHOMA

SECTION 2 - COVERAGE AND ELIGIBILITY

Citation
42 CFR
435.10 and
Subpart J

2.1 Application, Determination of Eligibility and Furnishing Medicaid

[redacted]

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APP'D MAR - 3 1992
DATE EFF OCT - 1 1991
HCFA 179 92-02
A

State/Territory: OKLAHOMA

Citation			
42 CFR 435.914 1902(a)(34) of the Act	2.1(b)	(1)	Except as provided in items 2.1(b)(2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in Attachment 2.6-A.
1902(e)(8) and 1905(a) of the Act		(2)	For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under section 1902(a)(10)(E)(i) of the Act, coverage is available for services furnished after The end of the month which the individual is first Determined to be a qualified Medicare beneficiary. Attachment 2.6-A specifies the requirements for Determination of eligibility for this group.
1902(a)(47) and	X	(3)	Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with section 1920 of the Act. Attachment 2.6-A specifies the requirements for Determination of eligibility for this group.

STATE Oklahoma
DATE REC'D 9-23-03
DATE APPV'D 12-9-03
DATE EFF 8-13-03
HCFA 179 03-12

A

SUPERSEDES: TN- 95-01

Revised 08-13-03

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August l991

State: OKLAHOMA

Citation
42 CFR
435.10 &
435.300

2.2 Coverage and Conditions of Eligibility

Medicaid is available to the groups specified in ATTACHMENT 2.2-A.

__ Mandatory categorically needy and other required special groups only.

__ Mandatory categorically needy, other required special groups, and the medically needy, but no other optional groups.

_X_ Mandatory categorically needy, other required special groups, and specified optional groups.

__ Mandatory categorically needy, other required special groups, specified optional groups, and the medically needy.

The conditions of eligibility that must be met are specified in ATTACHMENT 2.6-A.

All applicable requirements of 42 CFR Part 435 and sections 1902(a)(10)(A)(i)(IV), (V), and (VI),1902(a)(l0)(A)(ii)(XI), l902(a)(l0)(E), l902(l) and (m), 1905(p), (q) and (s), 1920, and 1925 of the Act are met.

Revised 02-01-03

TN# 03-07 Approval Date 6-17-03 Effective Date 2-1-03
Supersedes
TN# 92-02

STATE Oklahoma
DATE REC'D 3-26-03
DATE APPV'D 6-17-03
DATE EFF 2-1-03
HCFA 179 OK 03-07

A

SUPERSEDES: TN- 92-02

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

OMB No.: 0938-0193

State: Oklahoma

Citation	2.4 Blindness
42 CFR 435.530(b) 42 CFR 435.531 AT-78-90 AT-79-29	All of the requirements of 42 CFR 435.530 and 42 CFR 435.531 are met. The more restrictive definition of blindness in terms of ophthalmic measurement used in this plan is specified in ATTACHMENT 2.2-A.

2.6-A 78?

STATE OK
DATE RCVD JUN 2 9 1987
DATE APVD JAN 11 1988
DATE EFF APR 1 1987
HCFA ID 87-9

A

Revision: HCFA-PM-91-4 (BPD) OMB No. 0938-
AUGUST 1991

State: OKLAHOMA

Citation	2.5	Disability
42 CFR 435.121, 435.540(b) 435.541		All of the requirements of 42 CFR 435.540 and 435.541 are met. The State uses the same definition of disability used under the SSI program unless a more restrictive definition of disability is specified in Item ~~A.14.b.~~ A.13.b. of ATTACHMENT 2.2-A of this plan.

2.6A Pg 10

TN No. 92-02
Supersedes TN No. 87-9
Approval Date MAR - 3 1992
Effective Date OCT - 1 1991

HCFA ID: 7982E

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APPV'D MAR - 3 1992
DATE EFF OCT - 1 1991
HCFA 179 92-02

A

Revision: HCFA-PM-91-4 (BPD) AUGUST 1991 OMB No.: 0938-

State: OKLAHOMA

Citation 42 CFR 435.10 and Subparts G & H

1902(a)(10)(A)(i)(III), (IV), (V), and (VI), 1902(a)(10)(A)(ii)(IX), 1902(a)(10)(A)(ii)(X), 1902(a)(10)(C), 1902(f), 1902(l) and (m), 1905(p) and (s), 1902(r)(2), and 1920 of the Act

2.6 Financial Eligibility

(a) The financial eligibility conditions for Medicaid-only eligibility groups and for persons deemed to be cash assistance recipients are described in ATTACHMENT 2.6-A.

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APPV'D MAR - 3 1992
DATE EFF OCT - 1 1991
HCFA 179 92-02

A

Revision: HCFA-PM-86-20 (BERC) OMB-No. 0938-0193
SEPTEMBER 1986

State/Territory: Oklahoma

Citation	2.7	Medicaid Furnished Out of State
431.52 and 1902(b) of the Act, P.L. 99-272 (Section 9529)		Medicaid is furnished under the conditions specified in 42 CFR 431.52 to an eligible individual who is a resident of the State while the individual is in another State, to the same extent that Medicaid is furnished to residents in the State.

STATE OK
DATE REC'D JAN 0 2 1987
DATE APPV'D AUG 1 1 1987
DATE EFF OCT 0 1 1986
HCFA 179 86-20
A

Revision: HCFA-PM-94-6 (MB)
APRIL 1994

State/Territory: OKLAHOMA

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation

3.1 Amount, Duration, and Scope of Services

42 CFR Part 440, Subpart B 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act

(a) Medicaid is provided in accordance with the requirements of 42 CFR Part 440, Subpart B and sections 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act.

(1) Categorically needy.

Services for the categorically needy are described below and in ATTACHMENT 3.1-A. These services include:

1902(a)(10)(A) and 1905(a) of the Act

(i) Each item or service listed in section 1905(a)(1) through (5) and (21) of the Act, is provided as defined in 42 CFR Part 440, Subpart A, or, for EPSDT services, section 1905(r) and 42 CFR Part 441, Subpart B.

(ii) Nurse-midwife services listed in section 1905(a)(17) of the Act, are provided to the extent that nurse-midwives are authorized to practice under State law or regulation and without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

___ Not applicable. Nurse-midwives are not authorized to practice in this State.

RECEIVED NOV 15 1994 Systems Development

Revised 07-01-94

TN No. 94-20 Approval Date 11/4/94 Effective Date 7/1/94
Superseded TN No. 93-23

STATE Oklahoma
DATE REC'D 10-04-94
DATE APPV'D 11-04-94
DATE EFF 07-01-94
HCFA 179 94-20
A

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: OKLAHOMA

Citation 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1902(e)(5) of the Act

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

☐ (iv) Services for medical conditions that may complicate the pregnancy (other than pregnancy-related or postpartum services) are provided to pregnant women.

1902(a)(10), clause (VII) of the matter following (E) of the Act

(v) Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy are the same services provided to poverty level pregnant women eligible under the provision of sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.

Revised 10-01-91

TN No. 92-03
Supersedes TN No. 91-04
Approval Date FEB 27 1992
Effective Date OCT - 1 1991

HCFA ID: 7982E

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APPV'D FEB 27 1992
DATE EFF OCT - 1 1991
HCFA 179 92-03

A

Revision: HCFA-PM-91-4 (BPD) AUGUST 1991 OMB No.: 0938-

State/Territory: OKLAHOMA

Citation 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

(vi) Home health services 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) and 1925 of the Act

(ix) Services are provided to families eligible under section 1925 of the Act as indicated in item ~~3.7~~ 3.5 of this plan.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy, specifies all limitations on the amount, duration and scope of those services, and lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

TN No. 92-03 Supersedes TN No. _____ Approval Date FEB 27 1992 Effective Date OCT -1 1991

New 10-01-91

HCFA ID: 7982E

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APPV'D FEB 27 1992
DATE EFF OCT -1 1991
HCFA 179 92-03

A

Revision: HCFA-PM-91-4TC (BPD) OMB No.: 0938-

August 1991

State: OKLAHOMA

Citation	3.1 Amount, Duration, and Scope of Services (continued)
42 CFR Part 440, Subpart B	(a)(2) Medically needy.
	_This State plan covers the medically needy. The services described below and in ATTACHMENT 3.1-B are provided.
	Services for the medically needy include:
1902(a)(10)(C)(iv) of the Act 42 CFR 440.220	(i) If services in an institution for mental diseases (42 CFR 440.140 and 440.160) or an intermediate care facility for the mentally retarded (or both) are provided to any medically needy group, then each medically needy group is provided either the services listed in section 1905(a)(l) through (5) and (17) of the Act, or seven of the services listed in section 1905(a)(1)through (20). The services are provided as defined in 42 CFR Part 440, Subpart A and in sections 1902, 1905, and 1915 of the Act.
	_Not applicable with respect to nurse-midwife services under section 1902(a)(17). Nurse-midwives are not authorized to practice in this State.
1902(e)(5) of the Act	(ii) Prenatal care and delivery services for pregnant women.

SUPERSEDES: TN- 92-03

STATE Oklahoma	A
DATE REC'D 3-26-03	
DATE APPV'D 6-17-03	
DATE EFF 2-1-03	
HCFA 179 OK 03-07	

Revised 02-01-03

TN# 03-07 Approval Date 6-17-03 Effective Date 2-1-03
Supersedes
TN# 92-03

Revision: HCFA-PM-91-4 (BPD) AUGUST 1991 OMB No.: 0938-

State/Territory: OKLAHOMA

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

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day the pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

☐ (iv) Services for any other medical condition that may complicate the pregnancy (other than pregnancy-related and postpartum services) are provided to pregnant women.

(v) Ambulatory services, as defined in ATTACHMENT 3.1-B, for recipients under age 18 and recipients entitled to institutional services.

☐ Not applicable with respect to recipients entitled to institutional services; the plan does not cover those services for the medically needy.

(vi) Home health services to recipients entitled to nursing facility services as indicated in item 3.1(b) of this plan.

42 CFR 440.140, 440.150, Subpart B, 442.441, Subpart C 1902(a)(20) and (21) of the Act

☐ (vii) Services in an institution for mental diseases for individuals over age 65..

☐ (viii) Services in an intermediate care facility for the mentally retarded.

Revised 10-01-91

TN No. 92-03 Supersedes TN No. ____ Approval Date FEB 27 1992 Effective Date OCT - 1 1991

HCFA ID: 7982E

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APP'VD FEB 27 1992
EFF DATE OCT - 1 1991
TN # 92-03

A

Revision: HCFA-PM-93- 5 (MB)
MAY 1993

State: OKLAHOMA

Citation

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

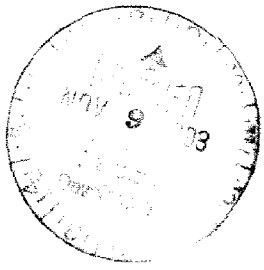
1902(e)(9) of Act

___ (x) Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.

1905(a)(23) and 1929 of the Act

___ (xi) 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.

ATTACHMENT 3.1-B identifies the services provided to each covered group of the medically needy; specifies all limitations on the amount, duration, and scope of those items; and specifies the ambulatory services provided under this plan and any limitations on them. It also lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.



STATE Oklahoma
DATE REC'D OCT 04 1993
DATE APP'D OCT 27 1993
DATE EFF JUL 01 1993
HCFA 179 93-15

A

TN No. 93-15 Revised 07-01-93
Supersedes TN No. 92-03 Approval Date OCT 27 1993 Effective Date JUL 01 1993

Revision: HCFA-PM-98-1 (CMSO)
APRIL 1998

State: OKLAHOMA

Citation		
	3.1	Amount, Duration, and Scope of Services (continued)
	(a)(3)	Other Required Special Groups: Qualified Medicare Beneficiaries
1902(a)(10)(E)(i) and clause (VIII) of the matter following (F), and 1905(p)(3) of the Act		Medicare cost sharing for qualified Medicare beneficiaries described in section 1905(p) of the Act is provided only as indicated in item 3.2 of this plan.
1902(a)(10)(E)(ii) and 1905(s) of the Act	(a)(4)(i)	Other Required Special Groups: Qualified Disabled and Working Individuals Medicare Part A premiums for qualified disabled and working individuals described in section 1902(a)(10)(E)(ii) of the Act are provided as indicated in item 3.2 of this plan.
1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act	(ii)	Other Required Special Groups: Specified Low-Income Medicare Beneficiaries Medicare Part B premiums for specified low-income Medicare beneficiaries described in section 1902(a)(10)(E)(iii) of the Act are provided as indicated in item 3.2 of this plan.
1902(a)(10)(E)(iv)(I)1905(p)(3)(A)(ii), and 1933 of the Act	(iii)	Other Required Special Groups: Qualifying Individuals - 1 Medicare Part B premiums for qualifying individuals described in 1902(a)(10)(E)(iv)(I) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.

STATE Oklahoma
DATE REC'D 3-17-03
DATE APP'VD 4-4-03
DATE EFF 1-1-03
HCFA 179 OK 03-03

A

SUPERSEDES: TN- OK 98-04

Revised 01-01-03

TN No. OK 03-03
Supersedes Approval Date 4/4/03 Effective Date 1/1/03
TN No. OK 98-04

Revision: HCFA-PM-97-3 (CMSO)
December 1997

State: OKLAHOMA

Citation 3.1 Amount, Duration, and Scope or Servies (Cont.)

1925 of the Act (a)(5) Other Required Special Groups: Families Receiving Extended Medicaid Benefits

Extended Medicaid benefits for families described in section 1925 of the Act are provided as indicated in item 3.5 of this plan.

STATE OK DATE RCVD 3-20-98 DATE APPVD 4-10-98 DATE EFF 1-1-98 HCFA ID 98-054	A

TN No. 98-05 4
Supersedes TN No. New Page
Approval Date 4-10-98 Effective Date 1-1-98

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: OKLAHOMA

Citation 3.1 Amount, Duration, and Scope of Services (Continued)

Sec. 245A(h) of the Immigration and Nationality Act

(a)(6) Limited Coverage for Certain Aliens

(i) Aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who meet the financial and categorical eligibility requirements under the approved State Medicaid plan are provided the services covered under the plan if they--

(A) Are aged, blind, or disabled individuals as defined in section 1614(a)(1) of the Act;

(B) Are children under 18 years of age; or

(C) Are Cuban or Haitian entrants as defined in section 501(e)(1) and (2)(A) of P.L. 96-422 in effect on April 1, 1983.

(ii) Except for emergency services and pregnancy-related services, as defined in 42 CFR 447.53(b) aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who are not identified in items 3.1(a)(6)(i)(A) through (C) above, and who meet the financial and categorical eligibility requirements under the approved State plan are provided services under the plan no earlier than five years from the date the alien is granted lawful temporary resident status.

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APP'V'D FEB 27 1992
DATE EFF OCT - 1 1991
HCFA 179 92-03

A

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: OKLAHOMA

Citation 3.1(a)(6) Amount, Duration, and Scope of Services: Limited Coverage for Certain Aliens (continued)

1902(a) and 1903(v) of the Act

(iii) Aliens who are not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law who meet the eligibility conditions under this plan, except for the requirement for receipt of AFDC, SSI, or a State supplementary payment, are provided Medicaid only for care and services necessary for the treatment of an emergency medical condition (including emergency labor and delivery) as defined in section 1903(v)(3) of the Act.

1905(a)(9) of the Act

(a)(7) Homeless Individuals.

Clinic services furnished to eligible individuals who do not reside in a permanent dwelling or do not have a fixed home or mailing address are provided without restrictions regarding the site at which the services are furnished.

1902(a)(47) and 1920 of the Act

X

(a)(8) Ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider that is eligible for payment under the State plan.

42 CFR 441.55
50 FR 43654
1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act

(a)(9) EPSDT Services.

The Medicaid agency meets the requirements of sections 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act with respect to early and periodic screening, diagnostic, and treatment (EPSDT) services.

TN No. 92-03 Approval Date FEB 27 1992 New 10-01-91
Supersedes TN No. _____ Effective Date OCT - 1 1991
HCFA ID: 7982E

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APPV'D FEB 27 1992
DATE EFF OCT - 1 1991
HCFA 179 92-03
A

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: OKLAHOMA

Citation 3.1(a)(9) Amount, Duration, and Scope of Services: EPSDT Services (continued)

42 CFR 441.60 ☑ The Medicaid agency has in effect agreements with continuing care providers. Described below are the methods employed to assure the providers' compliance with their agreements.

42 CFR 440.240 and 440.250 (a)(10) Comparability of Services

1902(a) and 1902 (a)(10), 1902(a)(52), 1903(v), 1915(g), and 1925(b)(4) of the Act

Except for those items or services for which sections 1902(a), 1902(a)(10), 1903(v), 1915 and 1925 of the Act, 42 CFR 440.250, and section 245A of the Immigration and Nationality Act, permit exceptions:

(i) Services made available to the categorically needy are equal in amount, duration, and scope for each categorically needy person.

(ii) The amount, duration, and scope of services made available to the categorically needy are equal to or greater than those made available to the medically needy.

(iii) Services made available to the medically needy are equal in amount, duration, and scope for each person in a medically needy coverage group.

☑ (iv) Additional coverage for pregnancy-related services and services for conditions that may complicate the pregnancy are equal for categorically and medically needy.

Revised 10-01-91

TN No. 92-03
Supersedes TN No. 87-9 Approval Date FEB 27 1992 Effective Date OCT - 1 1991

HCFA ID: 7982E

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APPV'D FEB 27 1992
DATE EFF OCT - 1 1991
HCFA 179 92-03

A

Citation
42 CFR Part
440, Subpart B
42 CFR 441.15

3.1 (b) Home health services are provided in accordance with the requirements of 42 CFR 441.15

(1) Home health services are provided to all categorically needy individuals 21 years of age or over.

_X_ Yes.

(2) Home health services are provided to all categorically needy individuals under 21 years of age.

_X_ Yes.

__ Not applicable. The State plan does not provide for skilled nursing facility services for such individuals.

(3) Home health services are provided to the medically needy:

___ Yes, to all.

___ Yes, to individuals age 21 or over; SNF services provided.

___ Yes, to individuals under 21; SNF services provided.

___ No; SNF services are not provided.

_X_ Not applicable; the medically needy are not included under this plan.

Revision: HCFA-PM-93-8 (BPD)
December 1993

State/Territory: OKLAHOMA

Citation 3.1 Amount, Duration, and Scope of Services (continued)

42 CFR 431.53 (c)(1) Assurance of Transportation

Provision is made for assuring necessary transportation of recipients to and from providers. Methods used to assure such transportation are described in ATTACHMENT 3.1-D.

42 CFR 483.10 (c)(2) Payment for Nursing Facility Services

The State includes in nursing facility services at least the items and services specified in 42 CFR 483.10 (c) (8) (i).

STATE Oklahoma
DATE REC'D 1-4-94
DATE APPV'D 2-3-94
DATE EFF 10-1-93
HCFA 179 93-22
A

TN No. 93-22 Approval Date 2/3/94 Effective Date 10/1/93
Supersedes TN No. 92-03

Revision: HCFA-AT-80-18 (BPP)
May 22, 1980

State OKLAHOMA

Citation		
42 CFR 440.260 AT-78-90	3.1(d)	Methods and Standards to Assure Quality of Services The standards established and the methods used to assure high quality care are described in ATTACHMENT 3.1-C.

TN # 78-3
Supersedes TN # ____

Approval Date 3/20/78 Effective Date 2/1/78

Revision: HCFA-AT-80-38 (EPP)
May 22, 1980

State OKLAHOMA

Citation		
42 CFR 441.20 AT-78-90	3.1(e)	Family Planning Services The requirements of 42 CFR 441.20 are met regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning.

Revision: HCFA-PM-87-5 (BERC)
APRIL 1987

OMB No.: 0938-0193

State/Territory: Oklahoma

Citation
42 CFR 441.30
AT-78-90

3.1 (f) (1) Optometric Services

Optometric services (other than those provided under §§435.531 and 436.531) are not now but were previously provided under the plan. Services of the type an optometrist is legally authorized to perform are specifically included in the term "physicians' services" under this plan and are reimbursed whether furnished by a physician or an optometrist.

/ / Yes.

/ / No. The conditions described in the first sentence apply but the term "physicians' services" does not specifically include services of the type an optometrist is legally authorized to perform.

/X/ Not applicable. The conditions in the first sentence do not apply.

1903(i)(1)
of the Act,
P.L. 99-272
(Section 9507)

(2) Organ Transplant Procedures

Organ transplant procedures are provided.

/ / No.

/X/ Yes. Similarly situated individuals are treated alike and any restriction on the facilities that may, or practitioners who may, provide those procedures is consistent with the accessibility of high quality care to individuals eligible for the procedures under this plan. Standards for the coverage of organ transplant procedures are described at ATTACHMENT 3.1-E.

STATE OK
DATE REC'D JUL 29 1987
DATE APPV'D SEP 11 1987
DATE EFF APR 1 1987
HCFA 179 87-11
A

Revised 04-01-87

TN No. 87-11
Supersedes TN No. 78-3

Approval Date SEP 11 1987

Effective Date APR 1 1987

HCFA ID: 1008P/0011P

☆ U.S. GOVERNMENT PRINTING OFFICE: 1987—181-270/60174

Revision: HCFA-PM-87-4 (BERC) MARCH 1987 OMB No.: 0938-0193

State/Territory: Oklahoma

Citation
42 CFR 431.110(b)
AT-78-90

3.1 (g) Participation by Indian Health Service Facilities

Indian Health Service facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.

1902(e)(9) of the Act, P.L. 99-509 (Section 9408)

(h) Respiratory Care Services for Ventilator-Dependent Individuals

Respiratory care services, as defined in section 1902(e)(9)(C) of the Act, are provided under the plan to individuals who--

(1) Are medically dependent on a ventilator for life support at least six hours per day;

(2) Have been so dependent as inpatients during a single stay or a continuous stay in one or more hospitals, SNFs or ICFs for the lesser of--

/ / 30 consecutive days;

/ / ___ days (the maximum number of inpatient days allowed under the State plan);

(3) Except for home respiratory care, would require respiratory care on an inpatient basis in a hospital, SNF, or ICF for which Medicaid payments would be made;

STATE OK
DATE REC'D JUN 29 1987
DATE APPV'D JAN 11 1988
DATE EFF APR 1 1987
HCFA I/P 87-9
A

(4) Have adequate social support services to be cared for at home; and

(5) Wish to be cared for at home.

/ / Yes. The requirements of section 1902(e)(9) of the Act are met.

/X/ Not applicable. These services are not included in the plan.

Revised 04-01-87

TN No. 87-9
Supersedes TN No. 78-3

Approval Date JAN 11 1988

Effective Date ~~APR 1 1987~~

HCFA ID: 1008P/0011P

Revision: HCFA-PM-93-5 (MB)
MAY 1993

State: OKLAHOMA

Citation

3.2 Coordination of Medicaid with Medicare and Other Insurance

(a) Premiums

(1) Medicare Part A and Part B

1902(a)(10)(E)(i) and 1905(p)(1) of the Act

(i) Qualified Medicare Beneficiary (QMB)

The Medicaid agency pays Medicare Part A premiums (if applicable) and Part B premiums for individuals in the QMB group defined in Item A.25 of ATTACHMENT 2.2-A, through the group premium payment arrangement, unless the agency has a Buy-in agreement for such payment, as indicated below.

Buy-In agreement for:

X Part A X Part B

___ The Medicaid agency pays premiums, for which the beneficiary would be liable, for enrollment in an HMO participating in Medicare.

APPROVED NOV 8 1993

STATE Oklahoma
DATE REC'D OCT 04 1993
DATE APPV'D OCT 27 1993
DATE EFF JUL 01 1993
HCFA 179 93-15

A

Revised 07-01-93

TN No. 93-15
Supersedes TN No. 93-08 Approval Date OCT 27 1993 Effective Date JUL 01 1993

Revision: HCFA-PM-97-3 (CMSO)
December 1997

State: OKLAHOMA

Citation 3.1 Amount, Duration, and Scope or Services (Cont.)

1902(a)(10)(E)(ii) and 1905(s) of the Act	(ii)	Qualified Disabled and Working Individual (QDWI) The Medicaid agency pays Medicare Part A premiums under a group premium payment arrangement, subject to any contribution required as described in ATTACHMENT 4.18-B for individuals in the QDWI group defined in item A.26 of ATTACHMENT 2.2-A of this plan.
1902(a)(10)(E)(iii)(I), and 1905(p)(3)(A)(ii) of the Act	(iii)	Specified Low-Income Medicare Beneficiary (SLMB) The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals in the SLMB group defined in item A.27 of Attachment 2.2-A of this plan.
1902(a)(10)(E)(iv)(I), 1905(p)(3)(A)(ii), and 1933 of the Act	(iv)	Qualifying Individual-1 QI-1) The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals described in 1902(a)(10(E)(iv)(I)and subject to 1933 of the Act.

SUPERSEDES: TN- OK 98-04

STATE Oklahoma
DATE REC'D 3-17-03
DATE APPV'D 4-4-03
DATE EFF 1-1-03
HCFA 179 OK 03-03
A

Revision: HCFA-PM-93-2 (MB)
MARCH 1993

State: OKLAHOMA

Citation

1843(b) and 1905(a) of the Act and 42 CFR 431.625

(iv) Other Medicaid Recipients

The Medicaid agency pays Medicare Part B premiums to make Medicare Part B coverage available to the following individuals:

X All individuals who are: a) receiving benefits under titles I, IV-A, X, XIV, or XVI (AABD or SSI); b) receiving State supplements under title XVI; or c) within a group listed at 42 CFR 431.625(d)(2).

___ Individuals receiving title II or Railroad Retirement benefits.

___ Medically needy individuals (FFP is not available for this group).

1902(a)(30) and 1905(a) of the Act

(2) Other Health Insurance

___ The Medicaid agency pays insurance premiums for medical or any other type of remedial care to maintain a third party resource for Medicaid covered services provided to eligible individuals (except individuals 65 years of age or older and disabled individuals, entitled to Medicare Part A but not enrolled in Medicare Part B).

STATE Oklahoma
DATE REC'D APR 06 1993
DATE APP'D MAY 03 1993
DATE EFF JAN 01 1993
HCFA 179 93-08

A

Revised 01-01-93

TN No. 93-08
Supersedes TN No. 92-03
Approval Date MAY 03 1993
Effective Date JAN 01 1993

Revision: HCFA-PM-93-2 (MB)
MARCH 1993

State: OKLAHOMA

Citation

(b) Deductibles/Coinsurance

(1) Medicare Part A and B

1902(a)(30), 1902(n), 1905(a), and 1916 of the Act

Supplement 1 to ATTACHMENT 4.19-B describes the methods and standards for establishing payment rates for services covered under Medicare, and/or the methodology for payment of Medicare deductible and coinsurance amounts, to the extent available for each of the following groups.

Sections 1902 (a)(10)(E)(i) and 1905(p)(3) of the Act

(i) Qualified Medicare Beneficiaries (QMBS)

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for QMBs (subject to any nominal Medicaid copayment) for all services available under Medicare.

1902(a)(10), 1902(a)(30), and 1905(a) of the Act

(ii) Other Medicaid Recipients

The Medicaid agency pays for Medicaid services also covered under Medicare and furnished to recipients entitled to Medicare (subject to any nominal Medicaid copayment). For services furnished to individuals who are described in section 3.2(a)(1)(iv), payment is made as follows:

42 CFR 431.625

_X_ For the entire range of services available under Medicare Part B.

___ Only for the amount, duration, and scope of services otherwise available under this plan.

1902(a)(10), 1902(a)(30), 1905(a), and 1905(p) of the Act

(iii) Dual Eligible--QMB plus

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for all services available under Medicare and pays for all Medicaid services furnished to individuals eligible both as QMBs and categorically or medically needy (subject to any nominal Medicaid copayment).

STATE Oklahoma
DATE REC'D APR 06 1993
DATE APPV'D MAY 03 1993
DATE EFF JAN 01 1993
HCFA 179 93-08
A

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State OKLAHOMA

Citation
42 CFR 441.101,
42 CFR 431.620(c)
and (d)
AT-79-29

3.3 Medicaid for Individuals Age 65 or Over in Institutions for Mental Diseases

Medicaid is provided for individuals 65 years of age or older who are patients in institutions for mental diseases.

/X/ Yes. The requirements of 42 CFR Part 441, Subpart C, and 42 CFR 431.620(c) and (d) are met.

/ / Not applicable. Medicaid is not provided to aged individuals in such institutions under this plan.

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State OKLAHOMA

Citation	3.4	Special Requirements Applicable to Sterilization Procedures
42 CFR 441.252 AT-78-99		All requirements of 42 CFR Part 441, Subpart F are met.

Revision: HCFA-PM-91-4 (BPD) AUGUST 1991 OMB No.: 0938-

State: OKLAHOMA

Citation 1902(a)(52) and 1925 of the Act

3.5 Families Receiving Extended Medicaid Benefits

(a) Services provided to families during the first 6-month period of extended Medicaid benefits under Section 1925 of the Act are equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

(b) Services provided to families during the second 6-month period of extended Medicaid benefits under section 1925 of the Act are--

☒ Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

☐ Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients, (or may be greater if provided through a caretaker relative employer's health insurance plan) minus any one or more of the following acute services:

☐ Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

☐ Medical or remedial care provided by licensed practitioners.

☐ Home health services.

Revised 10-01-91

TN No. 92-03 Supersedes TN No. 89-2 Approval Date FEB 27 1992 Effective Date OCT - 1 1991

HCFA ID: 7982E

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APPV'D FEB 27 1992
DATE EFF OCT - 1 1991
HCFA 179 92-03

A

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State: OKLAHOMA

Citation 3.5 Families Receiving Extended Medicaid Benefits (Continued)

- ☐ Private duty nursing services.
- ☐ Physical therapy and related services.
- ☐ Other diagnostic, screening, preventive, and rehabilitation services.
- ☐ Inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases.
- ☐ Intermediate care facility services for the mentally retarded.
- ☐ Inpatient psychiatric services for individuals under age 21.
- ☐ Hospice services.
- ☐ Respiratory care services.
- ☐ Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.

STATE Oklahoma
DATE RECD JAN 29 1992
DATE APPVD FEB 27 1992
DATE EFF OCT - 1 1991
HCFA 179 92-03
A

Revision: HCFA-PM-91-4 (BPD) AUGUST 1991 OMB No.: 0938-

State: OKLAHOMA

Citation 3.5 Families Receiving Extended Medicaid Benefits (Continued)

(c) ☐ The agency pays the family's premiums, enrollment fees, deductibles, coinsurance, and similar costs for health plans offered by the caretaker's employer as payments for medical assistance--

☐ 1st 6 months ☐ 2nd 6 months

☐ The agency requires caretakers to enroll in employers' health plans as a condition of eligibility.

☐ 1st 6 mos. ☐ 2nd 6 mos.

(d) ☐ (1) The Medicaid agency provides assistance to families during the second 6-month period of extended Medicaid benefits through the following alternative methods:

☐ Enrollment in the family option of an employer's health plan.

☐ Enrollment in the family option of a State employee health plan.

☐ Enrollment in the State health plan for the uninsured.

☐ Enrollment in an eligible health maintenance organization (HMO) with a prepaid enrollment of less than 50 percent Medicaid recipients (except recipients of extended Medicaid).

Revised 10-01-91

TN No. 92-03
Supersedes TN No. 90-10 Approval Date FEB 27 1992 Effective Date OCT - 1 1991

HCFA ID: 7982E

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APPV'D FEB 27 1992
DATE EFF OCT - 1 1991
HCFA 179 92-03

A

Revision: HCFA-PM-91-4 (BPD) AUGUST 1991 OMB No.: 0938-

State: OKLAHOMA

Citation 3.5 Families Receiving Extended Medicaid Benefits (Continued)

Supplement 2 to ATTACHMENT 3.1-A specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

(2) The agency--

(i) Pays all premiums and enrollment fees imposed on the family for such plan(s).

☐ (ii) Pays all deductibles and coinsurance imposed on the family for such plan(s).

TN No. 92-03 Supersedes TN No. 90-10 Approval Date FEB 27 1992 Effective Date OCT - 1 1991

HCFA ID: 7982E

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APP'D FEB 27 1992
DATE EFF OCT - 1 1991
HCFA 179 92-03
A

Revision: HCFA Region VI
May 1990

State/Territory: OKLAHOMA

31e

/_/ Enrollment in an eligible health maintenance organization (HMO) that has an enrollment of less than 50 percent of Medicaid recipients who are not recipients of extended Medicaid.

Supplement 2 to ATTACHMENT 3.1-A specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

(2) The agency--

(i) Pays all premiums and enrollment fees imposed on the family for such plan(s).

/_/ (ii) Pays all deductibles and coinsurance imposed on the family for such plan(s).

STATE Oklahoma	A
DATE REC'D 6-25-90	
DATE APPV'D 7-19-90	
DATE EFF 4-1-90	
HCFA 179 90-10	

Revision: HCFA - Region VI
DECEMBER 1990

State/Territory: OKLAHOMA

Sec 1905(o)(3) of the Act. (Sec 6408(c) of P.L. 100-239 and Sec 4705 of P.L. 101-508)

3.8 Additional amounts for Nursing Facility Residents

When hospice care is furnished to an individual residing in a nursing facility or intermediate care facility for the mentally retarded, the hospice is paid an additional amount on routine home care and continuous home care days to take into account the room and board furnished by the facility. The additional amount paid to the hospice on behalf of an individual residing in a nursing facility or intermediate care facility for the mentally retarded equals at least 95 percent of the per diem rate that would have paid to the facility for that individual in that facility under this State Plan.

STATE Oklahoma	A
DATE REC'D 1-7-91	
DATE APPV'D 2-1-91	
DATE EFF 10-1-90	
HCFA ID# 90-23	

TN No 90-23 New 10-01-90
Supersedes Approval Date 2/1/91 Effective Date 10/1/90
Tn No New Page

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

OMB No.: 0938-0193

State/Territory: Oklahoma

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation
42 CFR 431.15
AT-79-29

4.1 Methods of Administration

The Medicaid agency employs methods of administration found by the Secretary of Health and Human Services to be necessary for the proper and efficient operation of the plan.

STATE OK
DATE REC'D JUN 29 1987
DATE APPV'D JAN 11 1988
DATE EFF APR 1 1987
HCFA 179 87-9
A

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State OKLAHOMA

Citation		
42 CFR 431.202 AT-79-29 AT-80-34	4.2	Hearings for Applicants and Recipients The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR Part 431, Subpart E.

Revision: HCFA-AT-87-9 (BERC) OMB No.: 0938-0193
AUGUST1987

State/Territory: Oklahoma

Citation	4.3 Safeguarding Information on Applicants and Recipients
42 CFR 431.301 AT-79-29 1902(a)(7)	Under State statute which imposes legal sanctions, safeguards are provided that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.
52 FR 5967	All other requirements of 42 CFR Part 431, Subpart F are met.

STATE OK
DATE REC'D OCT 19 1987
DATE APPV'D JUN 23 1988
DATE EFF OCT 1 1987
HCFA 179 87-18
A

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State/Territory: Oklahoma

Citation
42 CFR 431.800(c)
50 FR 21839
1903(u)(1)(D) of the Act,
P.L. 99-509
(Section 9407)

4.4 Medicaid Quality Control

(a) A system of quality control is implemented in accordance with 42 CFR Part 431, Subpart P.

(b) The State operates a claims processing assessment system that meets the requirements of 431.800(e), (g), (h) and (k).

/X/ Yes.

/ / Not applicable. The State has an approved Medicaid Management Information System (MMIS).

STATE OK
DATE RECD JUN 29 1987
DATE APVD JAN 11 1988
EFF DATE APR 1 1987
TN # 87-9
A

Revised 04-01-87

TN No. 87-9
Supersedes TN No. 85-6

Approval Date JAN 11 1988 Effective Date ~~APR 1 1987~~

HCFA ID: 1010P/0012P

Revision: HCFA-PM-88-10 (BERC) OMB No.: 0938-0193
SEPTEMBER 1988

State/Territory: OKLAHOMA

Citation	
42 CFR 455.12	4.5 Medicaid Agency Fraud Detection and Investigation Program
AT-78-90	
48 FR 3742	The Medicaid agency has established and will maintain methods, criteria, and procedures that meet all requirements of 42 CFR 455.13 through 455.21 and 455.23 for prevention and control of program fraud and abuse.
52 FR 48817	

STATE OK
DATE RECD DEC 15 1988
DATE APPVD JAN 05 1989
DATE EFF OCT 01 1988
HCFA 179 88-08
A

Revised 10-01-88

TN No. 88-08
Supersedes TN No. 83-18

Approval Date JAN 05 1989

Effective Date OCT 01 1988

HCFA ID: 1010P/0012P

New: HCFA-PM-99-3 (CMSO)
JUNE 1999

State: OKLAHOMA

Citation		
Sectio 1902(a)(64) of the Social Security Act P.L. 105-33	4.5a	Medicaid Agency Fraud Detection and Investigation Program The Medicaid agency has established a mechanism to receive reports from beneficiaries and others and compile data concerning alleged instances of waste, fraud, and abuse relating to the operation of this title.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State OKLAHOMA

Citation
42 CFR 431.16
AT-79-29

4.6 Reports

The Medicaid agency will submit all reports in the form and with the content required by the Secretary, and will comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. All requirements of 42 CFR 431.16 are met.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State OKLAHOMA

Citation
42 CFR 431.17
AT-79-29

4.7 Maintenance of Records

The Medicaid agency maintains or supervises the maintenance of records necessary for the proper and efficient operation of the plan, including records regarding applications, determination of eligibility, the provision of medical assistance, and administrative costs, and statistical, fiscal and other records necessary for reporting and accountability, and retains these records in accordance with Federal requirements. All requirements of 42 CFR 431.17 are met.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State OKLAHOMA

Citation
42 CFR 431.18(b)
AT-79-29

4.8 Availability of Agency Program Manuals

Program manuals and other policy issuances that affect the public, including the Medicaid agency's rules and regulations governing eligibility, need and amount of assistance, recipient rights and responsibilities, and services offered by the agency are maintained in the State office and in each local and district office for examination, upon request, by individuals for review, study, or reproduction. All requirements of 42 CFR 431.18 are met.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State OKLAHOMA

Citation
42 CFR 433.37
AT-78-90

4.9 Reporting Provider Payments to Internal Revenue Service

There are procedures implemented in accordance with 42 CFR 433.37 for identification of providers of services by social security number or by employer identification number and for reporting the information required by the Internal Revenue Code (26 U.S.C. 6041) with respect to payment for services under the plan.

Revision: HCFA-PM-99-3 (CMSO)
JUNE 1999

State: OKLAHOMA

Citation
42 CFR 431.51
AT-78-90
46 FR48524
48 FR23212
1902 (a)(23)
of the Act
P.L. 100-203
(Section 4113)

4.10 Free Choice of Providers

(a) Except as provided in paragraph (b), the Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services, including an organization that provides these services or arranges for their availability on a pre-payment basis.

(b) Paragraph (a) does not apply to services furnished to an individual - -

(1) Under an exception allowed under 42 CFR 431.54, subject to the limitations in paragraph (c), or

(2) Under a waiver approved under 42 CFR 431.55, subject to the limitation in paragraph (c), or

(3) By an individual or entity excluded from participation in accordance with section 1902 (p) of the ACT, or

Section 1902(a)(23)
of the Social Security Act
P.L. 105-33

(4) By individuals or entities who have been convicted of a felony under Federal or State law and for which the State determined that the offense is inconsistent with the best interests of the individual eligible to obtain Medicaid services.

(c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in section 1915(b)(1), a health maintenance organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services or services under section 1905(a)(4)(c).

Revision: HCFA-AT-80-38 (BPP) OMB No.: 0938-0193
May 22, 1980

State/Territory: OKLAHOMA

Citation
42 CFR 431.610
AT-78-90
AT-80-34

4.11 Relations with Standard-Setting and Survey Agencies

(a) The State agency utilized by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions (exclusive of Christian Science sanatoria) that provide services to Medicaid recipients. This agency is the Oklahoma State Department of Health.

(b) The State authority(ies) responsible for establishing and maintaining standards, other than those relating to health, for public or private institutions that provide services to Medicaid recipients is (are): Oklahoma State Department of Health, Oklahoma State Department of Mental Health and Substance Abuse Services, Oklahoma Department of Human Services.

(c) ATTACHMENT 4.11-A describes the standards specified in paragraphs (a) and (b) above, that are kept on file and made available to the Health Care Financing Administration on request.

STATE Oklahoma
DATE REC'D 03-31-95
DATE APPV'D 04-27-95
DATE EFF 01-01-95
HCFA 179 95-06
A

Revised 01-01-95

TN No. 95-06
Supersedes TN No. 84-05 Approval Date 4/27/95 Effective Date 1/1/95

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State OKLAHOMA

Citation
42 CFR 431.610
AT-78-90
AT-89-34

4.11(d) The Oklahoma State Department of Health (agency) which is the State agency responsible for licensing health institutions, determines if institutions and agencies meet the requirements for participation in the Medicaid program. The requirements in 42 CFR 431.610(e), (f) and (g) are met.

approved under this plan

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State OKLAHOMA

Citation
42 CFR 431.105(b)
AT-78-90

4.12 Consultation to Medical Facilities

(a) Consultative services are provided by health and other appropriate State agencies to hospitals, nursing facilities, home health agencies, clinics and laboratories in accordance with 42 CFR 431.105(b).

(b) Similar services are provided to other types of facilities providing medical care to individuals receiving services under the programs specified in 42 CFR 431.105(b).

☐ Yes, as listed below:

☒ Not applicable. Similar services are not provided to other types of medical facilities.

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: OKLAHOMA

Citation 4.13 Required Provider Agreement

With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:

42 CFR 431.107 (a) For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met.

42 CFR Part 483 1919 of the Act (b) For providers of NF services, the requirements of 42 CFR Part 483, Subpart B, and section 1919 of the Act are also met.

42 CFR Part 483, Subpart ~~B~~ I (c) For providers of ICF/MR services, the requirements of participation in 42 CFR Part 483, Subpart ~~B~~ I are also met.

1920 of the Act (d) For each provider that is eligible under the plan to furnish ambulatory prenatal care to pregnant women during a presumptive eligibility period, all the requirements of section 1920(b)(2) and (c) are met.

/ Not applicable. Ambulatory prenatal care is not provided to pregnant women during a presumptive eligibility period.

STATE Oklahoma
DATE RECD JAN 2 9 1992
DATE APP FEB 2 8 1992
DATE EFF OCT 0 1 1991
HCFA ID 92-01
A

State: OKLAHOMA

Citation			
1902 (a)(58) 1902(w)	4.13	(e)	For each provider receiving funds under the plan, all the requirements for advance directives of section 1902(w) are met:

(1) Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans (unless the PAHP excludes providers in 42 CFR 489.102), and health insuring organizations are required to do the following:

(a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

(b) Provide written information to all adult individuals on their policies concerning implementation of such rights;

(c) Document in the individual's medical records whether or not the individual has executed an advance directive;

(d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(e) Ensure compliance with requirements of State Law (whether

SUPERSEDES: TN. 91-16

STATE Oklahoma A
DATE RECD 9-23-03
DATE APP'D 12-9-03
DATE EFF 8-13-03
HCFA 179 03-12

Revised 08-13-03

State/Territory: OKLAHOMA

statutory or recognized by the courts) concerning advance directives; and

(f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.

(2) Providers will furnish the written information described in paragraph (1)(a) to all adult individuals at the time specified below:

(a) Hospitals at the time an individual is admitted as an inpatient.

(b) Nursing facilities when the individual is admitted as a resident.

(c) Providers of home health care or personal care services before the individual comes under the care of the provider;

(d) Hospice program at the time of initial receipt of hospice care by the individual from the program; and

(e) Managed care organizations, health insuring organizations, prepaid inpatient health plans, and prepaid ambulatory health plans (as applicable) at the time of enrollment of the individual with the organization.

(3) Attachment 4.34A describes law of the State (whether statutory or as Recognized by the courts of the State) concerning advance directives.

_____ Not applicable. No State law Or court decision exist regarding advance directives.

SUPERSEDES: TN: 91-16

STATE Oklahoma
DATE REC'D 9-23-03
DATE APP'D 12-9-03
DATE EFF 8-13-03
HCFA 179 03-12
A

Revised 08-13-03

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: **Oklahoma**

4.13 Provider Screening and Enrollment

Citation	
1902(a)(77) 1902(a)(39) adds 1902(kk); P.L. 111-148 and P.L. 111-152	The State Medicaid agency gives the following assurances:
42 CFR 455 Subpart E	PROVIDER SCREENING X Assures that the State Medicaid agency complies with the process for screening providers under section 1902(a)(39), 1902(a)(77) and 1902(kk) of the Act.
42 CFR 455.410	ENROLLMENT AND SCREENING OF PROVIDERS X Assures enrolled providers will be screened in accordance with 42 CFR 455.400 et seq. X Assures that the State Medicaid agency requires all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the Plan as a participating provider.
42 CFR 455.412	VERIFICATION OF PROVIDER LICENSES X Assures that the State Medicaid agency has a method for verifying providers licensed by a State and that such providers licenses have not expired or have no current limitations.
42 CFR 455.414	REVALIDATION OF ENROLLMENT X Assures that providers will be revalidated regardless of provider type at least every 5 years.
42 CFR 455.416	TERMINATION OR DENIAL OF ENROLLMENT X Assures that the State Medicaid agency will comply with section 1902(a)(39) of the Act and with the requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: **Oklahoma**

4.13 Provider Screening and Enrollment (cont.)

42 CFR 455.420 REACTIVATION OF PROVIDER ENROLLMENT

X Assures that any reactivation of a provider, will include re-screening and payment of application fees as required by 42 CFR 455.460.

42 CFR 455.422 APPEAL RIGHTS

X Assures that all terminated providers and providers denied enrollment as a result of the requirements of 42 CFR 455.416 will have appeal rights available under procedures established by State law or regulation.

42 CFR 455.432 SITE VISITS

X Assures that pre-enrollment and post enrollment site visits of providers who are in "moderate" or "high risk" categories will occur.

42 CFR 455.434 CRIMINAL BACKGROUND CHECKS

X Assures that providers as a condition of enrollment will be required to consent to criminal background checks including fingerprints if required to do so under State law or by the level of screening based on risk of fraud, waste or abuse for that category of provider.

42 CFR 455.436 FEDERAL DATABASE CHECKS

X Assures that the State Medicaid agency will perform Federal database checks on all providers or any person with an ownership or controlling interest or who is an agent or managing employee of the provider.

42 CFR 455.440 NATIONAL PROVIDER IDENTIFIER

X Assures that the State Medicaid agency requires the National Provider Identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.

42 CFR 455.450 SCREENING LEVELS FOR MEDICAID PROVIDERS

X Assures that the State Medicaid agency complies with 1902(a)(77) and 1902(kk) of the Act and with the requirements outlined in 42 CFR 455.450 for screening levels based upon the categorical risk level determined for a provider.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: **Oklahoma**

4.13 Provider Screening and Enrollment (cont.)

42 CFR 455.460

APPLICATION FEE

X Assures that the State Medicaid agency complies with the requirements for collection of the application fee set forth in section 1866(j)(2)(C) of the Act and 42 CFR 455.460.

42 CFR 455.470

TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS

X Assures that the State Medicaid agency complies with any temporary moratorium on the enrollment of new providers or provider types imposed by the Secretary under section 1866(j)(7) and 1902(kk)(4) of the Act, subject to any determination by the State and written notice to the Secretary that such a temporary moratorium would not adversely impact beneficiaries' access to medical assistance.

State/Territory: OKLAHOMA

Citation		
42 CFR 431.60 42 CFR 456.2 50 FR 15312 1902(a)(30)(C) and 1902(d) of the Act, P.L. 99-509 (Section 9431)	4.14	Utilization/Quality Control (a) A Statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services. The requirements of 42 CFR Part 456 are met:
	X	Directly
	X	By undertaking medical and utilization review requirements through a contract with a Utilization and Quality Control Peer Review Organization (PRO) designated under 42 CFR Part 462. The contract with the PRO —
		(1) Meets the requirements of §434.6(a):
		(2) Includes a monitoring and evaluation plan to ensure satisfactory performance;
		(3) Identifies the services and providers subject to PRO review;
		(4) Ensures that PRO review activities are not inconsistent with the PRO review of Medicare services; and
		(5) Includes a description of the extent to which PRO determinations are considered conclusive for payment purposes.
1932(c)(2) and 1902(d) of the ACT, P.L. 99-509 (section 9431)	____	A qualified External Quality Review Organization performs an annual External Quality Review that meets the requirements of 42 CFR 438 Subpart E each managed care organization, prepaid inpatient health plan, and health insuring organizations under contract, except where exempted by the regulation.

STATE Oklahoma A
DATE RECD 9-23-03
DATE APPVD 12-9-03
DATE EFF 8-13-03
HCFA 179 03-12

SUPERSEDES: TN- 95-01

Revised 08-13-03

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

State: OKLAHOMA

OMB NO. 0938-0193

Citation
42 CFR 456.2
50 FR 15312

4.14 (b) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart C, for control of the utilization of inpatient hospital services.

/X/ Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

/ / Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart C for:

/ / All hospitals (other than mental hospitals).

/ / Those specified in the waiver.

/ / No waivers have been granted.

APPROVED BY DHHS/HCFA/DPO
DATE: AUG. 15 1986
TRANSMITTAL NO: 85-6

Revision: HCFA-PM-85-7 (BERC) OMB NO.: 0938-0193
JULY 1985

State/Territory: OKLAHOMA

Citation
42 CFR 456.2
50 FR 15312

4.14 (c) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart D, for control of utilization of inpatient services in mental hospitals.

/ / Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

/ / Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart D for:

/ / All mental hospitals.

/ / Those specified in the waiver.

/X/ No waivers have been granted.

/ / Not applicable. Inpatient services in mental hospitals are not provided under this plan.

APPROVED BY DHHS/HCFA/DPO
DATE: AUG. 15 1986
TRANSMITTAL NO: 85-6

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

State: OKLAHOMA

OMB NO. 0938-0193

Citation
42 CFR 456.2
50 FR 15312

4.14 (d) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart E, for the control of utilization of skilled nursing facility services.

/ / Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

/ / Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart E for:

/ / All skilled nursing facilities.

/ / Those specified in the waiver.

/X/ No waivers have been granted.

APPROVED BY DHHS/HCFA/DPO
DATE: AUG. 15 1986
TRANSMITTAL NO: 85-6

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

State: OKLAHOMA

OMB NO. 0938-0193

Citation
42 CFR 456.2
50 FR 15312

4.14 /_/(e) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart F, for control of the utilization of intermediate care facility services. Utilization review in facilities is provided through:

/_/ Facility-based review.

/X/ Direct review by personnel of the medical assistance unit of the State agency.

/_/ Personnel under contract to the medical assistance unit of the State agency.

/_/ Utilization and Quality Control Peer Review Organizations.

/_/ Another method as described in ATTACHMENT 4.14-A.

/_/ Two or more of the above methods. ATTACHMENT 4.14-B describes the circumstances under which each method is used.

/_/ Not applicable. Intermediate care facility services are not provided under this plan.

APPROVED BY DHHS/HCFA/DPO
DATE: AUG. 15 1986
TRANSMITTAL NO: 85-6

State/Territory: OKLAHOMA

Citation	4.14 Utilization/Quality Control (Continued)
42 CFR 438.356(e)	For each contract, the State must follow an open, competitive procurement process that is in accordance with State law and regulations and consistent with 45 CFR part 74 as it applies to State procurement of Medicaid services.
42 CFR 438.354 42 CFR 438.356(b) and (d)	The State must ensure that an External Quality Review Organization and its subcontractors performing the External Quality Review or External Quality Review-related activities meets the competence and independence requirements.

___ Not applicable.

STATE Oklahoma
DATE REC'D 9-23-03
DATE APPV'D 12-9-03
DATE EFF 8-13-03
HCFA 179 03-12

A

SUPERSEDES: TN- 93-07

Revised 08-13-03

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State OKLAHOMA

Citation
42 CFR 456.2
AT-78-90

4.15 Inspections of Care in Skilled Nursing and Intermediate Care Facilities and Institutions for Mental Diseases

All applicable requirements of 42 CFR Part 456, Subpart I, are met with respect to periodic inspections of care and services.

☐ Not applicable with respect to intermediate care facility services; such services are not provided under this plan.

☐ Not applicable with respect to services for individuals age 65 or over in institutions for mental diseases; such services are not provided under this plan.

☐ Not applicable with respect to inpatient psychiatric services for individuals under age 22; such services are not provided under this plan.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State OKLAHOMA

Citation
42 CFR 431.615(c)
AT-78-90

4.16 Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees

The Medicaid agency has cooperative arrangements with State health and vocational rehabilitation agencies and with title V grantees, that meet the requirements of 42 CFR 431.615.

ATTACHMENT 4.16-A describes the cooperative arrangements with the health and vocational rehabilitation agencies.

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OKLAHOMA

Citation (s)
42 CFR 433.36 (c)
1902(a) (18) and
1917(a) and (b) of
The Act

4.17 Liens and Adjustments or Recoveries

(a) Liens

___ The State imposes liens against an individual's real property on account of medical assistance paid or to be paid.

The State complies with the requirements of section 1917 (a) of the Act and regulations at 42 CFR 433.36 (c)-(g) with respect to any lien imposed against the property of any individual prior to his or her death on account of medical assistance paid or to be paid on his or her behalf.

STATE Oklahoma
DATE REC'D 3-31-10
DATE APP'D 11-12-10
DATE EFF 1-1-10
HCFA 179 10-09
A

___ The State imposes liens on real property on account of benefits incorrectly paid.

X The State imposes TEFRA liens 1917 (a) (1) (B) on real property of an individual who is an inpatient of a nursing facility, ICF/MR, or other medical institution, where the individual is required to contribute toward the cost of institutional care all but a minimal amount of income required for personal needs.

SUPERSEDES: TN- 91-21

The procedures by the State for determining that an institutionalized individual cannot reasonably be expected to be discharged are specified in Attachment 4.17-A. (NOTE: If the State indicates in its State Plan that it is imposing TEFRA liens, then the State is required to determine whether an institutionalized individual is permanently institutionalized and afford these individuals notice, hearing procedures, and due process requirements.)

___ The State imposes liens on both real and personal property of an individual after the individual's death.

Revised 01-01-10

TN No.: 10-09
Supersedes
TN No.: 91-21

Approval Date: 11-12-10 Effective Date: 1-1-10

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OKLAHOMA

(b) Adjustments or Recoveries

The State complies with the requirements of section 1917(b) of the Act and regulations at 42 CFR 433.36 (h)-(i).

Adjustments or recoveries for Medicaid claims correctly paid are as follows:

(1) For permanently institutionalized individuals, adjustments or recoveries are made from the individual's estate or upon sale of the property subject to a lien imposed because of medical assistance paid on behalf of the individual for services provided in a nursing facility, ICF/MR, or other medical institution.

X Adjustments or recoveries are made for all other medical assistance paid on behalf of the individual.

(2) The State determines "permanent institutional status" of individuals under the age of 55 other than those with respect to whom it imposes liens on real property under §1917 (a) (1) (B) (even if it does not impose those liens).

SUPERSEDES: TN- 94-21

(3) For any individual who received medical assistance at age 55 or older, adjustments or recoveries of payments are made from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services.

X In addition to adjustment or recovery of payments for services listed above, payments are adjusted or recovered for other services under the State Plan as listed below: None

STATE Oklahoma
DATE REC'D 3-31-10
DATE APP'D 11-12-10
DATE EFF 1-1-10
HCFA 179 10-09
A

Revised 01-01-10

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OKLAHOMA

4.17 (b) Adjustments or Recoveries

(3) (Continued)

Limitations on Estate Recovery - Medicare Cost Sharing:

(i) Medical assistance for Medicare cost sharing is protected from estate recovery for the following categories of dual eligibles: QMB, SLMB, QI, QDWI, QMB+, SLMB+. This protection extends to medical assistance for four Medicare cost sharing benefits: (Part A and B premiums, deductibles, coinsurance, co-payments) with dates of service on or after January 1,2010. The date of service for deductibles, coinsurance, and co-payments is the date the request for payment is received by the State Medicaid Agency. The date of service for premiums is the date the State Medicaid Agency paid the premium.

(ii) In addition to being a qualified dual eligible the individual must also be age 55 or over. The above protection from estate recovery for Medicare cost sharing benefits (premiums, deductibles, coinsurance, co-payments) applies to approved mandatory (i.e., nursing facility, home and community-based services, and related prescription drugs and hospital services) as well as optional Medicaid services identified in the State plan, which are applicable to the categories of duals referenced above.

STATE Oklahoma
DATE REC'D 3-31-10
DATE APPV'D 11-12-10
DATE EFF 1-1-10
HCFA 179 10-09

A

New 01-01-10

TN No.: 10-09
Supersedes
TN No.: SUPERSEDES: NONE - NEW PAGE

Approval Date: 11-12-10 Effective Date: 1-1-10

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OKLAHOMA

Citation (s)

____ The State disregards assets or resources for individuals who receive or are entitled to receive benefits under a long term care insurance policy as provided for in Attachment 2.6-A, Supplement 8b.

____ The State adjusts or recovers from the individual's estate on account of all medical assistance paid for nursing facility and other long term care services provided on behalf of the individual. (States other than California, Connecticut, Indiana, Iowa, and New York which provide long term care insurance policy-based asset and resource disregard must select this entry. These five States may either check this entry or one of the following entries.)

____ The State does not adjust or recover from the individual's estate on account of any medical assistance paid for nursing facility or other long term care services provided on behalf of the individual.

____ The State adjusts or recovers from the assets or resources on account of medical assistance paid for nursing facility or other long term care services provided on behalf of the individual to the extent described below:

X__ If an individual covered under a long-care insurance policy received benefits for which assets or resources were disregarded as provided for in Attachment 2.6-A, Supplement 8c (State Long-Term Care Insurance Partnership), the State does not seek adjustment or recovery from the individual's estate for the amount of assets or resources disregarded.

STATE Oklahoma
DATE RECD 3-31-10
DATE APPVD 11-12-10
DATE EFF 1-1-10
HCFA 179 10-09
A

SUPERSEDES: TN- 07-16

Revised 01-01-10

TN No.: 10-09
Supersedes TN No.: 07-16

Approval Date: 11-12-10

Effective Date: 1-1-10

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OKLAHOMA

Citation (s)

(c) Adjustments or Recoveries: Limitations

The State complies with the requirements of section 1917(b) (2) of the Act and regulations at 42 CFR §433.36(h)-(i).

(1) Adjustments or recovery of medical assistance correctly paid will be made only after the death of the individual's surviving spouse, and only when the individual has no surviving child who is either under age 21, blind, or disabled.

(2) With respect to liens on the home of any individual who the State determines is permanently institutionalized and who must as a condition of receiving services in the institution apply their income to the cost of care, the State will not seek adjustments or recovery of medical assistance correctly paid on behalf of the individual until such time as none of the following individuals are residing in the individual's home:

(a) a sibling of the individual (who was residing in the individual's home for at least one year immediately before the date that the individual was institutionalized), or

(b) a child of the individual (who was residing in the individual's home for at least two years immediately before the date that the individual was institutionalized) who establishes to the satisfaction of the State that the care the child provided permitted the individual to reside at home rather than become institutionalized.

(3) No money payments under another program are reduced as a means of adjusting or recovering Medicaid claims incorrectly paid.

STATE Oklahoma
DATE REC'D 3-31-10
DATE APPV'D 11-12-10
DATE EFF 1-1-10
HCFA 179 10-09

A

New 01-01-10

TN No.: 10-09
Supersedes TN No.: SUPERSEDES: NONE - NEW PAGE

Approval Date: 11-12-10 Effective Date: 1-1-10

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OKLAHOMA

Citation (s)

(d) **ATTACHMENT 4.17-A**

(1) Specifies the procedures for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home. The description of the procedure meets the requirements of 42 CFR 433.36 (d).

(2) Specifies the criteria by which a son or a daughter can establish that he or she has been providing care, as specified under 42 CFR 433.36(f).

(3) Defines the following terms:

- estate (at a minimum, estate as defined under State probate law). Except for the grandfathered States listed in section 4.17(b)(3), if the State provides a disregard for assets or resources for any individual who received or is entitled to receive benefits under a long term care insurance policy, the definition of estate must include all real, personal property, and assets of an individual (including any property or assets in which the individual had any legal title or interest at the time of death to the extent of the interest and also including the assets conveyed through devices such as joint tenancy, life estate, living trust, or other arrangements).
- individual's home,
- equity interest in the home.
- Residing in the home for at least 1 or 2 years,
- on a continuous basis,
- discharge from the medical institution and return home, and
- lawfully residing.

STATE Oklahoma
DATE REC'D 3-31-10
DATE APP'D 11-12-10
DATE EFF 1-1-10
HCFA 179 10-09

New 01-01-10

SUPERSEDES: NONE - NEW PAGE

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OKLAHOMA

(4) Describes the standards and procedures for waiving estate recovery when it would cause undue hardship.

(5) Defines when adjustment or recovery is not cost-effective. Defines cost-effective and includes methodology or thresholds used to determine cost effectiveness.

(6) Describes collection procedures. Includes advance notice requirements, specifies the method for applying for a waiver, hearing and appeals procedures, and the time frames involved.

STATE Oklahoma
DATE REC'D 3-31-10
DATE APP'VD 11-12-10
DATE EFF 1-1-10
HCFA 179 10-09
A

New 01-01-10

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OKLAHOMA

Citation (s)

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- individual's home,
- equity interest in the home.
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- on a continuous basis,
- discharge from the medical institution and return home, and
- lawfully residing.

STATE Oklahoma
DATE REC'D 3-31-10
DATE APPV'D 11-12-10
DATE EFF 1-1-10
HCFA 179 10-09

New 01-01-10

SUPERSEDES: NONE - NEW PAGE

State/Territory: OKLAHOMA

4.18 Recipient Cost Sharing and Similar Charges

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State: Oklahoma
Date Received: 30 September, 2014
Date Approved: 4 October, 2019
Effective Date: 1 July, 2014
Transmittal Number: 14-0014

State/Territory: OKLAHOMA

4.18(b)(2) *(continued)*

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State: Oklahoma
Date Received: 30 September, 2014
Date Approved: 4 October, 2019
Effective Date: 1 July, 2014
Transmittal Number: 14-0014

4.18(b) *(continued)*

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State: Oklahoma
Date Received: 30 September, 2014
Date Approved: 4 October, 2019
Effective Date: 1 July, 2014
Transmittal Number: 14-0014

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

OMB No.: 0938-

State/Territory: OKLAHOMA

4.18(b)(3) *(continued)*

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State: Oklahoma
Date Received: 30 September, 2014
Date Approved: 4 October, 2019
Effective Date: 1 July, 2014
Transmittal Number: 14-0014

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

OMB No.: 0938-

State/Territory: OKLAHOMA

4.18(b)(4)
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State: Oklahoma
Date Received: 30 September, 2014
Date Approved: 4 October, 2019
Effective Date: 1 July, 2014
Transmittal Number: 14-0014

TN# OK 14-0014 Approval Date 10/04/2019 Effective Date 07/01/2014

Supersedes TN# 92-0001

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State: OKLAHOMA

4.18(c)

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State: Oklahoma
Date Received: 30 September, 2014
Date Approved: 4 October, 2019
Effective Date: 1 July, 2014
Transmittal Number: 14-0014

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

OMB No.: 0938-

State: OKLAHOMA

4.18(c)(2) *(continued)*

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State: Oklahoma
Date Received: 30 September, 2014
Date Approved: 4 October, 2019
Effective Date: 1 July, 2014
Transmittal Number: 14-0014

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

OMB No.: 0938-

State/Territory: OKLAHOMA

4.18(c)(3)

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State: Oklahoma
Date Received: 30 September, 2014
Date Approved: 4 October, 2019
Effective Date: 1 July, 2014
Transmittal Number: 14-0014

Revised 07-01-14

Revision: HCFA Region VI
SEPTEMBER 1992

OMB No.: 0938-

State/Territory: OKLAHOMA

4.18(c)(3) *(continued)*

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State: Oklahoma
Date Received: 30 September, 2014
Date Approved: 4 October, 2019
Effective Date: 1 July, 2014
Transmittal Number: 14-0014

Revision: HCFA Region VI
July 1990

STATE OKLAHOMA

Citation(s)	4.18 (d)	
1916 of the Act. Section 6408(d)(3) of P.L. 101-239	_____	For qualified disabled working individuals (QDWI's) whose income exceeds 150 percent of the Federal income poverty level, the State imposes a premium expressed as a percentage of the Medicare cost sharing described in Section 1905 (p)(3)(A)(i), according to a sliding scale, in reasonable increments, as the individual's income increases between 150 and 200 percent of the Federal income poverty level.

STATE Oklahoma
DATE REC'D 10-2-90
DATE APPV'D 10-17-90
DATE EFF 7-1-90
HCFA 179 90-18

A

New 07-01-90

TN No. 90-18
Supersedes TN No. New Page

Approval Date 10/17/90 Effective Date 7/1/90

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: OKLAHOMA

Citation 4.19 Payment for Services

42 CFR 447.252
1902(a)(13)
and 1923 of
the Act
1902(e)(7)

m 93-5

(a) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, and sections 1902(a)(13) and 1923 of the Act with respect to payment for inpatient hospital services.

ATTACHMENT 4.19-A describes the methods and standards used to determine rates for payment for inpatient hospital services.

[ ] Inappropriate level of care days are covered and are paid under the State plan at lower rates than other inpatient hospital services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G) of the Act.

[X] Inappropriate level of care days are not covered.

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APP'D FEB 28 1992
DATE EFF OCT 01 1991
HCFA ID 92-01
A

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: OKLAHOMA

Citation		
42 CFR 447.201 42 CFR 447.302 52 FR 28648 1902(a)(13)(E) 1903(a)(1) and (n), 1920, and 1926 of the Act	4.19(b)	In addition to the services specified in paragraphs 4.19(a), (d), (k), (l), and (m), the Medicaid agency meets the following requirements:
	(1)	Section 1902(a)(13)(E) of the Act regarding payment for services furnished by Federally qualified health centers (FQHCs) under section 1905(a)(2)(C) of the Act The agency meets the requirements of section 6303 of the State Medicaid Manual (HCFA-Pub. 45-6) regarding payment for FQHC services. ATTACHMENT 4.19-B describes the method of payment and how the agency determines the reasonable costs of the services (for example, cost-reports, cost or budget reviews, or sample surveys).
	(2)	Sections 1902(a)(13)(E) and 1926 of the Act, and 42 CFR Part 447, Subpart D, with respect to payment for all other types of ambulatory services provided by rural health clinics under the plan.

ATTACHMENT 4.19-B describes the methods and standards used for the payment of each of these services except for inpatient hospital, nursing and intermediate care facility services that are described in other attachments.

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APPVD FEB 28 1992
DATE EFF OCT 01 1991
HCFA ID 92-01

A

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State OKLAHOMA

Citation		
42 CFR 447.40 AT-78-90	4.19(c)	Payment is made to reserve a bed during a recipient's temporary absence from an inpatient facility.

☒ Yes. The State's policy is described in ATTACHMENT 4.19-C.

☐ No.

TN # 77-23
Supersedes
TN #

Approval Date 2/9/78 Effective Date 1/1/78

RECEIVED
FEB 11 1992
EXEC. DIV.

Revision: HCFA - Region VI
November 1990

State/Territory: OKLAHOMA

Citation
42 CFR 447.252
47 FR 47964
48 FR 56046
42 CFR 447.280
47 FR 31518
52 FR 28141
Section 1902(a)(13)(A) of Act (Section 4211 (h)(2)(A) of P.L. 100-203).

4.19 (d)

(1) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, with respect to payments for nursing facility services and intermediate care facility services for the mentally retarded.

ATTACHMENT 4.19-D describes the methods and standards used to determine rates for payment for nursing facility services and intermediate care facility services for the mentally retarded.

(2) The Medicaid agency provides payment for routine nursing facility services furnished by a swing-bed hospital.

☐ At the average rate per patient day paid to NFs for routine services furnished during the previous calendar year.

☐ At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

☒ Not applicable. The agency does not provide payment for NF services to a swing-bed hospital.

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FEB 11 1992
I&R
MGMT. SERVS.

STATE Oklahoma
DATE REC'D JAN - 7 1991
DATE APPV'D JAN 17 1992
DATE EFF OCT - 1 1990
HCFA 179 90-24
A

Revision: HCFA-Region VI
March 1991

State OKLAHOMA

Citation		
42 CFR 447.45 AT-79-50 Sec. 1915(b)(4), (Sec. 4742 of P.L. 101-508)	4.19(e)	The Medicaid agency meets all requirements of 42 CFR 447.45 for timely payment of claims. ATTACHMENT 4.19-E specifies, for each type of service, the definition of a claim for purposes of meeting these requirements.

TN# 91-06 Approval Date 4/24/91 Effective Date 1/1/91
Supersedes
TN# 79-13

STATE Oklahoma
DATE REC'D 4-1-91
DATE APPV'D 4-24-91
DATE EFF 1-1-91
HCFA 179 91-06
A

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-019!
MARCH 1987

State/Territory: Oklahoma

Citation		
42 CFR 447.15	4.19 (f)	The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447.15.
AT-78-90		
AT-80-34		
48 FR 5730		No provider participating under this plan may deny services to any individual eligible under the plan on account of the individual's inability to pay a cost sharing amount imposed by the plan in accordance with 42 CFR 431.55(g) and 447.53. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing change.

STATE OK
DATE REC'D JUN 29 1987
DATE APPV'D JAN 11 1988
DATE EFF APR 1 1987
HCFA 179 87-9
A

Revised 04-01-87

TN No. 87-9
Supersedes TN No. 83-7

Approval Date JAN 11 1988 Effective Date APR 1 1987

HCFA ID: 1010P/0012P

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State OKLAHOMA

Citation		
42 CFR 447.201 42 CFR 447.202 AT-78-90	4.19(g)	The Medicaid agency assures appropriate audit of records when payment is based on costs of services or on a fee plus cost of materials.

Revision: HCFA-AT-80-60 (BPP)
August 12, 1980

State OKLAHOMA

Citation		
42 CFR 447.201 42 CFR 447.203 AT-78-90	4.19(h)	The Medicaid agency meets the requirements of 42 CFR 447.203 for documentation and availability of payment rates.

Revised 10-1-80

TN # 80-13
Supersedes
TN # 79-11

Approval Date FEB 2 1981 Effective Date 10-1-80

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State OKLAHOMA

Citation		
42 CFR 447.201 42 CFR 447.204 AT-78-90	4.19(i)	The Medicaid agency's payments are sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State: OKLAHOMA

Citation

42 CFR 447.201 and 447.205	4.19(j)	The Medicaid agency meets the requirements of 42 CFR 447.205 for public notice of any changes in Statewide method or standards for setting payment rates.
1903(v) of the Act	(k)	The Medicaid agency meets the requirements of section 1903(v) of the Act with respect to payment for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Payment is made only for care and services that are necessary for the treatment of an emergency medical condition, as defined in section 1903(v) of the Act.

STATE Oklahoma
DATE SUBMITTED JAN 2 9 1992
DATE APPROVED FEB 2 8 1992
DATE EFFECTIVE OCT 0 1 1991
HCFA ID 92-01
A

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

4.19 (m) Medicaid Reimbursement for Administration of Vaccines under the Pediatric Immunization Program

1928 (c) (2) (C) (ii) of the Act

(i) A provider may impose a charge for the administration of a qualified vaccine as stated in 1928(c)(2)(C)(ii) of the Act. Within this overall provision, Medicaid reimbursement to providers will be administered as follows.

(ii) The State:

_X_ sets a payment rate at the level of the regional maximum established by the DHHS Secretary for public providers.
The rate for public providers is $19.58.

___ is a Universal Purchase State and sets a payment rate at the level of the regional maximum established in accordance with State law.

_X_ sets a payment rate below the level of the regional maximum established by the DHHS Secretary for non-public providers.
The rate for private providers is $19.58 minus the rate reductions that are in effect.

___ is a Universal Purchase State and sets a payment rate below the level of the regional maximum established by the Universal Purchase State.

The agency's fee schedule rate was set as of October 1, 2019 and is effective for services provided on or after that date. All rates are published on the agency's website at www.okhca.org/feeschedules. As indicated above, public providers are reimbursed at the level of the regional maximum.

Private providers are defined as providers that do not have an affiliation with a government agency.

(iii) Medicaid beneficiary access to immunizations is assured through the following methodology:

"Other"-The State will attempt to set administration fee at Regional Maximum at earliest opportunity for non-public providers.

State: Oklahoma
Date Received: 4 October, 2019
Date Approved: 28 October, 2019
Effective Date: 1 October, 2019
Transmittal Number: 19-0034

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State OKLAHOMA

Citation
42 CFR 447.25(b)
AT-78-90

4.20 Direct Payments to Certain Recipients for Physicians' or Dentists' Services

Direct payments are made to certain recipients as specified by, and in accordance with, the requirements of 42 CFR 447.25.

☐ Yes, for ☐ physicians' services

☐ dentists' services

ATTACHMENT 4.20-A specifies the conditions under which such payments are made.

☒ Not applicable. No direct payments are made to recipients.

Revision: HCFA-AT-81-34 (BPP) 10-81

State OKLAHOMA

Citation		
42 CFR 447.10(c) AT-78-90 46 FR 42699	4.21	Prohibition Against Reassignment of Provider Claims Payment for Medicaid services furnished by any provider under this plan is made only in accordance with the requirements of 42 CFR 447.10.

TN # 81-11
Supersedes
TN # —

Approval Date JAN 18 1982 Effective Date [illegible]

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

State/Territory: OKLAHOMA

RECEIVED JUL 28 1994 Planning & Systems Development

Citation

4.22 Third Party Liability

42 CFR 433.137

(a) The Medicaid agency meets all requirements of:

(1) 42 CFR 433.138 and 433.139.
(2) 42 CFR 433.145 through 433.148.
(3) 42 CFR 433.151 through 433.154.

1902(a)(25)(H) and (I) of the Act

(4) Sections 1902(a)(25)(H) and (I) of the Act.

42 CFR 433.138(f)

(b) ATTACHMENT 4.22-A --

(1) Specifies the frequency with which the data exchanges required in §433.138(d)(1), (d)(3) and (d)(4) and the diagnosis and trauma code edits required in §433.138(e) are conducted;

42 CFR 433.138(g)(1)(ii) and (2)(ii)

(2) Describes the methods the agency uses for meeting the followup requirements contained in §433.138(g)(1)(i) and (g)(2)(i);

42 CFR 433.138(g)(3)(i) and (iii)

(3) Describes the methods the agency uses for following up on information obtained through the State motor vehicle accident report file data exchange required under §433.138(d)(4)(ii) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources; and

42 CFR 433.138(g)(4)(i) through (iii)

(4) Describes the methods the agency uses for following up on paid claims identified under §433.138(e) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources.

STATE Oklahoma
DATE REC'D 6-24-94
DATE APP'D 7-22-94
DATE EFF 10-01-93
HCFA 179 94-06
A

State/Territory: Oklahoma

Citation

42 CFR 433.139(b)(3)(ii)(A)	X	(c)	Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.
		(d)	ATTACHMENT 4.22-B specifies the following:
42 CFR 433.139(b)(3)(ii)(C)			(1) The method used in determining a provider's compliance with the third party billing requirements at §433.139(b)(3)(ii)(C).
42 CFR 433.139(f)(2)			(2) The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.
42 CFR 433.139(f)(3)			(3) The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.
42 CFR 447.20		(e)	The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

State/Territory: OKLAHOMA

Citation

4.22 (continued)

42 CFR 433.151(a)

(f) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with the following: (Check as appropriate.)

X State title IV-D agency. The requirements of 42 CFR 433.152(b) are met.

___ Other appropriate State agency(s)--

_____

_____

___ Other appropriate agency(s) of another State--

_____

_____

___ Courts and law enforcement officials.

1902(a)(60) of the Act

(g) The Medicaid agency assures that the State has in effect the laws relating to medical child support under section 1908 of the Act.

1906 of the Act

(h) The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following.

___ The Secretary's method as provided in the State Medicaid Manual, Section 3910.

X The State provides methods for determining cost effectiveness on ATTACHMENT 4.22-C.

RECEIVED SEP 14 1994 Planning & Systems Development

STATE Oklahoma
DATE REC'D 7-5-94
DATE APPV'D 8-25-94
DATE EFF 4-1-94
HCFA 179 94-08
A

Revised 04-01-94

TN No. 94-08
Supersedes TN No. 86-04
Approval Date 8/25/94
Effective Date 4/1/94

State/Territory: OKLAHOMA

Citation	4.23	Use of Contracts
42 CFR Part 434 48 FR 54013		The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42 CFR Part 434.
		/_/ Not applicable. The State has no such contracts.
42 CFR Part 438		The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 438. All contracts meet the requirements of 42 CFR Part 438. Risk contracts are procured through an open, competitive procurement process that is consistent with 45 CFR Part 74. The risk contract is with (check all that apply):
		___ a Managed Care Organization that meets the definition of 1903(m) of the Act and 42 CFR 438.2
		___ a Prepaid Inpatient Health Plan that meets the definition of 42 CFR 438.2
		_X_ a Prepaid Ambulatory Health Plan that meets the definition of 42 CFR 438.2.
		___ Not applicable.

STATE Oklahoma
DATE RECD 9-29-04
DATE APPVD 11-1-04
DATE EFF 7-1-04
HCFA ID 79 04-07

A

SUPERSEDES TN 03-12

Revised 07/01/04

Revision: HCFA-PM-94-2 (BPD)
APRIL 1994

State/Territory: OKLAHOMA

Citation	4.24	Standards for Payments for Nursing Facility and Intermediate Care Facility for the Mentally Retarded Services
42 CFR 442.10 and 442.100 AT-78-90 AT-79-18 AT-80-25 AT-80-34 52 FR 32544 P.L 100-203 (Sec. 4211) 54 FR 5316 56 FR 48826		With respect to nursing facilities and intermediate care facilities for the mentally retarded, all applicable requirements of 42 CFR Part 442, Subparts B and C are met. ___ Not applicable to intermediate care facilities for the mentally retarded; such services are not provided under this plan.

RECEIVED SEP 22 1994 I & R MGMT. SERVS.

RECEIVED SEP 23 1994 Planning & Systems Development

STATE Oklahoma
DATE REC'D 9-9-94
DATE APPV'D 9-16-94
DATE EFF 7-1-94
HCFA 179 94-12

A

Revised 07-01-94

TN No. 94-12
Supersedes TN No. None-New Page
Approval Date 9/16/94 Effective Date 7/1/94

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State OKLAHOMA

Citation		
42 CFR 431.702 AT-78-90	4.25	Program for Licensing Administrators of Nursing Homes The State has a program that, except with respect to Christian Science sanatoria, meets the requirements of 42 CFR Part 431, Subpart N, for the licensing of nursing home administrators.

Revision: HCFA-PM- (MB)

State/Territory: OKLAHOMA

Citation

1927(g)
42 CFR 456.700

4.26. Drug Utilization Review Program

A.1. The Medicaid agency meets the requirements of the Section 1927(g) of the Act for a drug use review (DUR) program for outpatient drug claims.

1927(g)(1)(A)

2. The DUR program assures that prescriptions for outpatient drugs are:
   - Appropriate
   - Medically necessary
   - Are not likely to result in adverse medical results

1927(g)(1)(a)
42 CFR 456.705(b)
and 456.709(b)

B. The DUR program is designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and patients or associated with specific drugs or groups of drugs, as well as:
   - Potential and actual adverse drug reactions
   - Therapeutic appropriateness
   - Overutilization and underutilization
   - Appropriate use of generic products
   - Therapeutic duplication
   - Drug-disease contraindications
   - Drug-drug interactions
   - Incorrect drug dosage or duration of drug treatment
   - Drug-allergy interactions
   - Clinical abuse-misuse

1927(g)(1)(B)
42 CFR 456.703
(d) and (f)

C. The DUR program shall assess data use against predetermined standards whose source materials for their development are consistent with peer-reviewed medical literature which has been critically reviewed by unbiased independent experts and the following compendia:
   - American Hospital Formulary Service Drug Information (AHFS-DI)
   - United States Pharmacopeia-Drug Information
   - Micromedex DrugDEX (DrugDEX)
   - American Medical Association Drug Evaluations

Revision: HCFA-PM- (MB)

State/Territory: OKLAHOMA

Citation

1927(g)(1)(D)
42 CFR 456.703(b)

D. DUR is not required for drugs dispensed to residents of nursing facilities that are in compliance with drug regimen review procedures set forth in 42 CFR 483.60. The State has never-the-less chose to include nursing home drugs in:
_X_ Prospective DUR
_X_ Retrospective DUR

1927(g)(2)(A)
42 CFR 456.705(b)

E.1. The DUR program includes prospective review of drug therapy at the point of sale or point of distribution before each prescription is filled or delivered to the Medicaid recipient.

1927(g)(2)(A)(i)
42 CFR 456.705(b), (1)-(7))

2. Prospective DUR includes screening each prescription filled or delivered to an individual receiving benefits for potential drug therapy problems due to:
- Therapeutic duplication
- Drug-disease contraindications
- Drug-drug interaction
- Drug interactions with no-prescription or over-the-counter drugs
- Incorrect drug dosage or duration of drug treatment
- Drug-allergy interactions
- Clinical abuse/misuse

At the option of the State, the screenings also include review for:
- High drug dosages
- Drug age precaution
- Drug-pregnancy
- Ingredient duplication

1927(g)(2)(A)(ii)
42 CFR 456.705(c) and d

2. Prospective DUR includes counseling for Medicaid recipients based on standards established by State law and maintenance of patient profiles.

1927(g)(2)(B)
42 CFR 456.709(a)

F.1. The DUR program includes retrospective DUR through its mechanized drug claims processing and information retrieval system or otherwise which undertakes ongoing periodic examination of claims data and other records to identify:

- Patterns of fraud and abuse
- Gross overuse
- Excessive utilization
- Inappropriate or medically unnecessary care or prescribing or billing practices that indicate abuse or excessive utilization among physicians, pharmacists, Medicaid members, or associated with specific drugs or groups of drugs.

Revision: HCFA-PM- (MB)

State/Territory: OKLAHOMA

Citation		
927(g)(2)(C) 42 CFR 456.709(b)	F.2.	The DUR program assesses data on drug use against explicit predetermined standards including but not limited to monitoring for: -Therapeutic appropriateness -Overutilization and underutilization -Appropriate use of generic products -Therapeutic duplication -Drug-disease contraindications -Drug-drug interactions -Incorrect drug dosage/duration of drug treatment -Clinical abuse/misuse
1927(g)(2)(D) 42 CFR 456.711	3.	The DUR program through its State DUR Board, using data provided by the Board, provides for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices.
1927(g)(3)(A) 42 CFR 456.716(a)	G.1.	The DUR program has established a State DUR Board either: X Directly, or ___ Under contract with a private organization
1927(g)(3)(B) 42 CFR 456.716 (A) AND (B)	2.	The DUR Board membership includes health professionals (one-third licensed actively practicing pharmacists and one-third but no more than 51 percent licensed and actively practicing physicians) with knowledge and experience in one or more of the following: - Clinically appropriate prescribing of covered outpatient drugs. - Clinically appropriate dispensing and monitoring of covered outpatient drugs. - Drug use review, evaluation and intervention. - Medical quality assurance.
927(g)(3)(C) 42 CFR 456.716(d)	3.	The activities of the DUR Board include: - Retrospective DUR, - Application of Standards as defined in section 1927(g)(2)(C), and - Ongoing interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the course of retrospective DUR.

STATE Oklahoma
DATE REC'D APR 14 1993
DATE APPV'D JUN 08 1993
DATE EFF APR 01 1993
HCFA 179 93-09
A

New 01-01-93

TN No. 93-09
Supersedes TN No. [illegible] Approval Date JUN 08 1993 Effective Date APR 01 1993

Revision: HCFA-PM- (MB) OMB No.

State/Territory: OKLAHOMA

Citation			
1927(g)(3)(C) 42 CFR 456.711 (a)-(d)		G.4	The interventions include in appropriate instances: - Information dissemination - Written, oral, and electronic reminders - Face-to-Face discussions - Intensified monitoring/review of prescribers/dispensers
1927(g)(3)(D) 42 CFR 456.712 (A) and (B)		H.	The State assures that it will prepare and submit an annual report to the Secretary, which incorporates a report from the State DUR Board, and that the State will adhere to the plans, steps, procedures as described in the report.
1927(h)(1) 42 CFR 456.722	X	I.1.	The State establishes, as its principal means of processing claims for covered outpatient drugs under this title, a point-of-sale electronic claims management system to perform on-line: - real time eligibility verification - claims data capture - adjudication of claims - assistance to pharmacists, etc. applying for and receiving payment.
1927(g)(2)(A)(i) 42 CFR 456.705(b)	X	2.	Prospective DUR is performed using an electronic point of sale drug claims processing system.
1927(j)(2) 42 CFR 456.703(c)		J.	Hospitals which dispense covered outpatient drugs are exempted from the drug utilization review requirements of this section when facilities use drug formulary systems and bill the Medicaid program no more than the hospital's purchasing cost for such covered outpatient drugs.

STATE Oklahoma
DATE REC'D APR 14 1993
DATE APPV'D JUN 08 1993
DATE EFF APR 01 1993
HCFA 179 92-09

A

* U.S. G.P.O.:1993-342-239:80043

Citation

K. Provisions of Section 1004 of the SUPPORT ACT

1902(a)(85) and Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act)

a. **Claim Review Limitations**

- Prospective safety edits on opioid prescriptions to address days' supply, early refills, duplicate fills and quantity limitations for clinical appropriateness.
- Prospective safety edits on maximum daily morphine milligram equivalents (MME) on opioids prescriptions to limit the daily morphine milligram equivalent (as recommended by clinical guidelines).
- Retrospective reviews on opioid prescriptions exceeding these above limitations on an ongoing basis.
- Retrospective reviews on concurrent utilization of opioids and benzodiazepines as well as opioids and antipsychotics on a periodic basis.

b. **Programs to monitor antipsychotic medications to children:**

Antipsychotic agents are reviewed for appropriateness for all members aged 18 and younger, including foster children, based on approved indications and clinical guidelines.

c. **Fraud and abuse identification:**

The DUR program has established a process that identifies potential fraud or abuse of controlled substances by enrolled individuals, health care providers and pharmacies.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State OKLAHOMA

Citation		
42 CFR 431.115(c) AT-78-90 AT-79-74	4.27	Disclosure of Survey Information and Provider or Contractor Evaluation The Medicaid agency has established procedures for disclosing pertinent findings obtained from surveys and provider and contractor evaluations that meet all the requirements in 42 CFR 431.115.

Revision: HCFA-PM-93-1 (BPD)
January 1993

State/Territory: OKLAHOMA

Citation	4.28 Appeals Process
42 CFR 431.152; AT-79-18 52 FR 22444; Secs. 1902(a)(28)(D)(i) and 1919(e)(7) of the Act; P.L. 100-203 (Sec. 4211(c)).	(a) The Medicaid agency has established appeals procedures for NFs as specified in 42 CFR 431.153 and 431.154. (b) The State provides an appeals system that meets the requirements of 42 CFR 431 Subpart E, 42 CFR 483.12, and 42 CFR 483 Subpart E for residents who wish to appeal a notice of intent to transfer or discharge from a NF and for individuals adversely affected by the preadmission and annual resident review requirements of 42 CFR 483 Subpart C.

STATE Oklahoma
DATE REC'D 10-12-94
DATE APPV'D 01-23-96
DATE EFF 07-01-94
HCFA 179 94-19
A

TN No. 94-19
Supersedes TN No. 88-08
Approval Date 01/23/96
Effective Date 07/01/94
Revised 07-01-94

State: OKLAHOMA

Citation	
1902(a)(4)(C) of the Social Security Act P.L. 105-33	4.29 Conflict of Interest Provisions The Medicaid agency meets the requirements of Section 1902(a)(4)(C) of the Act concerning the Prohibition against acts, with respect to any activity Under the plan, that is prohibited by section 207 or 208 of title 18, United States Code.
1902(a)(4)(D) of the Social Security Act P.L. 105-33 1932(d)(3) 42 CFR 438.58	The Medicaid agency meets the requirements of 1902(a)(4)(D) of the Act concerning the safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).

STATE Oklahoma
DATE REC'D 9-23-03
DATE APPV'D 12-9-03
DATE EFF 8-13-03
HCFA 179 03-12

A

SUPERSEDES: TN- 01-09

Revised 08-13-03

Revision: HCFA-PM-87-14 (BERC) OMB No.: 0938-0193
OCTOBER 1987

State/Territory: Oklahoma

Citation	4.30 Exclusion of Providers and Suspension of Practitioners and Other Individuals
42 CFR 1002.203 AT-79-54 48 FR 3742 51 FR 34772	(a) All requirements of 42 CFR Part 1002, Subpart B are met. /_/ The agency, under the authority of State law, imposes broader sanctions.

STATE OK
DATE REC'D FEB 8 1988
DATE APPV'D MAR 1 1988
DATE EFF SEP 30 1988
HCFA 179 88-1
A

State/Territory: OKLAHOMA

Citation		
	(b)	The Medicaid agency meets the requirements of –
1902(p) of the Act		(1) Section 1902(p) of the Act by excluding from participation—
		(A) At the State's discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII in accordance with sections 1128, 1128A, or 1866(b)(2).
42 CFR 438.808		(B) An MCO (as defined in section 1903(m) of the Act), or an entity furnishing services under a waiver approved under section 1915(b)(1) of the Act, that –
		(i) Could be excluded under section 1128(b)(8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions, or
		(ii) Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b)(8)(B) of the Act.
1932(d)(1) 42 CFR 438.610		(2) An MCO, PIHP, PAHP, or PCCM may not have prohibited affiliations with individuals (as defined in 42 CFR 438,610(b)) suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549. If the State finds that an MCO, PCCM, PIPH, or PAHP is not in compliance the State will comply with the requirements of 42 CFR 438.610(c)

A

STATE Oklahoma
DATE RECD 9-23-03
DATE APPVD 12-9-03
DATE EFF 8-13-03
HCFA 179 03-12

SUPERSEDES: TN- 88-01

Revised 08-13-03

TN # 03-12 Approval Date 12-9-03 Effective Date 8-13-03
Supersedes
TN # 88-01

Revision: HCFA-AT-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193
4.30 Continued

State/Territory: Oklahoma

Citation	
1902(a)(39) of the Act P.L. 100-93 (sec. 8(f))	(2) Section 1902(a)(39) of the Act by--
	(A) Excluding an individual or entity from participation for the period specified by the Secretary, when required by the Secretary to do so in accordance with sections 1128 or 1128A of the Act; and
	(B) Providing that no payment will be made with respect to any item or service furnished by an individual or entity during this period.
	(c) The Medicaid agency meets the requirements of--
1902(a)(41) of the Act P.L. 96-272, (sec. 308(c))	(1) Section 1902(a)(41) of the Act with respect to prompt notification to HCFA whenever a provider is terminated, suspended, sanctioned, or otherwise excluded from participating under this State plan; and
1902(a)(49) of the Act P.L. 100-93 (sec. 5(a)(4))	(2) Section 1902(a)(49) of the Act with respect to providing information and access to information regarding sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1921 of the Act.

STATE OK
DATE REC'D FEB 8 1988
DATE APPV'D MAR 1 1988
DATE EFF OCT 1 1987
HCFA ID 88-1

A

New 01-30-88

TN No. 88-1
Supersedes TN No. New

Approval Date MAR 1 1988 Effective Date OCT 1 1987

HCFA ID: 1010P/0012P

State: OKLAHOMA

Citation
42 CFR 455.103
1902(a)(38)
of the Act

4.31 **Disclosure of Information by Providers and Fiscal Agents**

The Medicaid agency has established procedures for the disclosure of information by providers and fiscal agents as specified in 42 CFR 455.104 through 455.105 and sections 1128(b)(9) and 1902(a)(38) of the Act.

42 CFR 435.940
through 435.960
Section 1137 of
the Act

4.32 **Income and Eligibility Verification System**

(a) The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of 42 CFR 435.940 through 435.960. **(Section 1137** of the **Act)**

(b) ATTACHMENT 4.32-A describes in accordance with 42 CFR 435.948 the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested.

(c) The State has an eligibility determination system that provides for data matching through the Public Assistance Reporting Information System (PARIS), or any successor system, including matching with medical assistance programs operated by other States. The information that is requested will be exchanged with States and other entities legally entitled to verify Title XIX applicants and individuals eligible for covered Title XIX services consistent with applicable PARIS agreements.

State: Oklahoma
Date Received: 30 March, 2017
Date Approved: 13 June, 2017
Effective Date: 1 January, 2017
Transmittal Number: 17-01

Revision: HCFA-PM-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193

State/Territory: Oklahoma

Citation
1902(a)(48) of the Act, P.L. 99-570 (Section 11005) P.L 100-93 (sec. 5(a)(3))

4.33 Medicaid Eligibility Cards for Homeless Individuals

(a) The Medicaid agency has a method for making cards evidencing eligibility for medical assistance available to an individual eligible under the State's approved plan who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

(b) ATTACHMENT 4.33-A specifies the method for issuance of Medicaid eligibility cards to homeless individuals.

STATE OK
DATE REC'D FEB 8 1988
DATE APPV'D MAR 1 1988
DATE EFF OCT 1 1987
HCFA 179 88-1
A

Revised 01-30-88

TN No. 88-1
Supersedes TN No. 87-9

Approval Date MAR 1 1988

Effective Date OCT 1 1987

HCFA ID: 1010P/0012P

☆ U.S. GOVERNMENT PRINTING OFFICE: 1987— 201-818/60437

Revision: Region VI
September 1989

State/Territory: OKLAHOMA

Citation 1137 of the Act

P.L. 99-603 (sec. 121)

P.L.100-360 (Sec. 411(k)(15))

4.34 **Systematic Alien Verification for Entitlements**

The State Medicaid agency has established procedures for the verification of alien status through the Immigration & Naturalization Service (INS) designated system, Systematic Alien Verification for Entitlements (SAVE), effective October 1, 1988 , except for aliens seeking medical assistance for treatment of emergency medical conditions under Section 1903(v)(2) of Social Security Act.

☑ **The State Medicaid agency has elected to participate in the option period of October 1, 1987 to September 30, 1988 to verify alien status through the INS designated system (SAVE).**

☑ **The State Medicaid agency has received the following type(s) of waiver from participation in SAVE.**

☑ **Total waiver**

☑ **Alternative system**

☑ **Partial implementation**

STATE Oklahoma
DATE REC'D 12-12-89
DATE APP'D 01-11-90
DATE EFF 01-01-87
HCFA 179 8920

A

Revised 01-01-87

TN No. 89-20
Supersedes TN No. 88-08

Approval Date 01/11/90 **Effective Date** 01-01-87

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: OKLAHOMA

Citation

4.35 Enforcement of Compliance for Nursing Facilities

42 CFR §488.402(f)

(a) Notification of Enforcement Remedies

When taking an enforcement action against a non-State operated NF, the State provides notification in accordance with 42 CFR 488.402(f).

(i) The notice (except for civil money penalties and State monitoring) specifies the:

(1) nature of noncompliance,
(2) which remedy is imposed,
(3) effective date of the remedy, and
(4) right to appeal the determination leading to the remedy.

42 CFR §488.434

(ii) The notice for civil money penalties is in writing and contains the information specified in 42 CFR 488.434.

42 CFR §488.402(f)(2)

(iii) Except for civil money penalties and State monitoring, notice is given at least 2 calendar days before the effective date of the enforcement remedy for immediate jeopardy situations and at least 15 calendar days before the effective date of the enforcement remedy when immediate jeopardy does not exist.

42 CFR §488.456(c)(d)

(iv) Notification of termination is given to the facility and to the public at least 2 calendar days before the remedy's effective date if the noncompliance constitutes immediate jeopardy and at least 15 calendar days before the remedy's effective date if the noncompliance does not constitute immediate jeopardy. The State must terminate the provider agreement of an NF in accordance with procedures in parts 431 and 442.

(b) Factors to be Considered in Selecting Remedies

42 CFR §488.488.404(b)(1)

(i) In determining the seriousness of deficiencies, the State considers the factors specified in 42 CFR 488.404(b)(1) & (2).

___ The State considers additional factors. Attachment 4.35-A describes the State's other factors.

STATE Oklahoma
DATE REC'D SEP 26 1995
DATE APP'D JUN 20 1996
DATE EFF JUL 01 1995
HCFA 179 95-17

A

TN No. 95-17 Approval Date: 6/20/96 Effective Date: 7/1/95
Supersedes TN No. None-New Page

New 07-01-95

Corrected

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: OKLAHOMA

Citation

c) Application of Remedies

42 CFR §488.410

(i) If there is immediate jeopardy to resident health or safety, the State terminates the NF's provider agreement within 23 calendar days from the date of the last survey or immediately imposes temporary management to remove the threat within 23 days.

42 CFR §488.417(b) §1919(h)(2)(C) of the Act.

(ii) The State imposes the denial of payment (or its approved alternative) with respect to any individual admitted to an NF that has not come into substantial compliance within 3 months after the last day of the survey.

42 CFR §488.414 §1919(h)(2)(D) of the Act.

(iii) The State imposes the denial of payment for new admissions remedy as specified in §488.417 (or its approved alternative) and a State monitor as specified at §488.422, when a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys.

42 CFR §488.408 1919(h)(2)(A) of the Act.

(iv) The State follows the criteria specified at 42 CFR §488.408(c)(2), §488.408(d)(2), and §488.408(e)(2), when it imposes remedies in place of or in addition to termination.

42 CFR §488.412(a)

(v) When immediate jeopardy does not exist, the State terminates an NF's provider agreement no later than 6 months from the finding of noncompliance, if the conditions of 42 CFR 488.412(a) are not met.

(d) Available Remedies

42 CFR §488.406(b) §1919(h)(2)(A) of the Act.

(i) The State has established the remedies defined in 42 CFR 488.406(b).

X	(1)	Termination
*X	(2)	Temporary Management
	(3)	Denial of Payment for New Admissions
X	(4)	Civil Money Penalties
X	(5)	Transfer of Residents; Transfer of Residents with Closure of Facility
X	(6)	State Monitoring

Attachments 4.35-B through 4.35-G describe the criteria for applying the above remedies.

STATE Oklahoma
DATE REC'D SEP 26 1995
DATE APP'D JUN 20 1996
DATE EFF JUL 01 1995
HCFA 179 95-17
A

* In cases of widespread actual harm where there is not immediate jeopardy, Oklahoma will use temporary managers under Title XIX, when appropriate.

Under Title 63 of the Oklahoma State Statutes, we have authority to impose the federal enforcement remedies or rules mandated by OBRA '87.

New 07-01-95

TN No. 95-17
Supersedes TN No. None
Approval Date: 6/26/96
Effective Date: 7/1/95

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: OKLAHOMA

Citation

42 CFR §488.406(b) §1919(h)(2)(B)(ii) of the Act.

(ii) X The State uses alternative remedies. The State has established alternative remedies that the State will impose in place of a remedy specified in 42 CFR 488.406(b).

X (1) Temporary Management
X (2) Denial of Payment for New Admissions
___ (3) Civil Money Penalties
___ (4) Transfer of Residents; Transfer of Residents with Closure of Facility
___ (5) State Monitoring.

Attachments 4.35-B through 4.35-G describe the alternative remedies and the criteria for applying them.

42 CFR §488.303(b) 1910(h)(2)(F) of the Act.

(e) ___ State Incentive Programs

___ (1) Public Recognition
___ (2) Incentive Payments

42 CFR §488.303(e) 1919(h)(2)(A) of the Act

(f) X Optional Remedies

The State uses optional remedies.
X (1) Directed Plan of Correction
X (2) Directed In-Service Training

The State uses the Federal notice requirements specified in 42 CFR 488.402(f). Also, factors utilized in determining the selection of alternative remedies are the same as those specified in 42 CFR 488.404.

STATE Oklahoma
DATE REC'D SEP 26 1995
DATE APPV'D JUN 20 1996
DATE EFF JUL 01 1995
HCFA 179 95-17

A

TN No. 95-17
Supersedes TN No. New Page

Approval Date: 6/20/96

New 07-01-95
Effective Date: 7/1/95

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: OKLAHOMA

Citation	4.36	Required Coordination Between the Medicaid and WIC Programs
1902(a)(11)(C) and 1902(a)(53) of the Act		The Medicaid agency provides for the coordination between the Medicaid program and the Special Supplemental Food Program for Women, Infants, and Children (WIC) and provides timely notice and referral to WIC in accordance with section 1902(a)(53) of the Act.

STATE Oklahoma
DATE RECEIVED JAN 29 1992
DATE APPROVED FEB 28 1992
DATE EFF. OCT 01 1991
HCFA ITY 92-01

A

79n Corrected

Revision: HCFA-PM-91- 10 (BPD)
DECEMBER 1991

State/Territory: OKLAHOMA

Citation		
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).	4.38	Nurse Aide Training and Competency Evaluation for Nursing Facilities
		(a) The State assures that the requirements of 42 CFR 483.150(a), which relate to individuals deemed to meet the nurse aide training and competency evaluation requirements, are met.
	X	(b) The State waives the competency evaluation requirements for individuals who meet the requirements of 42 CFR 483.150(b)(1).
	___	(c) The State deems individuals who meet the requirements of 42 CFR 483.150(b)(2) to have met the nurse aide training and competency evaluation requirements.
		(d) The State specifies any nurse aide training and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.152 and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.154.
	___	(e) The State offers a nurse aide training and competency evaluation program that meets the requirements of 42 CFR 483.152.
	X	(f) The State offers a nurse aide competency evaluation program that meets the requirements of 42 CFR 483.154.

TN No. 93-07 New 01-01-89
Superseded TN No. 89-06 Approval Date MAY 03 1993 Effective Date JAN 01 1989

STATE Oklahoma
DATE REC'D APR 06 1993
DATE APPV'D MAY 03 1993
DATE EFF JAN 01 1989
HCFA 179 93-07

A

Revision: HCFA-PM-91- 10
DECEMBER 1991

State/Territory: OKLAHOMA

Citation	
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).	(g) If the State does not choose to offer a nurse aide training and competency evaluation program or nurse aide competency evaluation program, the State reviews all nurse aide training and competency evaluation programs and competency evaluation programs upon request.
	(h) The State survey agency determines, during the course of all surveys, whether the requirements of 483.75(e) are met.
	(i) Before approving a nurse aide training and competency evaluation program, the State determines whether the requirements of 42 CFR 483.152 are met.
	(j) Before approving a nurse aide competency evaluation program, the State determines whether the requirements of 42 CFR 483.154 are met.
	(k) For program reviews other than the initial review, the State visits the entity providing the program.
	(l) The State does not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in certain facilities as described in 42 CFR 483.151(b)(2) and (3).

STATE Oklahoma
DATE REC'D APR 06 1993
DATE APPV'D MAY 03 1993
DATE EFF JAN 01 1989
HCFA 179 93-07

A

TN No. 93-07
Supersedes TN No. 89-06

Approval Date MAY 03 1993

New 01-01-89
Effective Date JAN 01 1989

State/Territory: OKLAHOMA

Citation		
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).		(m) The State, within 90 days of receiving a request for approval of a nurse aide training and competency evaluation program or competency evaluation program, either advises the requestor whether or not the program has been approved or requests additional information from the requestor.
		(n) The State does not grant approval of a nurse aide training and competency evaluation program for a period longer than 2 years.
		(o) The State reviews programs when notified of substantive changes (e.g., extensive curriculum modification).
		(p) The State withdraws approval from nurse aide training and competency evaluation programs and competency evaluation programs when the program is described in 42 CFR 483.151(b)(2) or (3).
	X	(q) The State withdraws approval of nurse aide training and competency evaluation programs that cease to meet the requirements of 42 CFR 483.152 and competency evaluation programs that cease to meet the requirements of 42 CFR 483.154.
		(r) The State withdraws approval of nurse aide training and competency evaluation programs and competency evaluation programs that do not permit unannounced visits by the State.

STATE Oklahoma
DATE REC'D APR 06 1993
DATE APPV'D MAY 03 1993
DATE EFF JAN 01 1989
HCFA 179 93-07

A

Revision: HCFA-PM-91-10
DECEMBER 1991

State/Territory: OKLAHOMA

Citation	
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).	(s) When the State withdraws approval from a nurse aide training and competency evaluation program or competency evaluation program, the State notifies the program in writing, indicating the reasons for withdrawal of approval.
	(t) The State permits students who have started a training and competency evaluation program from which approval is withdrawn to finish the program.
	(u) The State provides for the reimbursement of costs incurred in completing a nurse aide training and competency evaluation program or competency evaluation program for nurse aides who become employed by or who obtain an offer of employment from a facility within 12 months of completing such program.
	(v) The State provides advance notice that a record of successful completion of competency evaluation will be included in the State's nurse aide registry.
	(w) Competency evaluation programs are administered by the State or by a State-approved entity which is neither a skilled nursing facility participating in Medicare nor a nursing facility participating in Medicaid.
X	(x) The State permits proctoring of the competency evaluation in accordance with 42 CFR 483.154(d).
	(y) The State has a standard for successful completion of competency evaluation programs.

STATE Oklahoma
DATE REC'D APR 06 1993
DATE APPV'D MAY 03 1993
DATE EFF JAN 01 1989
HCFA 179 93-07

A

New 01-01-89

TN No. 93-07
Superseded TN No. 89-06

Approval Date MAY 03 1993

Effective Date JAN 01 1989

Revision: HCFA-PM-91-10
DECEMBER 1991

State/Territory: OKLAHOMA

Citation			
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).		(z)	The State includes a record of successful completion of a competency evaluation within 30 days of the date an individual is found competent.
	X	(aa)	The State imposes a maximum upon the number of times an individual may take a competency evaluation program (any maximum imposed is not less than 3).
		(bb)	The State maintains a nurse aide registry that meets the requirements in 42 CFR 483.156.
	X	(cc)	The State includes home health aides on the registry.
	___	(dd)	The State contracts the operation of the registry to a non State entity.
	X	(ee)	ATTACHMENT 4.38 contains the State's description of registry information to be disclosed in addition to that required in 42 CFR 483.156(c)(1)(iii) and (iv).
	X	(ff)	ATTACHMENT 4.38-A contains the State's description of information included on the registry in addition to the information required by 42 CFR 483.156(c).

STATE Oklahoma
DATE REC'D APR 06 1993
DATE APP'D MAY 03 1993
DATE EFF JAN 01 1989
HCFA 179 93-07

A

TN No. 93-07
Supersedes TN No. 89-06

Approval Date MAY 03 1993 Effective JAN 01 1989

New 01-01-89

Revision: HCFA-PM-93-1 (BPD)
January 1993

State/Territory: OKLAHOMA

Citation
Secs.
1902(a)(28)(D)(i)
and 1919(e)(7) of
the Act;
P.L. 100-203
(Sec. 4211(c));
P.L. 101-508
(Sec. 4801(b)).

4.39 Preadmission Screening and Annual Resident Review in Nursing Facilities

(a) The Medicaid agency has in effect a written agreement with the State mental health and mental retardation authorities that meet the requirements of 42 (CFR) 431.621(c).

(b) The State operates a preadmission and annual resident review program that meets the requirements of 42 CFR 483.100-138.

(c) The State does not claim as "medical assistance under the State Plan" the cost of services to individuals who should receive preadmission screening or annual resident review until such individuals are screened or reviewed.

(d) With the exception of NF services furnished to certain NF residents defined in 42 CFR 483.118(c)(1), the State does not claim as "medical assistance under the State plan" the cost of NF services to individuals who are found not to require NF services.

___ (e) ATTACHMENT 4.39 specifies the State's definition of specialized services.

STATE Oklahoma	
DATE RECD 10-12-94	
DATE APPV'D 01-23-96	A
DATE EFF 07-01-94	
HCFA 179 94-19	

Revision: HCFA-PM-93-1 (BPD)
January 1993

State/Territory: OKLAHOMA

4.39 (Continued)

X (f) Except for residents identified in 42 CFR 483.118(c)(1), the State mental health or mental retardation authority makes categorical determinations that individuals with certain mental conditions or levels of severity of mental illness would normally require specialized services of such an intensity that a specialized services program could not be delivered by the State in most, if not all, NFs and that a more appropriate placement should be utilized.

(g) The State describes any categorical determinations it applies in ATTACHMENT 4.39-A.

STATE Oklahoma	A
DATE REC'D 10-12-94	
DATE APP'D 01-23-96	
DATE EFF. 07-01-94	
HCFA ID: 94-19	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: OKLAHOMA

Citation		
1902(a)(69) of the Act P.L. 109-171 (section 6034)	4.43	Cooperation with Medicaid Integrity Program Efforts. The Medicaid agency assures it complies with such requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936 of the Act.

STATE Oklahoma
DATE REC'D 5-13-08
DATE APP'VD 6-2-08
DATE EFF 4-1-08
HCFA 179 08-13

A

SUPERSEDES: NONE - NEW PAGE

New Page 04-01-08

TN # 08-13 Approval Date: 6-2-08 Effective Date: 4-1-08
Supersedes
TN # SUPERSEDES: NONE - NEW PAGE

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Citation:
Section 5006 of P-L 114-255

4.47 21st CENTURY CURES ACT – Section 5006:

Requiring Publication of Fee-for-Service Provider Directory

☒ State is in compliance with the requirements of Section 5006 of the 21st Century Cures Act.

☐ State will be in compliance with Section 5006 of the 21st Century Cures Act by _____.

☐ State Plan's managed care coverage exempts this state from the requirements of Section 5006 of the 21st Century Cures Act.

☐ State would potentially need to enact legislation to comply with Section 5006 of the 21st Century Cures Act and will discuss compliance with CMS.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State OKLAHOMA

SECTION 5 PERSONNEL ADMINISTRATION

Citation
42 CFR 432.10(a)
AT-78-90
AT-79-23
AT-80-34

5.1 Standards of Personnel Administration

(a) The Medicaid agency has established and will maintain methods of personnel administration in conformity with standards prescribed by the U.S. Civil Service Commission in accordance with Section 208 of the Intergovernmental Personnel Act of 1970 and the regulations on Administration of the Standards for a Merit System of Personnel Administration, 5 CFR Part 900, Subpart F. All requirements of 42 CFR 432.10 are met.

☐ The plan is locally administered and State-supervised. The requirements of 42 CFR 432.10 with respect to local agency administration are met.

(b) Affirmative Action Plan

The Medicaid agency has in effect an affirmative action plan for equal employment opportunity that includes specific action steps and timetables and meets all other requirements of 5 CFR Part 900, Subpart F.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State OKLAHOMA

5.2 [Reserved]

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State OKLAHOMA

Citation		
42 CFR Part 432, Subpart B AT-78-90	5.3	Training Programs; Subprofessional and Volunteer Programs The Medicaid agency meets the requirements of 42 CFR Part 432, Subpart B, with respect to a training program for agency personnel and the training and use of subprofessional staff and volunteers.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State OKLAHOMA

SECTION 6 FINANCIAL ADMINISTRATION

Citation
42 CFR 433.32
AT-79-29

6.1 Fiscal Policies and Accountability

The Medicaid agency and, where applicable, local agencies administering the plan, maintains an accounting system and supporting fiscal records adequate to assure that claims for Federal funds are in accord with applicable Federal requirements. The requirements of 42 CFR 433.32 are met.

Revision: HCFA-AT-82-10(BPP)

State Oklahoma

Citation
42 CFR 433.34
47 FR 17490

6.2 Cost Allocation

There is an approved cost allocation plan on file with the Department in accordance with the requirements contained in 45 CFR Part 95, Subpart E.

TN # 82-7
Supersedes
TN # 76-35

Approval Date 8/31/82 Effective Date 7/1/82

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State OKLAHOMA

Citation
42 CFR 433.33
AT-79-29
AT-80-34

6.3 State Financial Participation

(a) State funds are used in both assistance and administration.

[X] State funds are used to pay all of the non-Federal share of total expenditures under the plan.

[ ] There is local participation. State funds are used to pay not less than 40 percent of the non-Federal share of the total expenditures under the plan. There is a method of apportioning Federal and State funds among the political subdivisions of the State on an equalization or other basis which assures that lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of care and services or level of administration under the plan in any part of the State.

(b) State and Federal funds are apportioned among the political subdivisions of the State on a basis consistent with equitable treatment of individuals in similar circumstances throughout the State.

Revision: HCFA-PM-91-4 (BPD) OMB No. 0938-
AUGUST 1991

State/Territory: OKLAHOMA

SECTION 7 - GENERAL PROVISIONS

Citation	7.1	Plan Amendments
42 CFR 430.12(c)		The plan will be amended whenever necessary to reflect new or revised Federal statutes or regulations or material change in State law, organization, policy or State agency operation.

STATE Oklahoma
DATE JAN 29 1992
DATE FEB 28 1992
DATE OCT 01 1991
HCFA ID 92-01
A

Revision: HCFA-PM-91-4 (BPD) OMB No. 0938-
AUGUST 1991

State/Territory: OKLAHOMA

Citation	7.2 Nondiscrimination
45 CFR Parts 80 and 84	In accordance with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), and the regulations at 45 CFR Parts 80 and 84, the Medicaid agency assures that no individual shall be subject to discrimination under this plan on the grounds of race, color, national origin, or handicap. The Medicaid agency has methods of administration to assure that each program or activity for which it receives Federal financial assistance will be operated in accordance with title VI regulations. These methods for title VI are described in ATTACHMENT 7.2-A.

STATE Oklahoma
DATE RCVD JAN 2 9 1992
DATE APPVD FEB 2 8 1992
DATE EFF OCT 0 1 1991
HCFA ID 92-01
A

Revision: HCFA-PM-91-4 (BPD) OMB No. 0938-
AUGUST 1991

State/Territory: OKLAHOMA

Citation	7.3	Maintenance of AFDC Efforts
1902(c) of the Act	/X/	The State agency has in effect under its approved AFDC plan payment levels that are equal to or more than the AFDC payment levels in effect on May 1, 1988.

Revised 10-01-91

TN No. 92-01
Supersedes TN No. _____
Approval Date FEB 28 1992 Effective Date OCT 01 1991

HCFA ID: 7982E

STATE Oklahoma
DATE RECD JAN 29 1992
DATE APPD FEB 28 1992
DATE EFF OCT 01 1991
HCFA TN 92-01

A

Revision: HCFA-PM-01-4 (BPD)
January 1995

OMB NO. 0938

State/Territory: OKLAHOMA

Citation 7.4 State Governor's Review

42 CFR 430.12(b) The Medicaid Agency will provide opportunity for the Office of the Governor to review State plan amendments, long-range program planning projections, and other periodic reports there-on, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Health Care Financing Administration with such documents.

- ☐ Not applicable. The Governor...
- ☐ Does not wish to review any plan material
- ☐ Wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of:

The Oklahoma Health Care Authority
(Designated Single State Agency)

Date: 09/02/99

(Signature)

CEO, Oklahoma Health Care Authority
(Title)

STATE Oklahoma
DATE REC'D 1-28-00
DATE APPV'D 2-7-00
DATE EFF 9-2-99
HCFA 179 99-21

A

Revised 09-02-99

TN # 99-21 Approval Date 2/7/00 Effective Date 9-2-99
Supersedes
TN # 95-06

HCFA ID: 7982E

Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

Describe shorter period here.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

__**X**___ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. __**X**___SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. __**X**___ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. __**X**__ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

The State Medicaid Agency will notify tribal partners of all SPA changes on or before submission to CMS and will either offer a telephonic meeting to discuss or consult with Tribes at the next regularly schedule bi-monthly consultation meeting.

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

      Income standard: _____

      -or-

   b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

      Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

   Less restrictive income methodologies:

Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

Describe shorter period here.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

__**X**___ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. __**X**___SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. _____ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. __**X**_ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Oklahoma Medicaid state plan, as described below:

This SPA supersedes only page 5 of OK-20-0032 and all provisions on other pages of that SPA approved on 5/11/20 are still in effect.

The State Medicaid Agency will notify tribal partners of all SPA changes on or before submission to CMS and will either offer a telephonic meeting to discuss or consult with Tribes at the next regularly schedule bi-monthly consultation meeting.

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

      Income standard: _____

      -or-

   b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

      Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

   Less restrictive income methodologies:

This SPA supersedes only page 5 of OK-20-0032 and all provisions on other pages of that SPA approved on 5/11/20 are still in effect.

Less restrictive resource methodologies:

4. _____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in

accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. __**X**__ The agency adopts a total of _**12**_ months (not to exceed 12 months) continuous eligibility for children under age of _**19**_ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

    a. _____ The agency uses a simplified paper application.

    b. _____ The agency uses a simplified online application.

    c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. ____**X**___ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g). **The State waives cost-sharing for testing services (including in vitro diagnostic products), testing-related services, and treatments for COVID-19, including vaccines, specialized equipment and therapies (including drugs), for any quarter in which the temporary increased FMAP is claimed.**

2. _____ The agency suspends enrollment fees, premiums and similar charges for:

    a. ___ All beneficiaries

a. ____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

1. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. __**X**__ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

Per 42 CFR 440.60, Medical or other remedial care provided by licensed practitioners, the Agency seeks to allow independently contracted psychologists to serve SoonerCare adults only for crisis intervention services during the emergency period. Independently contracted psychologists are licensed and practicing within state scope of practice, as well as the limitation that only crisis intervention services may be provided by licensed psychologists during the disaster period.

2. __**X**__ The agency makes the following adjustments to benefits currently covered in the state plan:

Effective March 1, 2020, use flexibilities afforded through 42 CFR 440.30(d) for the purposes of testing to diagnose or detect COVID-19 and COVID-19 antibodies, tests conducted in non-office settings such as mobile test sites are covered, exempting requirements in 42 CFR 440.30(b).

3. __**X**__ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. _____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

    a. ____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

This SPA supersedes only page 5 of OK-20-0032 and all provisions on other pages of that SPA approved on 5/11/20 are still in effect.

b. _____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. _____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe.

Drug Benefit:

6. __**X**__ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs. **The State will change the 34-day supply prescription quantity limit to allow for a 90-day supply.**

7. __**X**__ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. __**X**__ Newly added benefits described in Section D are paid using the following methodology:

a. ____ Published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

b. __**X**__ Other:

Describe methodology here. **Payment is made for crisis intervention services provided by independently contracted psychologists services in accordance with the methodology described in Attachment 4.19-B, Page 8.** **Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of crisis intervention services. The agency's fee schedule rate was set as of July 1, 2018 and is effective for services provided on or after that date. All rates are published the agency's website at www.okhca.org/feeschedules.**

Increases to state plan payment methodologies:

2. ____ The agency increases payment rates for the following services:

Please list all that apply.

a. _____ Payment increases are targeted based on the following criteria:

Please describe criteria.

b. Payments are increased through:

i. ____ A supplemental payment or add-on within applicable upper payment limits:

Please describe.

ii. ____ An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

   a. ____ Are not otherwise paid under the Medicaid state plan;

   b. ____ Differ from payments for the same services when provided face to face;

   c. ____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

   d. ____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

      i. ____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

      ii. ____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. __**X**__ Other payment changes:

Please describe. **For the duration of the public health emergency, rural/independent Medicaid-enrolled hospitals may request an interim payment. If approved, the requesting provider will receive**

an amount equal to two months' payment at the historical average monthly Medicaid payment, based on the months of January and February 2020. Critical access hospitals would be eligible to receive up to 125% of the historical payment amount. The State will subsequently reconcile the interim payments with final payments that the provider is eligible for based on billed claims. After reconciliation, payments will be equal to the actual utilization during the period at current Medicaid rates.

The reconciliation will occur beginning 3 months after the end of the federal emergency declaration and be repaid by the end of the fiscal year the declaration ends. The State assures that FFP related to the overpaid interim payments will be returned to CMS; the State will return the federal share of such overpayments to CMS in accordance with the overpayment rules at 42 CFR Part 433, Subpart F.

For the duration of the public health emergency, private duty nursing (PDN) providers will receive an increase for PDN hours that result in over-time rate of pay for nursing staff. The increase from $32/hour to $40/hour is to be applied only for persons with tracheostomies or who are ventilator dependent. Applicable reimbursement methodology pages for PDN services y are within in Attachment 4.19-B, Page 28.8, Attachment 4.19-B, Page 3, and Attachment 4.19-B, Introduction Page 1.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of PDN services. The agency's fee schedule rate was set as of October 1, 2019 and is effective for services provided on or after that date. All rates are published the agency's website at www.okhca.org/feeschedules.

Section F – Post-Eligibility Treatment of Income

1. ____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

    a. ____ The individual's total income

    b. ____ 300 percent of the SSI federal benefit rate

    c. ____ Other reasonable amount: _____

2. ____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

    The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

Waive calendar year 2019 penalties for Potentially Preventable Readmissions program, for the duration of the public health emergency. This request seeks to waive the penalties for possibly preventable readmissions that exceed 100% of the statewide average delineated in the current Oklahoma State Plan at Attachment 4.19-A, Pages 14 through 14.2.

For the duration of the public health emergency, increase the number of therapeutic leave days in nursing facilities (NFs) and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) from 7 days NF & 60 days ICF-IID to 10 days NF & ICF-IID 70 days. Also waive the provision that payments for therapeutic leave days could not exceed a maximum of 14 consecutive days per absence for ICF/IIDs.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

This request is for a period from 7/1/2020 through the termination of the public health emergency declaration.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

_X_ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. __ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. _X_ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

This SPA is in addition to Oklahoma's Disaster Relief SPAs approved on 5/11/2020 and 8/18/2020 and does not supersede anything approved in those SPAs.

c. _X_ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Oklahoma Medicaid state plan, as described below:

The State Medicaid Agency will notify tribal partners of all SPA changes on or before submission to CMS and will either offer a telephonic meeting to discuss or consult with Tribes at the next regularly schedule bi-monthly consultation meeting.

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

      Income standard: _____

      -or-

   b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

      Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

   Less restrictive income methodologies:

This SPA is in addition to Oklahoma's Disaster Relief SPAs approved on 5/11/2020 and 8/18/2020 and does not supersede anything approved in those SPAs.

Less restrictive resource methodologies:

4. _____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

This SPA is in addition to Oklahoma's Disaster Relief SPAs approved on 5/11/2020 and 8/18/2020 and does not supersede anything approved in those SPAs.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

    a. _____ The agency uses a simplified paper application.

    b. _____ The agency uses a simplified online application.

    c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. _____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

2. _____ The agency suspends enrollment fees, premiums and similar charges for:

    a. _____ All beneficiaries

    b. _____ The following eligibility groups or categorical population

Please list the applicable eligibility groups or populations.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. ___ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. __ The agency makes the following adjustments to benefits currently covered in the state plan:

3. _____ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. _____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

    a. ____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

    b. ____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

This SPA is in addition to Oklahoma's Disaster Relief SPAs approved on 5/11/2020 and 8/18/2020 and does not supersede anything approved in those SPAs.

Telehealth:

5. _____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe.

Drug Benefit:

6. _____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. _____ Newly added benefits described in Section D are paid using the following methodology:

    a. ____ Published fee schedules –

    Effective date (enter date of change): _____

    Location (list published location):

b. ____ Other:

Describe methodology here.

Increases to state plan payment methodologies:

2. __X__ The agency increases payment rates for the following services:

Payment for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) in Nursing Facilities (NFs) to avoid any difficulty of transitioning from inpatient to nursing facility care. The eligible facilities will be identified by the Level of Care code S03 and there are currently four facilities.

a. _____ Payment increases are targeted based on the following criteria:

b. Payments are increased through:

i. __X__ A supplemental payment or add-on within applicable upper payment limits:

This will be a payment increase through a supplemental payment within the applicable upper payment limit. Payments are intended to cover increased DMEPOS cost related to ventilator dependent patients. Only facilities serving residents classified by the state as Ventilator Dependent will be eligible for payment. The eligible facilities are Countryside Estates, Inola Health and Rehabilitation, Riverside Health Services and Summers Health Services. The State will pay a supplemental payment based on cost for DMEPOS, in a form of a one-time lump sum to eligible nursing facilities. Payment to each facility will be the difference between the facility's SFY2021 actual DMEPOS cost for Medicaid residents and DMEPOS cost reported on the most recent Medicaid annual cost report.

ii. ____ An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

    a. ____ Are not otherwise paid under the Medicaid state plan;

    b. ____ Differ from payments for the same services when provided face to face;

    c. ____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

    d. ____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

        i. ____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

        ii. ____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. _____ Other payment changes:

Please describe.

Section F – Post-Eligibility Treatment of Income

1. ____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

    a. ____ The individual's total income

    b. ____ 300 percent of the SSI federal benefit rate

    c. ____ Other reasonable amount: _____

2. ____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

    The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

This SPA is in addition to Oklahoma's Disaster Relief SPAs approved on 5/11/2020 and 8/18/2020 and does not supersede anything approved in those SPAs.

Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

This request is for a period from 8/24/2020 through the termination of the public health emergency declaration or 10/1/2024, whichever happens first.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

_X_ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. _X_ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. _X_ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. _X_ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

The State Medicaid Agency will notify tribal partners of all SPA changes on or before submission to CMS and will either offer a telephonic meeting to discuss or consult with Tribes at the next regularly schedule bi-monthly consultation meeting.

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

      Income standard: _____

      -or-

   b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

      Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

   Less restrictive income methodologies:

_ This SPA is in addition to Oklahoma's Disaster Relief SPAs approved on 5/11/2020, 8/18/2020, 10/15/2020, and 12/31/2020 and does not supersede anything approved in those SPAs.

Less restrictive resource methodologies:

4. _____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

    a. _____ The agency uses a simplified paper application.

    b. _____ The agency uses a simplified online application.

    c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. _____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

2. _____ The agency suspends enrollment fees, premiums and similar charges for:

    a. _____ All beneficiaries

    b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. ___ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. _X_ The agency makes the following adjustments to benefits currently covered in the state plan:

Per 42 CFR 440.60, Medical or other remedial care provided by licensed practitioners, the OHCA will allow ordering of COVID-19 testing by licensed pharmacists, as well as administration of COVID-19 vaccinations, COVID testing, and all Advisory Committee on Immunization Practices (ACIP) recommended vaccines by licensed pharmacists, state-authorized pharmacy interns, qualified pharmacy technicians, and pharmacies to comply with the PREP Act.

3. _X_ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. _____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

    a. _____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

    b. _____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. _____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe.

Drug Benefit:

6. _____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. __ Newly added benefits described in Section D are paid using the following methodology:

    a. __ Published fee schedules –

    Effective date (enter date of change): __

    Location (list published location): _____

b. __ Other:

Increases to state plan payment methodologies:

2. ____ The agency increases payment rates for the following services:

a. _____ Payment increases are targeted based on the following criteria:

b. Payments are increased through:

i. _____ A supplemental payment or add-on within applicable upper payment limits:

ii. _____ An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

a. _____ Are not otherwise paid under the Medicaid state plan;

b. _____ Differ from payments for the same services when provided face to face;

c. _____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

d. _____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

i. _____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

ii. _____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. _X_ Other payment changes:

COVID-19 Vaccine Administration Reimbursement Methodology:
In cases where vaccine administration is separately reimbursable at a fee amount, the OHCA will follow Medicare's reimbursement guidance for the COVID-19 vaccine: $16.94 for the administration fee of the 1st COVID vaccine and $28.39 for the administration fee of the 2nd COVID vaccine.

COVID vaccines administered to beneficiaries by a qualified facility operated by the Indian Health Service, tribal government(s), or urban Indian health program (I/T/U) will be reimbursed the outpatient Office of Management and Budget (OMB) rate, per the current State Plan methodology, for the administration of the COVID vaccine.

The aforementioned reimbursement methodology will apply to any approved route for the particular vaccine (percutaneous, intradermal, subcutaneous, intramuscular, intranasal, or oral route) during the public health emergency.

ACIP-recommended Vaccine Administration Reimbursement Methodology (non-COVID-19 specific)
The OHCA will follow the Agency's current reimbursement methodologies found at Attachment 4.19-B, Page 3 and page 66(b) of the Oklahoma State Plan as the rate it will reimburse professionals described within the PREP Act, including but not limited to licensed pharmacists, state-authorized pharmacy interns, qualified pharmacy technicians, and pharmacies for the administration of all ACIP-recommended vaccines other than those specific to COVID-19.

The aforementioned reimbursement methodologies will apply to any approved route for the particular vaccine (percutaneous, intradermal, subcutaneous, intramuscular, intranasal, or oral route) during the public health emergency.

Ordering and Administration of COVID-19 Testing Reimbursement Methodology
The OHCA will reimburse for the ordering and administration of COVID-19 testing by licensed pharmacists and administration of COVID-19 testing by licensed pharmacists, state-authorized pharmacy interns, qualified pharmacy technicians, and pharmacies using the established pricing and rate methodology for clinic laboratory services within the approved state plan at Attachment 4.19-B, Page 2b.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of vaccine administration services and laboratory services. The agency's fee schedule rate was set as of October 1, 2019 and is effective for services provided on or after that date. All rates are published the agency's website at www.okhca.org/feeschedules.

Section F – Post-Eligibility Treatment of Income

1. _____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

    a. _____ The individual's total income

    b. _____ 300 percent of the SSI federal benefit rate

    c. _____ Other reasonable amount: _____

2. _____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

    The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

State/Territory: Oklahoma

Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

This request will last through the termination of the public health emergency declaration.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

_X_ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. __ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. _X_ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. _X_ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

The State Medicaid Agency will notify tribal partners of all SPA changes on or before submission to CMS and will either offer a telephonic meeting to discuss or consult with Tribes at the next regularly schedule bi-monthly consultation meeting.

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

      Income standard: _____

      -or-

   b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

      Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

   Less restrictive income methodologies:

Less restrictive resource methodologies:

4. _____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for noncitizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. __X__ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

The Agency elects to allow hospitals to make presumptive eligibility (PE) determinations for nonMAGI individuals, including:

- Individuals Eligible for But Not Receiving Cash Assistance, 1902(a)((10)(A)(ii)(I);
- Individuals Eligible for Cash Except Institutionalization, 1902(a)(10)(A)(ii)(IV);
- Optional State Supplemental Beneficiaries, 1902(a)(10)(A)(ii)(XI);
- Individuals in Institutions Eligible under a Special Income Level, aged, blind and disabled individuals, 1902(a)(10)(A)(ii)(V) and 1905(a)(iii), (iv) and (v); and
- Age and Disability-Related Poverty Level, 1902(a)(10)(ii)(X) and 1902(m).

During the PHE, the OHCA will comport with current State plan requirements for HPE with certain exceptions. The exceptions include:

The OHCA will waive HPE performance standards in the current State Plan.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGIbased financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

    a. _____ The agency uses a simplified paper application.

    b. _____ The agency uses a simplified online application.

    c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. _____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

2. _____ The agency suspends enrollment fees, premiums and similar charges for:

    a. _____ All beneficiaries

    b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. _____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. _____ The agency makes the following adjustments to benefits currently covered in the state plan:

3. _____ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. _____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).
    a. ____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

    b. ____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. _____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe.

Drug Benefit:

6. _____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. _____ Newly added benefits described in Section D are paid using the following methodology: a.

_ Published fee schedules –

Effective date (enter date of change): _____

Location (list published location):

b. ____ Other:

Increases to state plan payment methodologies:

2. ____ The agency increases payment rates for the following services:

a. _____ Payment increases are targeted based on the following criteria:

b. Payments are increased through:

i. ____ A supplemental payment or add-on within applicable upper payment limits:

ii. ____ An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

a. _____ Are not otherwise paid under the Medicaid state plan;

b. _____ Differ from payments for the same services when provided face to face;

c. _____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

d. _____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

i. _____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

ii. _____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. _____ Other payment changes:

Please describe.

Section F – Post-Eligibility Treatment of Income

1. _____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

a. _____ The individual's total income
b. _____ 300 percent of the SSI federal benefit rate

c. _____ Other reasonable amount: _____

2. _____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

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Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

_X_ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. _X_ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. _X_ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans),

This SPA is in addition to Oklahoma's Disaster Relief SPAs approved on 5/11/2020, 8/18/2020, 10/15/2020, 12/10/20, 12/31/20, and 3/10/2021 and does not supersede any items approved in those SPAs.

42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. _X_ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Oklahoma Medicaid state plan, as described below:

The State Medicaid Agency will notify tribal partners of all SPA changes on or before submission to CMS and will either offer a telephonic meeting to discuss or consult with Tribes at the next regularly schedule bi-monthly consultation meeting.

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

      Income standard: _____

      -or-

   b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

      Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

   Less restrictive income methodologies:

This SPA is in addition to Oklahoma's Disaster Relief SPAs approved on 5/11/2020, 8/18/2020, 10/15/2020, 12/10/20, 12/31/20, and 3/10/2021 and does not supersede any items approved in those SPAs.

Less restrictive resource methodologies:

4. _____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

This SPA is in addition to Oklahoma's Disaster Relief SPAs approved on 5/11/2020, 8/18/2020, 10/15/2020, 12/10/20, 12/31/20, and 3/10/2021 and does not supersede any items approved in those SPAs.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

    a. _____ The agency uses a simplified paper application.

    b. _____ The agency uses a simplified online application.

    c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. _____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

2. _____ The agency suspends enrollment fees, premiums and similar charges for:

   a. _____ All beneficiaries

   b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. ___ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. _X_ The agency makes the following adjustments to benefits currently covered in the state plan:

The Oklahoma Health Care Authority (OHCA) will allow nurse practitioners, clinical nurse specialists, or physician assistants, working in accordance with State law, to order home health services as per the CARES Act.

3. _X_ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at

This SPA is in addition to Oklahoma's Disaster Relief SPAs approved on 5/11/2020, 8/18/2020, 10/15/2020, 12/10/20, 12/31/20, and 3/10/2021 and does not supersede any items approved in those SPAs.

1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. _____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

    a. ____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

    b. ____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. _____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe.

Drug Benefit:

6. _____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. __ Newly added benefits described in Section D are paid using the following methodology:

   a. __ Published fee schedules –

      Effective date (enter date of change): _____

      Location (list published location):

   b. __ Other:

Increases to state plan payment methodologies:

2. ____ The agency increases payment rates for the following services:

   a. _____ Payment increases are targeted based on the following criteria:

   b. Payments are increased through:

      i. ____ A supplemental payment or add-on within applicable upper payment limits:

      ii. ____ An increase to rates as described below.

This SPA is in addition to Oklahoma's Disaster Relief SPAs approved on 5/11/2020, 8/18/2020, 10/15/2020, 12/10/20, 12/31/20, and 3/10/2021 and does not supersede any items approved in those SPAs.

Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

   a. ____ Are not otherwise paid under the Medicaid state plan;

   b. ____ Differ from payments for the same services when provided face to face;

   c. ____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

   d. ____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

      i. ____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

      ii. ____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

This SPA is in addition to Oklahoma's Disaster Relief SPAs approved on 5/11/2020, 8/18/2020, 10/15/2020, 12/10/20, 12/31/20, and 3/10/2021 and does not supersede any items approved in those SPAs.

Other:

4. __ Other payment changes:

Please describe.

Section F – Post-Eligibility Treatment of Income

1. ____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

    a. ____ The individual's total income

    b. ____ 300 percent of the SSI federal benefit rate

    c. ____ Other reasonable amount: _____

2. ____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

    The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the

This SPA is in addition to Oklahoma's Disaster Relief SPAs approved on 5/11/2020, 8/18/2020, 10/15/2020, 12/10/20, 12/31/20, and 3/10/2021 and does not supersede any items approved in those SPAs.

information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

The effective date for the supplemental payments will be retroactive to July 1, 2020 through the end of the Public Health Emergency (PHE).

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

_X_ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. _X_ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. _X_ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans),

42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. _X_ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Oklahoma Medicaid state plan, as described below:

The State Medicaid Agency will notify tribal partners of all SPA changes on or before submission to CMS and will either offer a telephonic meeting to discuss or consult with Tribes at the next regularly schedule bi-monthly consultation meeting.

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

      Income standard: _____

      -or-

   b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

      Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

   Less restrictive income methodologies:

Less restrictive resource methodologies:

4. _____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

    a. _____ The agency uses a simplified paper application.

    b. _____ The agency uses a simplified online application.

    c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. _____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

2. _____ The agency suspends enrollment fees, premiums and similar charges for:

    a. _____ All beneficiaries

    b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. ___ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. ___ The agency makes the following adjustments to benefits currently covered in the state plan:

3. ___ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. _____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

    a. ____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

    b. ____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. _____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe.

Drug Benefit:

6. _____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. __ Newly added benefits described in Section D are paid using the following methodology:

   a. __ Published fee schedules –

      Effective date (enter date of change): _____

      Location (list published location):

   b. __ Other:

Increases to state plan payment methodologies:

2. _____ The agency increases payment rates for the following services:

   a. _____ Payment increases are targeted based on the following criteria:

   b. Payments are increased through:

      i. ____ A supplemental payment or add-on within applicable upper payment limits:

      ii. _____ An increase to rates as described below.

      Rates are increased:

This SPA is in addition to Oklahoma's Disaster Relief SPAs approved on 5/11/2020, 8/18/2020, 10/15/2020, 12/31/20, 3/10/21, 4/1/21, and 4/8/21 and does not supersede any items approved in those SPAs.

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

   a. ____ Are not otherwise paid under the Medicaid state plan;

   b. ____ Differ from payments for the same services when provided face to face;

   c. ____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

   d. ____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

      i. ____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

      ii. ____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. _X__ Other payment changes:

This SPA is in addition to Oklahoma's Disaster Relief SPAs approved on 5/11/2020, 8/18/2020, 10/15/2020, 12/31/20, 3/10/21, 4/1/21, and 4/8/21 and does not supersede any items approved in those SPAs.

Long-term care facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) will receive a temporary supplemental payment to support increased costs due to COVID-19.

Lump sum payments are made, as described below, to facilities that comply with CMS' Nursing Home Visitation Guidelines.

1. Facilities receive payments to incentivize direct care staff and provide enhanced dietary and housekeeping services. Seventy-five percent (75%) of available funds are paid to facilities as an across-the-board payment. The estimated total annual amount for this component is $48,434,077 for nursing facilities, and $2,966,854 for ICF/IID facilities. The payment amount for this component is calculated by multiplying the per day amount for this component by the number of paid Medicaid days for the payment period. The per day amount for this component is $11.87 for nursing facilities, and $5.93 for ICF/IID facilities for the payment period 7/1/2020 to 1/31/2021. For the payment period beginning 2/1/21 through the end of the PHE, the supplemental payment amount for this component is calculated by multiplying the per day amount for the component by the number of paid Medicaid days within the payment period. Facilities may use these funds for COVID-19-related expenses.

2. Facilities receive payment for the continuation of infection control and prevention programs and personal protective equipment (PPE). Twelve and a half percent (12.5%) of available funds are paid to facilities under this component. The estimated total annual amount for this component is $8,079,147 for nursing facilities, and $495,309 for ICF/IID facilities. Payment amount for this component is calculated by multiplying the per day amount for this component by the number of paid Medicaid days for the payment period, if the measure is met. The per day amount for this component is $1.98 for nursing facilities, and $0.99 for ICF/IID facilities for the payment period 7/1/2020 to 1/31/2021. For the payment period beginning 2/1/21 through the end of the PHE, the supplemental payment amount for this component is calculated by multiplying the per day amount for the component by the number of paid Medicaid days within the payment period.

3. Facilities receive payment for enhanced social and mental health programming and activities to ensure the health and wellness of Medicaid beneficiaries. Twelve and a half percent (12.5%) of available funds are paid to facilities under this component. The estimated total annual amount for this component is $8,079,147 for nursing facilities, and $495,309 for ICF/IID facilities. The payment amount for this component is calculated by multiplying the per day amount for this component by the number of paid Medicaid days for the payment period, if the measure is met. The per day amount for this component is $1.98 for nursing facilities, and $0.99 for ICF/IID facilities for the payment period 7/1/2020 to 1/31/2021. For the payment period beginning 2/1/21 through the end of the PHE, the supplemental payment amount for this component is calculated by multiplying the per day amount for the component by the number of paid Medicaid days within the payment period.

Section F – Post-Eligibility Treatment of Income

1. ____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

    a. _____ The individual's total income

    b. _____ 300 percent of the SSI federal benefit rate

    c. _____ Other reasonable amount: _____

2. _____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

    The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

PRA Disclosure Statement

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Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

This SPA is in addition to Oklahoma's Disaster Relief SPAs approved on 5/11/2020, 8/18/2020, 10/15/2020, 12/31/20, 3/10/21, 4/1/21, and 4/8/21 and does not supersede any items approved in those SPAs.

Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

This request is for a period from 3/15/2021 through the termination of the public health emergency declaration or 10/1/2024, whichever happens first.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

_X_ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. __ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. _X_ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans),

This SPA is in addition to Oklahoma's Disaster Relief SPAs approved on 5/11/2020, 8/18/2020, 10/15/2020, 3/10/2021, and 4/1/2021 and does not supersede anything approved in those SPAs.

42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. _X_ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

The State Medicaid Agency will notify tribal partners of all SPA changes on or before submission to CMS and will either offer a telephonic meeting to discuss or consult with Tribes at the next regularly schedule bi-monthly consultation meeting.

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

      Income standard: _____

      -or-

   b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

      Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

   Less restrictive income methodologies:

This SPA is in addition to Oklahoma's Disaster Relief SPAs approved on 5/11/2020, 8/18/2020, 10/15/2020, 3/10/2021, and 4/1/2021 and does not supersede anything approved in those SPAs.

Less restrictive resource methodologies:

4. _____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

    a. _____ The agency uses a simplified paper application.

    b. _____ The agency uses a simplified online application.

    c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. _____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

2. _____ The agency suspends enrollment fees, premiums and similar charges for:

    a. _____ All beneficiaries

    b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. ___ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. ___ The agency makes the following adjustments to benefits currently covered in the state plan:

3. ___ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. _____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

    a. ____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

    b. ____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. _____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe.

Drug Benefit:

6. _____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. ___ Newly added benefits described in Section D are paid using the following methodology:

This SPA is in addition to Oklahoma's Disaster Relief SPAs approved on 5/11/2020, 8/18/2020, 10/15/2020, 3/10/2021, and 4/1/2021 and does not supersede anything approved in those SPAs.

a. __ Published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

b. ___ Other:

Increases to state plan payment methodologies:

2. _X_ The agency increases payment rates for the following services:

In cases where vaccine administration is separately reimbursable at a fee amount, the OHCA will follow national Medicare rates, without geographic adjustment, in effect when the service is provided.

The aforementioned reimbursement methodology will apply to any approved route for the particular vaccine (percutaneous, intradermal, subcutaneous, intramuscular, intranasal, or oral route) during the public health emergency.

a. _____ Payment increases are targeted based on the following criteria:

b. Payments are increased through:

i. ____ A supplemental payment or add-on within applicable upper payment limits:

ii. __X__ An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

This SPA is in addition to Oklahoma's Disaster Relief SPAs approved on 5/11/2020, 8/18/2020, 10/15/2020, 3/10/2021, and 4/1/2021 and does not supersede anything approved in those SPAs.

Effective date (enter date of change): _____

Location (list published location): _____

__X__ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

    a. ____ Are not otherwise paid under the Medicaid state plan;

    b. ____ Differ from payments for the same services when provided face to face;

    c. ____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

    d. ____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

        i. ____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

        ii. ____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. ___ Other payment changes:

Section F – Post-Eligibility Treatment of Income

1. ____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

    a. ____ The individual's total income

    b. ____ 300 percent of the SSI federal benefit rate

    c. ____ Other reasonable amount: _____

2. ____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

    The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed,

forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

Describe shorter period here.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

__X__ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. ___ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. __**X**__ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. __**X**_ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Oklahoma Medicaid state plan, as described below:

The State Medicaid Agency will notify tribal partners of all SPA changes on or before submission to CMS and will either offer a telephonic meeting to discuss or consult with Tribes at the next regularly scheduled bi-monthly consultation meeting.

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

      Income standard: _____

      -or-

   b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

      Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

   Less restrictive income methodologies:

This SPA is in addition to Oklahoma's Disaster Relief SPAs approved on 5/11/20, 8/18/20, 10/15/2020, 12/31/20, 3/10/21, 4/1/21, 4/8/21, and 5/12/20, and does not supersede any items approved in those SPAs.

Less restrictive resource methodologies:

4. _____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435

Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

4. _____ The agency adopts a total of months (not to exceed 12 months) continuous eligibility for children under age of (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every_____months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

    a. _____ The agency uses a simplified paper application.

    b. _____ The agency uses a simplified online application.

    c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. _____The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

2. _____ The agency suspends enrollment fees, premiums and similar charges for:

    a. ___ All beneficiaries

    b. ____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. _____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. ____ The agency makes the following adjustments to benefits currently covered in the state plan:

3. ____ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. __X__ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

    a. __X__ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

    b. _____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. _____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe.

Drug Benefit:

6. ____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. _____ Newly added benefits described in Section D are paid using the following methodology:

   a. _____ Published fee schedules –

      Effective date (enter date of change): _____

      Location (list published location): _____

   b. ____ Other:

Increases to state plan payment methodologies:

2. _____ The agency increases payment rates for the following services:

Please list all that apply.

   a. _____ Payment increases are targeted based on the following criteria:

This SPA is in addition to Oklahoma's Disaster Relief SPAs approved on 5/11/20, 8/18/20, 10/15/2020, 12/31/20, 3/10/21, 4/1/21, 4/8/21, and 5/12/20, and does not supersede any items approved in those SPAs.

Please describe criteria.

b. Payments are increased through:

i. _____ A supplemental payment or add-on within applicable upper payment limits:

Please describe.

ii. _____ An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_____By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

a. _____ Are not otherwise paid under the Medicaid state plan;

b. _____ Differ from payments for the same services when provided face to face;

c. _____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

d. _____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

i. _____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

ii. _____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. _____ Other payment changes:

Please describe.

Section F – Post-Eligibility Treatment of Income

1. _____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

   a. _____ The individual's total income

   b. _____ 300 percent of the SSI federal benefit rate

   c. _____ Other reasonable amount: _____

2. _____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

   The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

Aligning the Expansion Adult ABP with the previously approved DRSPAs: 20-0032, 20-0040, 20-0042, and 21-0011.

PRA Disclosure Statement

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Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

Describe shorter period here.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

_X_ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. _X_ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. _X_ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans),

42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. _X_ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

The State Medicaid Agency will notify tribal partners of all SPA changes on or before submission to CMS and will either offer a telephonic meeting to discuss or consult with Tribes at the next regularly schedule bi-monthly consultation meeting.

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

      Income standard: _____

      -or-

   b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

      Income standard: _____

3. _X___ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

Less restrictive income methodologies:

Less restrictive resource methodologies:

Disregard resources or built-up assets that result from any payment made by the federal, state, local, or tribal government to relieve the adverse economic impacts of the COVID-19 pandemic that would have otherwise been part of an individual's liability for his or her institutional services based on application of the post-eligibility treatment-of income (PETI) rules but which became countable resources on or after March 1, 2020 and/or retained through the end of the COVID-related public health emergency for individuals who are 65 years of age or older or are disabled individuals under section 1902(a)(10)(A)(ii)(X).

4. _____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

    a. _____ The agency uses a simplified paper application.

    b. _____ The agency uses a simplified online application.

    c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. _____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

2. _____ The agency suspends enrollment fees, premiums and similar charges for:

    a. _____ All beneficiaries

    b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. ___ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. ___ The agency makes the following adjustments to benefits currently covered in the state plan:

3. ___ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. _____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

    a. ____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

    b. ____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. _____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe.

Drug Benefit:

6. _____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. ___ Newly added benefits described in Section D are paid using the following methodology:

   a. __ Published fee schedules –

      Effective date (enter date of change): _____

      Location (list published location): _____

   b. ___ Other:

Increases to state plan payment methodologies:

2. ___ The agency increases payment rates for the following services:

   a. _____ Payment increases are targeted based on the following criteria:

   b. Payments are increased through:

      i. ____ A supplemental payment or add-on within applicable upper payment limits:

      ii. _____ An increase to rates as described below.

      Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

    a. ____ Are not otherwise paid under the Medicaid state plan;

    b. ____ Differ from payments for the same services when provided face to face;

    c. ____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

    d. ____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

        i. ____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

        ii. ____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. ___ Other payment changes:

Section F – Post-Eligibility Treatment of Income

1. ___ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

    a. ____ The individual's total income

    b. ____ 300 percent of the SSI federal benefit rate

    c. ____ Other reasonable amount: _____

2. ____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

    The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05,

Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

This request is for a period from 7/1/2021 through the termination of the public health emergency Declaration.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

_X_ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. _X_ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. _X_ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans),

42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. _X_ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

The State Medicaid Agency will notify tribal partners of all SPA changes on or before submission to CMS and will either offer a telephonic meeting to discuss or consult with Tribes at the next regularly schedule bi-monthly consultation meeting.

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

      Income standard: _____

      -or-

   b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

      Income standard: _____

3. ___ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

   Less restrictive income methodologies:

Less restrictive resource methodologies:

4. _____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

    a. _____ The agency uses a simplified paper application.

    b. _____ The agency uses a simplified online application.

    c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. _____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

2. _____ The agency suspends enrollment fees, premiums and similar charges for:

    a. _____ All beneficiaries

    b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. ___ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. _X__ The agency makes the following adjustments to benefits currently covered in the state plan:

Per 42 CFR 440.60, medical or other remedial care provided by licensed practitioners, the Agency seeks to expand the role of independently contracted clinical psychologists beyond providing crisis intervention services, added through disaster relief SPA 20-0032, to the scope of practice defined under state law for SoonerCare adults. Independently contracted clinical psychologists are licensed and practicing within state scope of practice.

3. __X__ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. __X__ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

    a. __X__ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

    b. _____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. _____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe.

Drug Benefit:

6. _____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. ___ Newly added benefits described in Section D are paid using the following methodology:

   a. __ Published fee schedules –

      Effective date (enter date of change): _____

      Location (list published location): _____

   b. ___ Other:

Increases to state plan payment methodologies:

2. ___ The agency increases payment rates for the following services:

   a. _____ Payment increases are targeted based on the following criteria:

   b. Payments are increased through:

      i. ____ A supplemental payment or add-on within applicable upper payment limits:

      ii. _____ An increase to rates as described below.

      Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

    a. _____ Are not otherwise paid under the Medicaid state plan;

    b. _____ Differ from payments for the same services when provided face to face;

    c. _____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

    d. _____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

        i. _____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

        ii. _____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. ___ Other payment changes:

Section F – Post-Eligibility Treatment of Income

1. _____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

   a. _____ The individual's total income

   b. _____ 300 percent of the SSI federal benefit rate

   c. _____ Other reasonable amount: _____

2. _____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

   The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports

This SPA is in addition to Oklahoma's Disaster Relief SPAs approved on 5/11/20, 8/18/20, 10/15/20, 12/31/20, 3/10/21, 4/1/21, 4/8/21, 5/12/21, 7/28/21, 10/6/21 and does not supersede any items approved in those SPAs.

Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

Describe shorter period here.
The effective date for self-collected tests will be retroactive to August 30, 2021 through the end of the Public Health Emergency (PHE).

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

__**X**__ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. __**X**__ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. __**X**__ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These

This SPA is in addition to Oklahoma's Disaster Relief SPAs approved on 5/11/20, 8/18/20, 10/15/20, 12/31/20, 3/10/21, 4/1/21, 4/8/21, 5/12/21, 10/6/21, and 10/29/21 and does not supersede any items approved in those SPAs.

requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. __**X**__ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

Please describe the modifications to the timeline. ***The State Medicaid Agency will notify tribal partners of all SPA changes on or before submission to CMS and will either offer a telephonic meeting to discuss or consult with Tribes at the next regularly schedule bi-monthly consultation meeting.***

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

      Income standard: _____

      -or-

   b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

      Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

This SPA is in addition to Oklahoma's Disaster Relief SPAs approved on 5/11/20, 8/18/20, 10/15/20, 12/31/20, 3/10/21, 4/1/21, 4/8/21, 5/12/21, 10/6/21, and 10/29/21 and does not supersede any items approved in those SPAs.

Less restrictive income methodologies:

Less restrictive resource methodologies:

4. _____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

This SPA is in addition to Oklahoma's Disaster Relief SPAs approved on 5/11/20, 8/18/20, 10/15/20, 12/31/20, 3/10/21, 4/1/21, 4/8/21, 5/12/21, 10/6/21, and 10/29/21 and does not supersede any items approved in those SPAs.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

    a. _____ The agency uses a simplified paper application.

    b. _____ The agency uses a simplified online application.

    c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

This SPA is in addition to Oklahoma's Disaster Relief SPAs approved on 5/11/20, 8/18/20, 10/15/20, 12/31/20, 3/10/21, 4/1/21, 4/8/21, 5/12/21, 10/6/21, and 10/29/21 and does not supersede any items approved in those SPAs.

Section C – Premiums and Cost Sharing

1. _____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

2. _____ The agency suspends enrollment fees, premiums and similar charges for:

    a. _____ All beneficiaries

    b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. _____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. __**X**__ The agency makes the following adjustments to benefits currently covered in the state plan:

This SPA is in addition to Oklahoma's Disaster Relief SPAs approved on 5/11/20, 8/18/20, 10/15/20, 12/31/20, 3/10/21, 4/1/21, 4/8/21, 5/12/21, 10/6/21, and 10/29/21 and does not supersede any items approved in those SPAs.

Effective August 30, 2021, all types of FDA-authorized self-collected COVID-19 tests and laboratory processing of self-collected test systems for the purposes of diagnosis or detection of COVID-19 and COVID-19 antibodies, even if those self-collected tests would not otherwise meet requirements in 42 CFR 440.30(a) or (b), are covered as long as the self-collection of the test is intended to avoid transmission of COVID-19. Self-collected tests will be limited as determined necessary.

3. __**X**__ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. __**X**__ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

    a. __**X**__ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

    b. _____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. _____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe.

Drug Benefit:

6. _____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

This SPA is in addition to Oklahoma's Disaster Relief SPAs approved on 5/11/20, 8/18/20, 10/15/20, 12/31/20, 3/10/21, 4/1/21, 4/8/21, 5/12/21, 10/6/21, and 10/29/21 and does not supersede any items approved in those SPAs.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. ____ Newly added benefits described in Section D are paid using the following methodology:

   a. _____ Published fee schedules –

      Effective date (enter date of change): _____

      Location (list published location): _____

   b. ____ Other:

Describe methodology here.

Increases to state plan payment methodologies:

2. _____ The agency increases payment rates for the following services:

Please list all that apply.

   a. _____ Payment increases are targeted based on the following criteria:

This SPA is in addition to Oklahoma's Disaster Relief SPAs approved on 5/11/20, 8/18/20, 10/15/20, 12/31/20, 3/10/21, 4/1/21, 4/8/21, 5/12/21, 10/6/21, and 10/29/21 and does not supersede any items approved in those SPAs.

Please describe criteria.

b. Payments are increased through:

i. _____ A supplemental payment or add-on within applicable upper payment limits:

Please describe.

ii. _____ An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

a. _____ Are not otherwise paid under the Medicaid state plan;

b. _____ Differ from payments for the same services when provided face to face;

c. _____ Differ from current state plan provisions governing reimbursement for telehealth;

This SPA is in addition to Oklahoma's Disaster Relief SPAs approved on 5/11/20, 8/18/20, 10/15/20, 12/31/20, 3/10/21, 4/1/21, 4/8/21, 5/12/21, 10/6/21, and 10/29/21 and does not supersede any items approved in those SPAs.

Describe telehealth payment variation.

d. _____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

i. _____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

ii. _____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. __**X**___ Other payment changes:

Please describe. ***The OHCA will reimburse for self-collected COVID-19 tests using point-of-sale plus the professional dispensing fee for prescription drugs within the approved state plan at Attachment 4.19-B, Page 7.***

Section F – Post-Eligibility Treatment of Income

1. _____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

a. _____ The individual's total income

b. _____ 300 percent of the SSI federal benefit rate

c. _____ Other reasonable amount: _____

2. _____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

This SPA is in addition to Oklahoma's Disaster Relief SPAs approved on 5/11/20, 8/18/20, 10/15/20, 12/31/20, 3/10/21, 4/1/21, 4/8/21, 5/12/21, 10/6/21, and 10/29/21 and does not supersede any items approved in those SPAs.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

This SPA is in addition to Oklahoma's Disaster Relief SPAs approved on 5/11/20, 8/18/20, 10/15/20, 12/31/20, 3/10/21, 4/1/21, 4/8/21, 5/12/21, 10/6/21, and 10/29/21 and does not supersede any items approved in those SPAs.

Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

Describe shorter period here.
The previously approved private duty nursing (PDN) rate increase found within OK SPA 20-0032 was effective from 3/1/2020 through 12/31/2022. The new requested rate increase within this amendment is effective 1/1/2023 through the remainder of the COVID-19 Public Health Emergency.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

__**X**__ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. __**X**__ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. __**X**__ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These

This SPA is in addition to all previously approved disaster relief SPAs and does not supersede anything approved in those SPAs.

requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. __X__ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Oklahoma's Medicaid state plan, as described below:

Please describe the modifications to the timeline. ***The State Medicaid Agency will notify tribal partners of all SPA changes on or before submission to CMS and will either offer a telephonic meeting to discuss or consult with Tribes at the next regularly schedule bi-monthly consultation meeting.***

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

      Income standard: _____

      -or-

   b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

      Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

   Less restrictive income methodologies:

This SPA is in addition to all previously approved disaster relief SPAs and does not supersede anything approved in those SPAs.

Less restrictive resource methodologies:

4. _____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

This SPA is in addition to all previously approved disaster relief SPAs and does not supersede anything approved in those SPAs.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

    a. _____ The agency uses a simplified paper application.

    b. _____ The agency uses a simplified online application.

    c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. _____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

This SPA is in addition to all previously approved disaster relief SPAs and does not supersede anything approved in those SPAs.

2. _____ The agency suspends enrollment fees, premiums, and similar charges for:

    a. _____ All beneficiaries

    b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums, and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. _____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration, or scope of the benefit):

2. _____ The agency makes the following adjustments to benefits currently covered in the state plan:

3. ____ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. ____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

This SPA is in addition to all previously approved disaster relief SPAs and does not supersede anything approved in those SPAs.

a. ____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

b. _____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. _____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe.

Drug Benefit:

6. __**X**___ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Oklahoma is requesting to waive any signature requirements for the dispensing of drugs for the duration of the COVID-19 Public Health Emergency.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

This SPA is in addition to all previously approved disaster relief SPAs and does not supersede anything approved in those SPAs.

State/Territory: Oklahoma

Section E – Payments

Optional benefits described in Section D:

1. ____ Newly added benefits described in Section D are paid using the following methodology:

    a. _____ Published fee schedules –

    Effective date (enter date of change): _____

    Location (list published location): _____

    b. ____ Other:

Describe methodology here.

Increases to state plan payment methodologies:

2. _____ The agency increases payment rates for the following services:

Please list all that apply.

    a. _____ Payment increases are targeted based on the following criteria:

Please describe criteria.

    b. Payments are increased through:

        i. _____ A supplemental payment or add-on within applicable upper payment limits:

Please describe.

        ii. _____ An increase to rates as described below.

        Rates are increased:

This SPA is in addition to all previously approved disaster relief SPAs and does not supersede anything approved in those SPAs.

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

   a. _____ Are not otherwise paid under the Medicaid state plan;

   b. _____ Differ from payments for the same services when provided face to face;

   c. _____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

   d. _____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

      i. _____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

      ii. _____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. __**X**___ Other payment changes:

Effective January 1, 2023, through the remainder of the COVID-19 Public Health Emergency, private duty nursing providers will receive an increase in the PDN hourly base rate from $32.68 per hour to $40.00 per hour.

This SPA is in addition to all previously approved disaster relief SPAs and does not supersede anything approved in those SPAs.

Effective January 1, 2023, through the remainder of the COVID-19 Public Health Emergency, PDN providers will receive an increased over-time hourly rate from $40/hour to $48.92/hour for nursing staff to be applied only for persons with tracheostomies or who are ventilator dependent.

Applicable reimbursement methodology pages for PDN services are within Attachment 4.19-B, Page 28.8, Page 3, and Attachment 4.19-B, Introduction Page 1.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of PDN services. The agency's fee schedule rate was set as of October 1, 2019 and is effective for services provided on or after that date. All rates are published on the agency's website at www.okhca.org/feeschedules.

Section F – Post-Eligibility Treatment of Income

1. _____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

    a. _____ The individual's total income

    b. _____ 300 percent of the SSI federal benefit rate

    c. _____ Other reasonable amount: _____

2. _____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

    The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

This SPA is in addition to all previously approved disaster relief SPAs and does not supersede anything approved in those SPAs.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

This SPA is in addition to all previously approved disaster relief SPAs and does not supersede anything approved in those SPAs.

Vaccine and Vaccine Administration at Section 1905(a)(4)(E) of the Social Security Act

During the period starting March 11, 2021 and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (the Act):

Coverage

__**X**__ The state assures coverage of COVID-19 vaccines and administration of the vaccines. [1]

__**X**__ The state assures that such coverage:

1. Is provided to all eligibility groups covered by the state, including the optional Individuals Eligible for Family Planning Services, Individuals with Tuberculosis, and COVID-19 groups if applicable, with the exception of the Medicare Savings Program groups and the COBRA Continuation Coverage group for which medical assistance consists only of payment of premiums; and
2. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(H) and section 1916A(b)(3)(B)(xii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

__**X**__ Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing or similar charge, pursuant to section 1937(b)(8)(A) of the Act.

__**X**__ The state provides coverage for any medically necessary COVID-19 vaccine counseling for children under the age of 21 pursuant to §§1902(a)(11), 1902(a)(43), and 1905(hh) of the Act.

__**X**__ The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration, with respect to the providers that are considered qualified to prescribe, dispense, administer, deliver and/or distribute COVID-19 vaccines.

Additional Information (Optional):

[1] The vaccine will be claimed under this benefit once the federal government discontinues purchasing the vaccine.

Reimbursement

_____ The state assures that the state plan has established rates for COVID-19 vaccines and the administration of the vaccines for all qualified providers pursuant to sections 1905(a)(4)(E) and 1902(a)(30)(A) of the Act.

List Medicaid state plan references to payment methodologies that describe the rates for COVID-19 vaccines and their administration for each applicable Medicaid benefit:

__**X**__ The state is establishing rates for COVID-19 vaccines and the administration of the vaccines pursuant to sections 1905(a)(4)(E) and 1902(a)(30)(A) of the Act.

__**X**__ The state's rates for COVID-19 vaccines and the administration of the vaccines are consistent with Medicare rates for COVID-19 vaccines and the administration of the vaccines, including any future Medicare updates at the:

__**X**__ Medicare national average, OR

____Associated geographically adjusted rate.

____The state is establishing a state specific fee schedule for COVID-19 vaccines and the administration of the vaccines pursuant to sections 1905(a)(4)(E) and 1902(a)(30)(A) of the Act.

The state's rate is as follows and the state's fee schedule is published in the following location :

COVID-19 Vaccine Administration Reimbursement Methodology:

In cases where vaccine administration is separately reimbursable at a fee amount, the OHCA will follow Medicare's reimbursement guidance for the COVID-19 vaccine: $16.94 for the administration fee of the 1st COVID vaccine and $28.39 for the administration fee of the 2nd COVID vaccine.

The aforementioned reimbursement methodology will apply to any approved route for the particular vaccine (percutaneous, intradermal, subcutaneous, intramuscular, intranasal, or oral route) during the public health emergency.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of COVID-19 vaccine administration services. The agency's fee schedule rate was set as of August 24, 2020 and is effective for services provided on or after that date. All rates are published the agency's website at www.okhca.org/feeschedules.

__**X**__ The state's fee schedule is the same for all governmental and private providers.

__X__ The below listed providers are paid differently from the above rate schedules and payment to these providers for COVID-19 vaccines and the administration of the vaccines are described under the benefit payment methodology applicable to the provider type:

Qualified facilities operated by the Indian Health Service, tribal government(s), or urban Indian health program (I/T/U)

__X__ The payment methodologies for COVID-19 vaccines and the administration of the vaccines for providers listed above are described below:

COVID vaccines administered to beneficiaries by a qualified facility operated by the Indian Health Service, tribal government(s), or urban Indian health program (I/T/U) will be reimbursed the outpatient Office of Management and Budget (OMB) rate, per the current State Plan methodology, for the administration of the COVID vaccine.

__X__ The state is establishing rates for any medically necessary COVID-19 vaccine counseling for children under the age of 21 pursuant to sections 1905(a)(4)(E), 1905(r)(1)(B)(v) and 1902(a)(30)(A) of the Act.

__X__ The state's rate is as follows and the state's fee schedule is published in the following location :

The State's rate for COVID-19 vaccine counseling for children under the age of 21 is $33.55 (CPT 99401 with modifier CR).

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of EPSDT COVID-19 vaccine counseling. The agency's fee schedule rate was set as of December 2, 2021 and is effective for services provided on or after that date. All rates are published the agency's website at www.okhca.org/feeschedules.

PRA Disclosure Statement *Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 75). Public burden for all of the collection of information requirements under this control number is estimated to take up to 1 hour per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

COVID-19 Testing at section 1905(a)(4)(F) of the Social Security Act

During the period starting March 11, 2021, and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (the Act):

Coverage

__**X**__ The state assures coverage of COVID-19 testing consistent with the Centers for Disease Control and Prevention (CDC) definitions of diagnostic and screening testing for COVID-19 and its recommendations for who should receive diagnostic and screening tests for COVID-19.

__**X**__ The state assures that such coverage:

1. Includes all types of FDA authorized COVID-19 tests;
2. Is provided to all categorically needy eligibility groups covered by the state that receive full Medicaid benefits;
3. Is provided to the optional COVID-19 group if applicable; and
4. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(I) and 1916A(b)(3)(B)(xiii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

Please describe any limits on amount, duration or scope of COVID-19 testing consistent with 42 CFR 440.230(b).

__**X**__ Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing, or similar charge, pursuant to section 1937(b)(8)(B) of the Act.

__**X**__ The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration.

Additional Information (Optional):

Reimbursement

__**X**__ The state assures that it has established state plan rates for COVID-19 testing consistent with the CDC definitions of diagnostic and screening testing for COVID-19 and its recommendations for who should receive diagnostic and screening tests for COVID-19.

List references to Medicaid state plan payment methodologies that describe the rates for COVID-19 testing for each applicable Medicaid benefit:

The state makes payment for diagnostic and screening services for COVID-19 according to Attachment 4.19-B, page 2b, Clinic Laboratory Services.

____ The state is establishing rates for COVID-19 testing pursuant to pursuant to sections 1905(a)(4)(F) and 1902(a)(30)(A) of the Act.

____ The state's rates for COVID-19 testing are consistent with Medicare rates for testing, including any future Medicare updates at the:

____ Medicare national average, OR

____ Associated geographically adjusted rate.

__**X**__ The state is establishing a state specific fee schedule for COVID-19 testing pursuant to sections 1905(a)(4)(F) and 1902(a)(30)(A) of the Act.

The state's rate is as follows and the state's fee schedule is published in the following location:

The OHCA will reimburse for self-collected COVID-19 tests using point-of-sale plus the professional dispensing fee for prescription drugs within the approved state plan at Attachment 4.19-B, Page 7.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of self-collected COVID-19 tests. The agency's fee schedule rate was set as of August 30, 2021 and is effective for services provided on or after that date. All rates are published the agency's website at www.okhca.org/feeschedules.

__**X**__ The state's fee schedule is the same for all governmental and private providers.

__**X**__ The below listed providers are paid differently from the above rate schedules and payment to these providers for COVID-19 testing is described under the benefit payment methodology applicable to the provider type:

Self-collected COVID-19 tests dispensed to American Indian/Alaskan Native (AI/AN) members by a qualified facility operated by the Indian Health Service, tribal government(s), or urban Indian health programs (I/T/U) will be reimbursed the Office of Management and Budget (OMB) rate, per the current State Plan methodology.

Additional Information (Optional):

____ The payment methodologies for COVID-19 testing for providers listed above are described below:

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COVID-19 Treatment at section 1905(a)(4)(F) of the Social Security Act

During the period starting March 11, 2021 and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (the Act):

Coverage for the Treatment and Prevention of COVID

__**X**__ The state assures coverage of COVID-19 treatment, including specialized equipment and therapies (including preventive therapies).

__**X**__ The state assures that such coverage:

1. Includes any non-pharmacological item or service described in section 1905(a) of the Act, that is medically necessary for treatment of COVID-19;
2. Includes any drug or biological that is approved (or licensed) by the U.S. Food & Drug Administration (FDA) or authorized by the FDA under an Emergency Use Authorization (EUA) to treat or prevent COVID-19, consistent with the applicable authorizations;
3. Is provided without amount, duration or scope limitations that would otherwise apply when covered for purposes other than treatment or prevention of COVID-19;
4. Is provided to all categorically needy eligibility groups covered by the state that receive full Medicaid benefits;
5. Is provided to the optional COVID-19 group, if applicable; and
6. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(I) and 1916A(b)(3)(B)(xiii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

__**X**__ Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing, or similar charge, pursuant to section 1937(b)(8)(B) of the Act.

__**X**__ The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration.

Additional Information (Optional):

Coverage for a Condition that May Seriously Complicate the Treatment of COVID

__**X**__ The state assures coverage of treatment for a condition that may seriously complicate the treatment of COVID-19 during the period when a beneficiary is diagnosed with or is presumed to have COVID-19.

__**X**__ The state assures that such coverage:

1. Includes items and services, including drugs, that were covered by the state as of March 11, 2021;
2. Is provided without amount, duration or scope limitations that would otherwise apply when covered for other purposes;
3. Is provided to all categorically needy eligibility groups covered by the state that receive full Medicaid benefits;
4. Is provided to the optional COVID-19 group, if applicable; and
5. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(I) and 1916A(b)(3)(B)(xiii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

__**X**__ Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing, or similar charge, pursuant to section 1937(b)(8)(B) of the Act.

__**X**__ The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration.

Additional Information (Optional):

Reimbursement

__**X**__ The state assures that it has established state plan rates for COVID-19 treatment, including specialized equipment and therapies (including preventive therapies).

List references to Medicaid state plan payment methodologies that describe the rates for COVID-19 treatment for each applicable Medicaid benefit:

Outpatient Hospital Services within Attachment 4.19-B, Page 1, 1a, and 1b
Clinical Laboratory Services within Attachment 4.19-B, Page 2b
Physician Services within Attachment 4.19-B, Page 3
Home Health Services within Attachment 4.19-B, Page 4
Free-Standing Ambulatory Surgery Center-Clinic Services within Attachment 4.19-B, Page 4b
Renal Dialysis Facilities within Attachment 4.19-B, Page 19
Other Practitioners' Services within Attachment Pages 20, 20a, and 21
Nutritional Services within Attachment 4.19-B, Page 21-1
EPSDT within Attachment 4.19-B, Pages 17, 28.1, 28.2, 28.4
Respiratory Care within Attachment 4.19-B, Page 28.7
Private Duty Nursing Services within Attachment 4.19-B, Page 28.8
Pediatric or Family Nurse Practitioner (Advanced Practice Nurse) Services within Attachment 4.19-B, Page 32
Diabetes Self-management Training (DSMT) Services within Attachment 4.19-B, Page 43
ABP Hospice Services within Attachment 4.19-B, ABP 11
Federally Qualified Health Center Services within Attachment 4.19-B, Page 2a, 2a.1, and 2a.2
Indian Health Services within Attachment 4.19-B, Page 1g
Prescribed Drugs within Attachment 4.19-B, Page 7 and 7a
Personal care services within Attachment 4.19-B within Page 11
Clinic Services within Attachment 4.19-B, Page 23, 23a, 24, and 25
Critical Access Hospitals (CAHs) within Attachment 4.19-B, Page 35a

__**X**__ The state is establishing rates or fee schedule for COVID-19 treatment, including specialized equipment and therapies (including preventive therapies) pursuant to sections 1905(a)(4)(F) and 1902(a)(30)(A) of the Act

____ The below listed providers are paid differently from the above rate schedules and payment to these providers for COVID-19 treatment are described under the benefit payment methodology applicable to the provider type:

Additional Information (Optional):

Monoclonal Antibody (mAb) treatment for COVID-19 administered by licensed pharmacists, state-authorized pharmacy interns, qualified pharmacy technicians, and pharmacies to comply with the PREP Act is reimbursed at the geographical adjusted rate of $399.36 in the pharmacy setting and $665.21 in the home setting.

Prophylactic treatment for COVID-19 administered by licensed pharmacists, state-authorized pharmacy interns, qualified pharmacy technicians, and pharmacies to comply with the PREP Act as an injection in the pharmacy setting is reimbursed at $133.52 and $222.24 in the home setting.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of mAb treatment and prophylactic treatment services for COVID-19. The agency's fee schedule rate was set as of September 9, 2021, and is effective for services provided on or after that date. All rates are published the agency's website at www.okhca.org/feeschedules.

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State: OKLAHOMA

STATE PLAN DEFINITION OF HMO

The statutory definition of a HMO as identified in Oklahoma State Statute 2503 is used. Licensure by the Oklahoma Department of Health is the HMO indication of compliance with the statutory definition. The State Medicaid Agency further requires that the HMO minimally include the following:

1. Be organized primarily for the purpose of providing health care services.

2. Make the services it provides to its Medicaid enrollees as accessible to them (in terms of timeliness, amount, duration and scope) as those services are to nonenrolled Medicaid recipients within the area served by the HMO.

3. Make provision, satisfactory to the State Medicaid Agency, against the risk of insolvency and assure that Medicaid enrollees will not be liable for the HMO's debts if it does become insolvent.

A public HMO will meet all the above requirements for an HMO, including all the requirements for licensure. Licensure will not, however, be required for a public HMO (as defined in 42 CFR 434.26(b)(2)). The State Medicaid Agency will determine statutory compliance for a public HMO. The State Medicaid Agency further requires that a public HMO minimally include the following additional requirements:

1. Operate, or contract for the operation of, a public inpatient hospital facility
2. Operate, or contract for the operation of, a public medical pathology laboratory
3. Operate, or contract for the operation of, a public x-ray laboratory
4. Operate, or contract for the operation of, a public outpatient clinic
5. Operate, or contract for the operation of, at least a public marginal level 2 trauma center as determined by the State Department of Health, which provides enhanced pediatric trauma services.
6. Be owned or operated by an Oklahoma State, county, or municipal health department or hospital.

Public and private HMOs will be monitored for compliance with the Quality Assurance Reform Initiative (QARI). The State will monitor the credentialing and recredentialing process as identified in QARI for compliance with 42 CFR 434.67, subpart E(i). In addition, the State will inform health plans of any sanctioned providers as soon as the information is available to the State. Health plans not in compliance will be subject to intermediate sanctions as recommended in 42 CFR 434.67, subpart E(a).

New 07-01-95

STATE Oklahoma
DATE RECD 12-30-96
DATE APPD 01-09-97
DATE EFF 10-01-96
NO. 96-12

GARTH L. SPLINTER, M.D., M.B.A.
CHIEF EXECUTIVE OFFICER

FRANK KEATING
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

RECEIVED
DEC 30
HCFA
DIVISION OF MEDICAID
RO VI - DALLAS

December 20, 1996

Bart Lacey, Branch Chief
Program Operations Branch
Division of Medicaid
Health Care Financing Administration
1200 Main Tower Building
Dallas, TX 75202

Re: SPA 96-12

Dear Mr. Lacey:

As directed in the Department of Health and Human Services letter of October 4, 1996, this letter will serve as an interim State Plan Amendment that Oklahoma's State Plan for Medicaid will continue eligibility for all groups covered under the State's AFDC program as of July 16, 1996. Eligibility for all AFDC and deemed AFDC categories will be determined using the AFDC standards and methodologies in effect July 16, 1996.

Specifically, Oklahoma's State Plan will continue coverage for the following groups:

Mandatory Coverage - Categorically Needy

Those families who meet the provisions specified in Section 1931(b) of the Act as established by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, relating to the approved AFDC State Plan in effect on July 16, 1996, will continue to be covered. These include:

- Families with unemployed parents;
- Pregnant women with no other eligible children:
- AFDC children age 18 who are full-time students in secondary school or in the equivalent level of vocational or technical training.

The standards for AFDC payments under the July 16, 1996 approved AFDC State Plan are listed in Supplement 1 to Attachment 2.6-A, Page 1, and will be used to determine eligibility.

STATE Oklahoma
DATE 12-30-96
DATE 01-09-97
DATE 10-01-96
HCFA ID 96-12
A

Additionally, under Section 1931(b) of the Social Security Act, those recipients deemed eligible under the approved AFDC State Plan in effect on July 16, 1996, are:

- Individuals who would have been denied a Title IV-A cash payment solely because the amount would be less than $10.00.

- Participants in a work supplementation program under Title IV-A and any child or relative of such individual (or other individual living in the same household as such individuals) who would be eligible for AFDC if there were no work supplementation program.

Other Required Special Groups

Oklahoma Medicaid will also be made available to deemed recipients of AFDC who fall into the following categories:

- Under 1902(a)(10)(A)(i)(l) of the Act, effective October 1, 1990, participants in a work supplementation program under Title IV-A and any child or relative of such individual (or other individual living in the same household as such individuals) who would be eligible for AFDC if there were no work supplementation program, in accordance with Section 482(e)(6) of the Act.

- Under Section 402(a)(22)(A) of the Act, individuals whose AFDC payments are reduced to zero by reason of recovery of overpayment of AFDC funds.

- Under Sections 406(h), 408(a)(11), 1902(a)(10)(A)(i)(l), and 1931(c) of the Act, an assistance unit treated under Section 1931(b)(1)(A) as receiving AFDC (as in effect on July 16, 1996) for a period of four calendar months because the family would become ineligible for such assistance as a result of collection or increased collection of support and meets the requirements of Section 406(h) of the Act.

- Under Section 1902(a) of the Act, individuals deemed to be receiving AFDC who meet the requirements of Section 473(b)(1) or (2) (as in effect as of June 1, 1995) for whom an adoption assistance agreement is in effect or foster care maintenance payments are being made under Title IV-E of the Act.

STATE Oklahoma
DATE 12-30-96
DATE 01-09-97
DATE 10-01-96
HCFA 179
A

Those qualified family members under Sections 407(b), 1902(a)(10)(A)(i), and 1905(m)(1) of the Act as follows:

- Effective October 1, 1990, qualified family members who would be eligible to receive AFDC under Section 407 of the Act because the principal wage earner is unemployed are not included because cash assistance payments may be made to families with unemployed parents for 12 months per calendar year.

- Under Section 408(a)(11), 1902(a)(52), 1931(c), and 1925 of the Act, families treated (under Section 1931(b)(1)(A)) as receiving AFDC (as in effect on July 16, 1996, that would become ineligible for such assistance solely because of earnings, hours of employment, or loss of earned income disregards entitled up to twelve months of extended benefits in accordance with Section 1925 of the Act. (This provision expires on September 30, 1998).

For determination of eligibility under Section 1931(b), the income standards in the approved AFDC program in effect as of July 16, 1996, will be used.

In summation, all AFDC Title IV-A groups covered by Oklahoma's State Medicaid Plan on July 16, 1996, will continue to be eligible for Medicaid until such time as a future amendment is submitted. We are enclosing an appropriate HCFA-179 for submittal of this correspondence for inclusion and approval in the Oklahoma State Medicaid Plan as suggested by your office.

Sincerely,

Garth L. Splinter, M.D.
Chief Executive Officer

Enclosure

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: OKLAHOMA

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered
Department of Human Services		

The following groups are covered under this plan.

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups

[redacted]

42 CFR 435.115 2. Deemed Recipients of AFDC

a. Individuals denied a title IV-A cash payment solely because the amount would be less than $10

*Agency that determines eligibility for coverage.

TN No. 92-02 Approval Date MAR - 3 1992 Effective Date OCT - 1 1991
Supersedes
TN No. 90-22

HCFA ID: 7983E

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APPV'D MAR - 3 1992
DATE EFF OCT - 1 1991
HCFA 179 92-02

A

State: OKLAHOMA

Agency*	Citation	Groups Covered
Department of Human Services		

A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

2. Deemed Recipients of AFDC.

42 CFR 435.115, 408(a)(11)(B), 1931(c)(1), and 1902(a)(10)(A)(i)(I) of the Act	b.	An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support and meets the requirements of sections 408(a)(11)(B) and 1931(c)(1) of the Act.
42 CFR 435.145, 1902(a)(10)(A)(i)(I) and 473(b) of the Act	c.	Individuals deemed to be receiving AFDC who meet the requirements of section 473(b) of the Act for whom an adoption assistance agreement is in effect, foster care maintenance payments are being made, or kinship guardianship assistance payments are being made under title IV-E of the Act.

STATE Oklahoma
DATE REC'D 3·21·2013
DATE APPV'D 6·6·2013
DATE EFF 1·1·2013
HCFA 179 13·02

A

* Agency that determines eligibility for coverage for this population.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State OKLAHOMA

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

[redacted]

1902(e)(5) of the Act

11. a. A woman who, while pregnant, was eligible for, applied for, and receives Medicaid under the approved State plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day period (beginning on the last day of her pregnancy) and for any remaining days in the month in which the 60th day falls.

1902(e)(6) of the Act

b. A pregnant woman who would otherwise lose eligibility because of an increase in income (of the family in which she is a member) during the pregnancy or the postpartum period which extends through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends.

STATE OK DATE REC'D 1-5-98 DATE APPV'D 3-9-98 DATE EFF 12-1-97 HCFA 179 97-20	A

Revised 12-01-97

Agency* Citation(s) Groups Covered

Department of Human Services

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

1902(e)(5) of the Act

~~11.~~ A woman who, while pregnant, was eligible ~~for~~, applied for, and receives Medicaid under the approved State plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day period (beginning on the last day of her pregnancy) and for any remaining days in the month in which the 60th day falls.

see prev. page #11

1902(e)(4) of the Act

12. A child born to a woman who is eligible for and receiving Medicaid as categorically needy on the date of the child's birth. The child is deemed eligible for one year from birth as long a the mother remains eligible and the child remains in the same household as the mother.

*Agency that determines eligibility for coverage.

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APP'D MAR - 3 1992
DATE EFF OCT - 1 1991
HCFA 179 92-02
A

State: Oklahoma

Agency* Citation(s) Groups Covered
Department of Human Services

A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.120 13. Aged, Blind and Disabled Individuals Receiving Cash Assistance

[X] a. Individuals receiving SSI.

This includes beneficiaries' eligible spouses and persons receiving SSI benefits pending a final determination of blindness or disability or pending disposal of excess resources under an agreement with the Social Security Administration; and beginning January 1, 1981 persons receiving SSI under section 1619(a) of the Act or considered to be receiving SSI under section 1619(b) of the Act.

__X__ Aged

__X__ Blind

__X__ Disabled

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

*Agency that determines eligibility for coverage.

This page will become effective October 1, 2015.

State: Oklahoma

Agency* Citation(s) Groups Covered
Department of Human Services

A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

435.121

13. [X] b. Individuals who meet more restrictive requirements for Medicaid than the SSI requirements. (This includes persons who qualify for benefits under section 1619(a) of the Act or who meet the requirements for SSI status under section 1619(b)(1) of the Act and who met the State's more restrictive requirements for Medicaid in the month before the month they qualified for SSI under section 1619(a) or met the requirements under Section 1619(b)(1) of the Act. Medicaid eligibility for these individuals continues as long as they continue to meet the 1619(a) eligibility standard or the requirements of section 1619(b) of the Act).

1619(b)(1)
Of the Act

_x_ Aged

_x_ Blind

_x_ Disabled

The more restrictive categorical eligibility criteria are described below:

(Financial criteria are described in ATTACHMENT 2.6-A)

*Agency that determines eligibility for coverage.

State: Oklahoma
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This page will sunset effective October 1, 2015.

Agency* Citation(s) Groups Covered
Department of Human Services

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

1902(a)(10)(A)(i)(II) and 1905(q) of the Act

14. Qualified severely impaired blind and disabled individuals under age 65, who--

a. For the month preceding the first month of eligibility under the requirements of section 1905(q)(2) of the Act, received SSI, a State supplemental payment under section 1616 of the Act or under section 212 of P.L. 93-66 or benefits under section 1619(a) of the Act and were eligible for Medicaid; or

b. For the month of June 1987, were considered to be receiving SSI under section 1619(b) of the Act and were eligible for Medicaid. These individuals must--

(1) Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to be disabled;

(2) Except for earnings, continue to meet all nondisability-related requirements for eligibility for SSI benefits;

(3) Have unearned income in amounts that would not cause them to be ineligible for a payment under section 1611(b) of the Act;

*Agency that determines eligibility for coverage.

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APPV'D MAR - 3 1992
DATE EFF OCT - 1 1991
HCFA ID 92-02
A

Agency* Citation(s) Groups Covered
Department of Human Services

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

(4) Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and

(5) Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any Federally administered SSP), or public funded attendant care services that would be available if he or she did have such earnings.

☑ Not applicable with respect to individuals receiving only SSP because the State either does not make SSP payments or does not provide Medicaid to SSP-only recipients.

*Agency that determines eligibility for coverage.

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APPV'D MAR - 3 1992
DATE EFF OCT - 1 1991
HCFA 179 92-02
A

State: Oklahoma

Agency* Citation(s) Groups Covered
Department of Human Services

A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

1619(b)(3) of the Act

[x] The State applies more restrictive eligibility requirements for Medicaid than under SSI and under 42 CFR 432.121. Individuals who qualify for benefits under section 1619(a) of the Act or individuals described above who meet the eligibility requirements for SSI benefits under section 1619(b)(1) of the Act and who met the State's more restrictive requirements in the month before the month they qualified for SSI under section 1619(a) or met the requirements of section 1619(b)(1) of the Act are covered. Eligibility for these individuals continues as long as they continue to qualify for benefits under section 1619(a) of the Act or meet SSI requirements under section 1619(b)(1) of the Act.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

*Agency that determines eligibility for coverage.

This page will sunset effective October 1, 2015.

State: Oklahoma

Agency* Citation(s)	Groups Covered
Department of Human Services	

A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

1634(c) of the Act

15. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, blind or disabled individuals who—

a. Are at least 18 years of age;

b. Lose SSI eligibility because they become entitled to OASDI child's benefits under section 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility.

[x] c. The State applies more restrictive eligibility requirements than those under SSI, and part or all of the amount of the OASDI benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

[ ] d. The State applies more restrictive requirements than those under SSI, and none of the OASDI benefit is deducted in determining the amount of countable income for categorically needy eligibility.

42 CFR 435.122

16. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, individuals who are ineligible for SSI or optional State supplements (if the agency provides Medicaid under §435.230), because of requirements that do not apply under title XIX of the Act.

42 CFR 435.130

17. Individuals receiving mandatory State supplements.

*Agency that determines eligibility for coverage.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January 2015
Transmittal Number: 14-0027

This page will sunset effective October 1, 2015.

Agency* Citation(s) Groups Covered
Department of Human Services

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.131 18. Individuals who in December 1973 were eligible fc Medicaid as an essential spouse and who have continued, as spouse, to live with and be essential to the well-being of a recipient of ca assistance. The recipient with whom the essentia spouse is living continues to meet the December 1973 eligibility requirements of the State's approved plan for OAA, AB, APTD, or AABD and the spouse continues to meet the December 1973 requirements for having his or her needs includec in computing the cash payment.

☒ In December 1973, Medicaid coverage of the essential spouse was limited to the following group(s):

X Aged X Blind X Disabled

☐ Not applicable. In December 1973, the essential spouse was not eligible for Medicaid

*Agency that determines eligibility for coverage.

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APPV'D MAR - 3 1992
DATE EFF OCT - 1 1991
HCFA 179 92-02
A

Agency* Citation(s) Groups Covered
Department of Human Services

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.132 19. Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of title XIX medical institutions or residents of title XIX intermediate care facilities, if, for each consecutive month after December 1973, they-

a. Continue to meet the December 1973 Medicaid State plan eligibility requirements; and

b. Remain institutionalized; and

c. Continue to need institutional care.

42 CFR 435.133 20. Blind and disabled individuals who--

a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; and

b. Were eligible for Medicaid in December 1973 as blind or disabled; and

c. For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.

*Agency that determines eligibility for coverage.

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APP'VD MAR - 3 1992
DATE EFF OCT - 1 1991
HCFA 179 92-02
A

Agency* Citation(s) Groups Covered
Department of Human Services

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.134 21. Individuals who would be SSI/SSP eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASD in August 1972, and who were receiving cash assistance in August 1972.

☒ Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).

☒ Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).

☐ Not applicable with respect to intermediate care facilities; the State did or does not cover this service.

*Agency that determines eligibility for coverage.

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APP'D MAR - 3 1992
DATE EFF OCT - 1 1991
HCFA 179 92-02
A

State: Oklahoma

Agency* Citation(s) Groups Covered

Department of Human Services

A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.135

22. Individuals who –

a. Are receiving OASDI and were receiving SSI/SSP but became ineligible for SSI/SSP after April 1977; and

b. Would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under section 215(i) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income.

☐ Not applicable with respect to individuals receiving only SSP because the State either does not make such payments or does not provide Medicaid to SSP-only recipients.

☐ Not applicable because the State applies more restrictive eligibility requirements than those under SSI.

☒ The State applies more restrictive eligibility requirements than those under SSI and the amount of increase that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

*Agency that determines eligibility for coverage.

This page will sunset effective October 1, 2015.

State: Oklahoma

Agency* Citation(s) Groups Covered

Department of Human Services

A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.135

22. Individuals who –

a. Are receiving OASDI and were receiving SSI/SSP but became ineligible for SSI/SSP after April 1977; and

b. Would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under section 215(i) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income.

☐ Not applicable with respect to individuals receiving only SSP because the State either does not make such payments or does not provide Medicaid to SSP-only recipients.

☐ Not applicable because the State applies more restrictive eligibility requirements than those under SSI.

☐ The State applies more restrictive eligibility requirements than those under SSI and the amount of increase that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

*Agency that determines eligibility for coverage.

This page will be implemented October 1, 2015.

State: Oklahoma

Agency* Citation(s) Groups Covered

Department of Human Services

1634 of the Act

A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

23. Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by section 134 of Pub. L. 98-21 and who are deemed, for purposes of title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under section 1634(b) of the Act.

☐ Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients.

☒ The State applies more restrictive eligibility standards than those under SSI and considers these individuals to have income equaling the SSI Federal benefit rate, or the SSP benefit rate for individuals who would be eligible for SSP only, when determining countable income for Medicaid categorically needy eligibility.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

*Agency that determines eligibility for coverage.

This page will sunset effective October 1, 2015.

State: Oklahoma

Agency* Citation(s) Groups Covered

Department of Human Services

1634 of the Act

A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

23. Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by section 134 of Pub. L. 98-21 and who are deemed, for purposes of title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under section 1634(b) of the Act.

☐ Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients.

☐ The State applies more restrictive eligibility standards than those under SSI and considers these individuals to have income equaling the SSI Federal benefit rate, or the SSP benefit rate for individuals who would be eligible for SSP only, when determining countable income for Medicaid categorically needy eligibility.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

*Agency that determines eligibility for coverage.

This page will be implemented October 1, 2015.

State: Oklahoma

Agency*	Citation(s)	Groups Covered
Department of Human Services		
	1634(d) of the Act	A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

24. Disabled widows, disabled widowers, and disabled unmarried divorced spouses who had been married to the insured individual for a period of at least ten years before the divorce became effective, who have attained age of 50, who are receiving title II payments, and who because of the receipt of title II income lost eligibility for SSI or SSP which they received in the month prior to the month in which they began to receive title II payments, who would be eligible for SSI or SSP if the amount of the title II benefit were not counted as income, and who are not entitled to Medicare Part A.

~~x~~ The state applies more restrictive eligibility requirements for its blind and disabled than those of the SSI program.

XX In determining eligibility as categorically needy, the State disregards the amount of the title II benefits identified in §1634(d)(1)(A) in determining the income of the individual but does not disregard any more of this income than would reduce the individual's income to the SSI income standard.

___ In determining eligibility as categorically needy, the State disregards only part of the amount of the benefits identified in §1634(d)(1)(A) in determining the income of the individual which amount would not reduce the individual's income below the SSI income standard. The amount of these benefits disregarded is specified in Supplement 4 to attachment 2.6-A.

In determining eligibility as categorically needy, the State chooses not to deduct any of the benefit identified in §1634(d)(1)(A) in determining the income of the individual.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

*Agency that determines eligibility for coverage.
This page will sunset effective October 1, 2015.

State: Oklahoma

Agency* Citation(s) Groups Covered

Department of Human Services

1634(d) of the Act

A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

24. Disabled widows, disabled widowers, and disabled unmarried divorced spouses who had been married to the insured individual for a period of at least ten years before the divorce became effective, who have attained age of 50, who are receiving title II payments, and who because of the receipt of title II income lost eligibility for SSI or SSP which they received in the month prior to the month in which they began to receive title II payments, who would be eligible for SSI or SSP if the amount of the title II benefit were not counted as income, and who are not entitled to Medicare Part A.

___ The state applies more restrictive eligibility requirements for its blind and disabled than those of the SSI program.

_X_ In determining eligibility as categorically needy, the State disregards the amount of the title II benefits identified in §1634(d)(1)(A) in determining the income of the individual but does not disregard any more of this income than would reduce the individual's income to the SSI income standard.

___ In determining eligibility as categorically needy, the State disregards only part of the amount of the benefits identified in §1634(d)(1)(A) in determining the income of the individual which amount would not reduce the individual's income below the SSI income standard. The amount of these benefits disregarded is specified in Supplement 4 to attachment 2.6-A.

___ In determining eligibility as categorically needy, the State chooses not to deduct any of the benefit identified in §1634(d)(1)(A) in determining the income of the individual.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 Janaury, 2015
Transmittal Number: 14-0027

*Agency that determines eligibility for coverage.
This page will be implemented October 1, 2015.

State: OKLAHOMA

Agency* Citation	Groups Covered
Department of Human Services	
	A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)
1860D-14(a)(3)(D), 1902(a)(10)(E)(i), and 1905(p) of the Act	25. Qualified Medicare Beneficiaries— a. Who are entitled to hospital insurance benefits under Medicare Part A, (but not pursuant to an enrollment under section 1818A of the Act); b. Whose income does not exceed 100 percent of the Federal poverty level; and c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the Consumer Price Index (CPI). (Medical assistance for this group is limited to Medicare cost-sharing as defined in item 3.2 of this plan.)
1902(a)(10)(E)(ii), 1905(s), and 1905(p)(3)(A)(i) of the Act	26. Qualified Disabled and Working Individuals— a. Who are entitled to hospital insurance benefits under Medicare Part A under section 1818A of the Act; b. Whose income does not exceed 200 percent of the Federal poverty level; and c. Whose resources do not exceed twice the maximum standard under SSI. d. Who are not otherwise eligible for medical assistance under Title XIX of the Act. (Medical assistance for this group is limited to Medicare Part A premiums under section 1818A of the Act.)

* Agency that determines eligibility for coverage.

TN No. 10-11 Approval Date 6-25-10 Effective Date 1-1-10
Supersedes
TN No. 93-08

SUPERSEDES: TN- 93-08

STATE Oklahoma
DATE REC'D 3-31-10
DATE APPVD 6-25-10
DATE EFF 1-1-10
HCFA 179 10-11

A

State: OKLAHOMA

Agency* Department of Human Services	Citation	Groups Covered
		A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued) (Continued)
1860D-14(a)(3)(D), 1902(a)(10)(E)(iii), and 1905(p)(3)(A)(ii) of the Act		27. Specified Low-Income Medicare Beneficiaries-- a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act); b. Whose income is at least 100 percent, but does not exceed 120 percent of the Federal poverty level; and c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the Consumer Price Index (CPI). (Medical assistance for this group is limited to Medicare Part B premiums under section 1839 of the Act.)
1902(a)(10)(E)(iv), 1905(p)(3)(A)(ii) and 186D-14(a)(3)(D) of the Act		28. Qualifying Individuals— a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act); b. Whose income is at least 120 percent but less than 135 percent of the Federal poverty level; c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the Consumer Price Index (CPI). (Medical assistance for this group is limited to Medicare Part B premiums under section 1839 of the Act.)

* Agency that determines eligibility for coverage for this population.

State: Oklahoma

Agency* Citation(s) Groups Covered

Department of Human Services

A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

29. a. Each person to whom SSI benefits by reason of disability are not payable for any month solely by reason of clause (i) or (v) of Section 1611(e)(3)(A) shall be treated for purposes of title XIX, as receiving SSI benefits for the month.

x b. The State applies more restrictive eligibility standards than those under SSI.

Individuals whose eligibility for SSI benefits are based solely on disability who are not payable for any months solely by reason of clause (i) or (v) of Section 1611(e)(3)(A), and who continue to meet the more restrictive requirements for Medicaid eligibility under the State plan, are eligible for Medicaid as categorically needy.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

*Agency that determines eligibility for coverage.

This page will sunset effective October 1, 2015.

State: Oklahoma

Agency* Citation(s) Groups Covered

Department of Human Services

A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

29. a. Each person to whom SSI benefits by reason of disability are not payable for any month solely by reason of clause (i) or (v) of Section 1611(e)(3)(A) shall be treated for purposes of title XIX, as receiving SSI benefits for the month.

___ b. The State applies more restrictive eligibility standards than those under SSI.

Individuals whose eligibility for SSI benefits are based solely on disability who are not payable for any months solely by reason of clause (i) or (v) of Section 1611(e)(3)(A), and who continue to meet the more restrictive requirements for Medicaid eligibility under the State plan, are eligible for Medicaid as categorically needy.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January 2015
Transmittal Number: 14-0027

*Agency that determines eligibility for coverage.

This page will be implemented October 1, 2015.

State: OKLAHOMA

Agency* Citation(s) Groups Covered

Department of Human Services

B. Optional Groups Other Than the Medically Needy

42 CFR 435.210 1902(a)(10)(A)(ii) and 1905(a) of the Act

[X] 1. Individuals described below who meet the income and resource requirements of AFDC, SSI, or an optional State supplement as specified in 42 CFR 435.230, but who do not receive cash assistance.

[X] The plan covers all individuals as described above.

[ ] The plan covers only the following group or groups of individuals:

___ Aged
___ Blind
___ Disabled
[redacted]

42 CFR 435.211

[X] 2. Individuals who would be eligible for AFDC, SSI or an optional State supplement as specified in 42 CFR 435.230, if they were not in a medical institution.

*Agency that determines eligibility for coverage.

New 10-01-91

TN No. 92-02 Approval Date MAR - 3 1992 Effective Date OCT - 1 1991
Supersedes
TN No. New Page

HCFA ID: 7983E

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APPV'D MAR - 3 1992
DATE EFF OCT - 1 1991
HCFA 179 92-02

A

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (continued)

42 CFR 435.212 & 1902(e)(2) of the Act, P.L. 99-272 (section 9517) P.L. 101-508(section 4732)

[ ] 3. The State deems as eligible those individuals who became otherwise ineligible for Medicaid while enrolled in an HMO qualified under Title XIII of the Public Health Service Act, or a managed care organization (MCO), or a primary care case management (PCCM) program, but who have been enrolled in the entity for less than the minimum enrollment period listed below. Coverage under this section is limited to MCO or PCCM services and family planning services described in section 1905(a)(4)(C) of the Act.

X The State elects not to guarantee eligibility.

___ The State elects to guarantee eligibility. The minimum enrollment period is ___ months (not to exceed six).

The State measures the minimum enrollment period from:

[ ] The date beginning the period of enrollment in the MCO or PCCM, without any intervening disenrollment, regardless of Medicaid eligibility.

[ ] The date beginning the period of enrollment in the MCO or PCCM as a Medicaid patient (including periods when payment is made under this section), without any intervening disenrollment.

[ ] The date beginning the last period of enrollment in the MCO or PCCM as a Medicaid patient (not including periods when payment is made under this section) without any intervening disenrollment or periods of enrollment as a privately paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section).

*Agency that determines eligibility for coverage.

TN # 07-11 Approval Date 7-26-07 Effective Date 7-1-07
Supersedes
TN # 03-12

SUPERSEDES: TN- 03-12

STATE Oklahoma
DATE REC'D 6-25-07
DATE APP'D 7-26-07
DATE EFF 7-1-07
HCFA 179 07-11

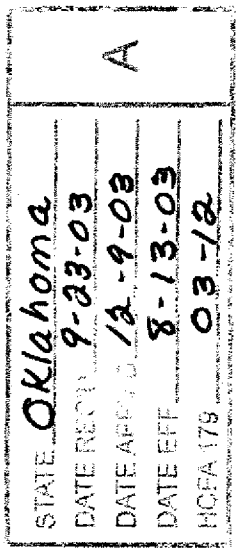
A

State: OKLAHOMA

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than Medically Needy
(continued)

1932(a)(4) of Act



The Medicaid Agency may elect to restrict the disenrollment of Medicaid enrollees of MCOs, PIHPs, PAHPs, and PCCMs in accordance with the regulations at 42 CFR 438.56. This requirement applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity's service area or becomes ineligible.

___ Disenrollment rights are restricted for a period of _____ months (not to exceed 12 months).

During the first month of each enrollment period the recipient may disenroll without cause. The State will provide notification, at least once per year, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment.

X No restrictions upon disenrollment rights.

1903(m)(2)(H), 1902(a)(52) of the Act
P.L. 101-508
42 CFR 438.56(g)

In the case of individuals who have become ineligible for Medicaid for the brief period described in section 1903(m)(2)(H) and who were enrolled with an MCO, PIHP, PAHP, or PCCM when they became ineligible, the Medicaid agency may elect to reenroll those individuals in the same entity if that entity still has a contract.

X The agency elects to reenroll the above individuals who are eligible in a month but in the succeeding two months become eligible, into the same entity in which they were enrolled at the time eligibility was lost.

___ The agency elects not to reenroll above individuals into the same entity in which they were previously enrolled.

SUPERSEDES TN 95-01

* Agency that determines eligibility for coverage.

Revised 08-13-03

State/Territory: OKLAHOMA

Agency*	Citation(s)	Groups Covered
Department of Human Services		

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.217

X 4. A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The group or groups covered are listed in the waiver request. This option is effective on the effective date of the State's section 1915(c) waiver under which this group(s) is covered. In the event an existing 1915(c) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment.

STATE Oklahoma
DATE REC'D APR 06 1993
DATE APPV'D MAY 03 1993
DATE EFF JAN 01 1993
HCFA 179 93-27

A

*Agency that determines eligibility for coverage.

Revised 01-01-93

TN No. 93-27 Approval Date MAY 03 1993 Effective Date JAN 01 1993
Supersedes
TN No. 92-02

HCFA ID: 7983E

State: OKLAHOMA

Agency* Citation(s) Groups Covered
Department of Human Services

B. Optional Groups Other Than the Medically Needy
(Continued)

1902(a)(10)(A)(ii)(VII) of the Act

☑ 5. Individuals who would be eligible for Medicaid under the plan if they were in a medical institution, who are terminally ill, and who receive hospice care in accordance with a voluntary election described in section 1905(o) of the Act.

☑ The State covers all individuals as described above.

☐ The State covers only the following group c groups of individuals:

___ Aged
___ Blind
___ Disabled
___ Individuals under the age of--
___ 21
___ 20
___ 19
___ 18
___ Caretaker relatives
___ Pregnant women

*Agency that determines eligibility for coverage.

New 10-01-91

TN No. 92-02 Approval Date MAR - 3 1992 Effective Date OCT - 1 1991
Supersedes
TN No. New Page

HCFA ID: 7983E

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APPV'D MAR - 3 1992
DATE EFF OCT - 1 1991
HCFA 179 92-02

A

Agency* Citation(s) Groups Covered
Department of Human Services

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.230 ☑ 10. States using SSI criteria with agreements under sections 1616 and 1634 of the Act.
42 CFR 435.120

The following groups of individuals who receive only a State supplementary payment (but no SSI payment) under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

a. Based on need and paid in cash on a regular basis.

b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.

c. Available to all individuals in the State.

d. Paid to one or more of the classifications of individuals listed below, who would be eligible for SSI except for the level of their income.

___ (1) All aged individuals.

___ (2) All blind individuals.

___ (3) All disabled individuals.

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APPV'D MAR - 3 1992
DATE EFF OCT - 1 1991
HCFA 179 92-02

A

Agency* Citation(s) Groups Covered
Department of Human Services

B. Optional Groups Other Than the Medically Needy
(Continued)

___ (4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.

42 CFR 435.230

___ (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.

___ (6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.

___ (7) Individuals receiving a Federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.

___ (8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.

___ (9) Individuals in additional classifications approved by the Secretary as follows:

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APPV'D MAR - 3 1992
DATE EFF OCT - 1 1991
HCFA 179 92-02
A

Agency* Citation(s) Groups Covered
Department of Human Services

B. Optional Groups Other Than the Medically Needy
(Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

___ Yes.

X No.

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APPV'D MAR - 3 1992
DATE EFF OCT - 1 1991
HCFA 179 92-02

A

Agency* Citation(s) Department of Human Services

Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.120
435.121
1902(a)(10)
(A)(ii)(XI)
of the Act
42 CFR 435.230

/X 11. Section 1902(f) States and SSI criteria States without agreements under section 1616 or 1634 of the Act.

The following groups of individuals who receive a State supplementary payment under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

a. Based on need and paid in cash on a regular basis.

b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.

c. Available to all individuals in each classification and available on a Statewide basis.

d. Paid to one or more of the classifications of individuals listed below:

___ (1) All aged individuals.

___ (2) All blind individuals.

___ (3) All disabled individuals.

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APPV'D MAR - 3 1992
DATE EFF OCT - 1 1991
HCFA 179 92-02
A

Agency* Citation(s) Groups Covered
Department of Human Services

B. Optional Groups Other Than the Medically Needy (Continued)

___ (4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.

___ (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.

___ (6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.

___ (7) Individuals receiving federally administered optional State supplemen that meets the conditions specified i 42 CFR 435.230.

X (8) Individuals receiving a State administered optional State supplemen that meets the conditions specified i 42 CFR 435.230.

___ (9) Individuals in additional classifications approved by the Secretary as follows:

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APPV'D MAR - 3 1992
DATE EFF OCT - 1 1991
HCFA 179 92-02

A

Agency* Citation(s) Groups Covered
Department of Human Services

B. Optional Groups Other Than the Medically Needy
(Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

___ Yes

_X_ No

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APPV'D MAR - 3 1992
DATE EFF OCT - 1 1991
HCFA ID 92-02
A

Agency* Citation(s) Groups Covered
Department of Human Services

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.231 211 /X
1902(a)(10) ✓
(A)(ii)(V) 336
of the Act

12. Individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in Supplement 1 to ATTACHMENT 2.6-A.

/ The State covers all individuals as described above.

/X The State covers only the following group or groups of individuals:

1902(a)(10)(A)
(ii) and 1905(a)
of the Act

X Aged
X Blind
X Disabled
___ Individuals under the age of--
___ 21
___ 20
___ 19
___ 18
___ Caretaker relatives
___ Pregnant women

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APP'D MAR - 3 1992
DATE EFF OCT - 1 1991
HCFA 179 92-22
A

STATE: OKLAHOMA

Agency*	Citation		Groups Covered
Department of Human Services	Section 4723 of P.L. 101-508 and Section 1903(f)(2)(B) of the Act	____	The State agency allows medically needy individuals and families to pay an amount to the State, which when combined with incurred medical costs in prior months, is sufficient when excluded from the family's income, to reduce such family's income below the applicable income limitation described in Section 1903(f)(1) of the Act.

STATE Oklahoma
DATE REC'D 1-7-91
DATE APPV'D 2-5-91
DATE EFF 11-5-90
HCFA 179 90-25

A

* Agency that determines eligibility for coverage

New 11-05-90

TN NO. 90-25

Supersedes TN NO. 90-18

Effective Date: 11/5/90

Approval Date: 2/5/91

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: OKLAHOMA

Agency	Citation(s)	Groups Covered
Oklahoma Health Care Authority		

B. Optional Groups Other Than the Medically Needy
(Continued)

1902(e)(3) of the Act

X 13. Certain disabled children age 18 or under who are living at home, who would be eligible for Medicaid under the plan if they were in a medical institution, and for whom the State has made a determination as required under section 1902(e)(3)(B) of the Act.

Supplement 3 to ATTACHMENT 2.2-A describes the method that is used to determine the cost effectiveness of caring for this group of disabled children at home.

[redacted]

STATE Oklahoma
DATE REC'D 7-12-05
DATE APPV'D 6-10-05
DATE EFF 10-1-05
HCFA 179 05-02

A

SUPERSEDES: TN 92-14

Revised 10-01-05

TN No. 05-02 Approval Date 6-10-05 Effective Date 10-1-05
Supersedes
TN No. 92-14

State: Oklahoma

Citation(s)	Groups Covered
1902(a)(10)(ii)(X) and 1902(m) of the Act	B. Optional Groups Other Than the Medically Needy (continued) [X] 16. Individuals- a. Who are 65 years of age or older or are disabled as determined under section 1614(a)(3) of the Act. Both aged and disabled individuals are covered under this eligibility group. b. Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal income poverty level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size; and c. Whose resources do not exceed the maximum amount allowed under SSI; under the State's more restrictive financial criteria; or under the State's medically needy program as specified in ATTACHMENT 2.6-A, and SUPPLEMENT 8b to ATTACHMENT 2.6-A, PAGE 1.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

This page will sunset effective October 1, 2015.

State: Oklahoma

Citation(s)	Groups Covered
1902(a)(10)(ii)(X) and 1902(m) of the Act	B. Optional Groups Other Than the Medically Needy (continued) [X] 16. Individuals- a. Who are 65 years of age or older or are disabled as determined under section 1614(a)(3) of the Act. Both aged and disabled individuals are covered under this eligibility group. b. Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal income poverty level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size; and c. Whose resources do not exceed the maximum amount allowed under SSI.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January 2015
Transmittal Number: 14-0027

This page will be implemented October 1, 2015.

STATE Oklahoma DATE REC'D 9-18-04 DATE APPV'D 11-16-04 DATE EFF 1-1-05 HCFA 179 04-04	A

Corrected
ATTACHMENT 2.2-A
Page 23a

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: OKLAHOMA

Agency	Citation(s)	Groups Covered
Oklahoma Health Care Authority		

B. Optional Groups Other Than the Medically Needy
(Continued)

1902(a)(10)(A)(ii) (XVIII) of the Act — X — 20. Women who:

a. have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act in accordance with the requirements of section 1504 of that Act and need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast of cervix;

b. are not otherwise covered under creditable coverage, as defined in section 2701(c) of the Public Health Service Act;

c. are not eligible for Medicaid under any mandatory categorically needy eligibility group; and

d. have not attained age 65.

1920B of the Act — _____ — 21. Women who are determined by a "qualified entity" (as defined in 1920B(b) based on preliminary information, to be a woman described in 1902(aa) of the Act related to certain breast and cervical cancer patients.

The presumptive period begins on the day that the determination is made. The period ends on the date that the State makes a determination with respect to the woman's eligibility for Medicaid, or if the woman does not apply for Medicaid (or a Medicaid application was not made on her behalf) by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on that last day.

SUPERSEDES: NONE - NEW PAGE

New Page 01-01-05

TN No. 04-04
Supersedes
Approval Date 11-16-04 Effective Date 1-1-05

SUPERSEDES: NONE - NEW PAGE
TN No. _____

Citation(s)	Groups Covered

C. Optional Coverage of the Medically Needy

42 CFR 435.300

This plan includes the medically needy.

* X No.

__ Yes. This plan covers:

1. Pregnant women who, except for income and/or resources, would be eligible as categorically needy under title XIX of the Act.

1902(e) of the Act

2. Women who, while pregnant, were eligible for and have applied for Medicaid and receive Medicaid as medically needy under the approved State plan on the date the pregnancy ends. These women continue to be eligible, as though they were pregnant, for all pregnancy-related and postpartum services under the plan for a 60-day period, beginning with the date the pregnancy ends, and any remaining days in the month in which the 60th day falls.

1902(a)(10)(C)(ii)(I) of

3. Individuals under age 18 who, but for income and/or resources, would be eligible the Act under section 1902(a)(10)(A)(i)

* Those persons determined eligible for the Medically Needy program prior to February 1, 2003, will continue to be eligible until the current certification expires.

Revised 02-01-03

Citation(s) | Groups Covered

C. Optional Coverage of Medically Needy (Continued)

[redacted]

42 CFR 435.308

5. ___ a. Financially eligible individuals who are not described in section C.3. above and who are under the age of–

__ 21
__ 20
__ 19
__ 18 or under age 19 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

___ b. Reasonable classifications of financially eligible individuals under the ages of 21, 20, 19, or 18 as specified below:

__ (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:

__ (a) In foster homes (and are under the age of __).

__ (b) In private institutions (and are under the age of __).

Revised 02-01-03

Citation(s) Groups Covered

C. Optional Coverage of Medically Needy (Continued)

_ c. In addition to the group under b.(1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of ____).

_ (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of 21).

_ (3) Individuals in NFs (who are under the age of ____). NF services are provided under this plan.

_ (4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of ____).

(5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of __). Inpatient psychiatric services for individuals under age 21 are provided under this plan.

_ (6) Other defined groups (and ages), as specified in Supplement 1 of Attachment 2.2-A.

Citation(s)	Groups Covered

C. Optional Coverage of Medically Needy (Continued)

42 CFR 435.310 __ 6. Caretaker relatives.

42 CFR 435.320 and 435.330 __ 7. Aged individuals.

42 CFR 435.322 and 435.330 __ 8. Blind individuals.

42 CFR 435.324 and 435.330 __ 9. Disabled individuals.

42 CFR 435.326 __ 10. Individuals who would be ineligible if they were not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.

435.340 11. Blind and disabled individuals who:

a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria;

b. Were eligible as medically needy in December 1973 as blind or disabled; and

c. For each consecutive month after December 1973 continue to meet the December 1973 eligibility criteria.

STATE Oklahoma
DATE REC'D 3-26-03
DATE APPV'D 6-17-03
DATE EFF 2-1-03
HCFA 179 OK 03-07

A

SUPERSEDES: TN- 92-02

State:

Citation(s) Groups Covered

C. Optional Coverage of Medically Needy (Continued)

1906 of the Act

12. Individuals required to enroll in cost effective employer-based group health plans remain eligible for a minimum enrollment period of _____ months.

STATE Oklahoma DATE REC'D 3-26-03 DATE APPV'D 6-17-03 DATE EFF 2-1-03 HCFA 179 OK 03-07	A

SUPERSEDES: TN- 92-14

State: OKLAHOMA

Citation		Groups Covered
Section 4723 of P. L. 101-508 and Section 1903(f)(2)(B)	_____	The State agency allows Medically Needy individuals and families to pay an amount to the State, which when combined with incurred medical costs in prior months, is sufficient when excluded from the family's income below the applicable income limitation described in Section 1903(f)(1) of the Act.

STATE Oklahoma
DATE REC'D 3-26-03
DATE APPV'D 6-17-03
DATE EFF 2-1-03
HCFA 179 OK 03-07

A

SUPERSEDES: TN- 92-14

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: OKLAHOMA

Agency	Citation(s)	Groups Covered
Oklahoma Health Care Authority		
	1935(a) and 1902(a)(66) 42 CFR 423.774 and 423.904	The agency provides for making Medicare prescription drug Low Income Subsidy determinations under Section 1935(a) of the Social Security Act. 1. The agency makes determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D-14 of the Social Security Act; 2. The agency provides for informing the Secretary of such determinations in cases in which such eligibility is established or redetermined; 3. The agency provides for screening of individuals for Medicare cost-sharing described in Section 1905(p)(3) of the Act and offering enrollment to eligible individuals under the State plan or under a waiver of the State plan.

STATE Oklahoma
DATE REC'D 9-30-05
DATE APPV'D 10-14-05
DATE EFF 7-1-05
HCFA 179 05-22

A

Revised 07-01-05

TN No. 05-22 Approval Date 10-14-05 Effective Date 7-1-05
Supersedes
TN No. SUPERSEDES NONE - NEW PAGE

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OKLAHOMA

Method for Determining Cost Effectiveness of Caring for Certain Disabled Children At Home

On an annual basis, each recipient's expenditures will be measured against the average cost of care in an appropriate institution to ensure that home care is more cost effective than institutional care. At least annually, a determination of the recipient's level of care will be completed.

For each recipient, the cost of home care services to the Medicaid Program must be no greater than the costs that would be incurred if the recipient were placed in an institution which meets the recipient's needs.

STATE Oklahoma DATE REC'D 4-12-05 DATE APPV'D 6-10-05 DATE EFF 10-1-05 HCFA 179 05-02	A

SUPERSEDES TN 92-02

Revised 10-01-05

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: OKLAHOMA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation	Condition or Requirement
	A. General Conditions of Eligibility
	Each individual covered under the plan:
42 CFR Part 435, Subpart G	1. Is financially eligible (using the methods and standards described in Parts B and C of this Attachment) to receive services.
42 CFR Part 435, Subpart F	2. Meets the applicable non-financial eligibility conditions.
	a. For the categorically needy:
	[redacted]
	(ii) For SSI-related individuals, meets the non-financial criteria of the SSI program or more restrictive SSI-related categorically needy criteria.
	[redacted]
1902(m) of the Act	(iv) For financially eligible aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, meets the non-financial criteria of section 1902(m) of the Act.

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APPV'D MAR - 3 1992
DATE EFF OCT - 1 1991
HCFA 179 92-02

A

Citation	Condition or Requirement
	b. For the medically needy, meets the non-financial eligibility conditions of 42 CFR Part 435.
1905(p) of the Act	c. For financially eligible qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, meets the non-financial criteria of section 1905(p) of the Act.
1905(s) of the Act	d. For financially eligible qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, meets the non-financial criteria of section 1905(s).
42 CFR 435.402(b)	3. Is residing in the United States and--

[redacted]

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APPV'D MAR - 3 1992
DATE EFF OCT - 1 1991
HCFA ID 92-02

A

Citation	Condition or Requirement
	[redacted]
42 CFR 435.403 1902(b) of the Act	4. Is a resident of the State, regardless of whether or not the individual maintains the residence permanently or maintains it at a fixed address. [ ] State has interstate residency agreement with the following States: [ ] State has open agreement(s). [X] Not applicable; no residency requirement.

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APPV'D MAR - 3 1992
DATE EFF OCT - 1 1991
HCFA 179 92-02
A

Citation	Condition or Requirement
435.1008	5. a. Is not an inmate of a public institution. Public institutions do not include medical institutions, intermediate care facilities, or publicly operated community residences that serve no more than 16 residents, or certain child care institutions.
42 CFR 435.1008 1905(a) of the Act	b. Is not a patient under age 65 in an institution for mental diseases except as an inpatient under age 22 receiving active treatment in an accredited psychiatric facility or program. ☐ Not applicable with respect to individuals under age 22 in psychiatric facilities or programs. Such services are not provided under the plan.
433.145 435.604 1912 of the Act	6. Is required, as a condition of eligibility, to assign rights to medical support and to payments for medical care from any third party, to cooperate in obtaining such support and payments, and to cooperate in identifying and providing information to assist in pursuing any liable third party. The assignment of rights obtained from an applicant or recipient is effective only for services that are reimbursed by Medicaid. The requirements of 42 CFR 433.146 through 433.148 are met. ☐ Assignment of rights is automatic because of State law.
42 CFR 435.910	7. Is required, as a condition of eligibility, to furnish his/her social security account number (or numbers, if he/she has more than one number).

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APPV'D MAR - 3 1992
DATE EFF OCT - 1 1991
HCFA 179 92-02

A

Citation(s)	Condition or Requirement

42 CFR § 435.725
435.733
435.832

B. Post Eligibility Treatment of Institutionalized Individuals

The following amounts are deducted from gross income when computing the application of an individual's or couples

1. Personal Needs Allowance.
   a. Aged, blind, disabled - -

      Individuals $75.00 *

      Couples $75.00 each person

      For the following individuals with greater need - -

   b. AFDC related - -

      Children $75.00

      Adults $75.00

2. For maintenance of the non-institutionalized spouse only. The amount must be based on a reasonable assessment of need but must not exceed the highest of - -

SSI level	$_____
SSP level	$_____
Medical needy level	$_____
Other as follows	$See Attachment 2.6-A, Page 9a

*For individuals receiving a VA pension limited to $90.00 per month under section 8003 of P.L. 101-508, the personal needs allowance is the greater of the amount permitted to be paid under section 8003 (up to $90) and the amount specified in this section.

State: Oklahoma
Date Received: 2 October, 2019
Date Approved: 2 December, 2019
Effective Date: 1 October, 2019
Transmittal Number: OK 19--0031A

State OKLAHOMA

Citation	Condition or Requirement

3. For families and children, each family member.

AFDC level $ *
Medically needy level $
Other as follows $

4. Amounts for incurred medical expenses not subject to payment by a third party.

a. Health insurance premiums, deductibles and co-insurance charges.

b. Necessary medical or remedial care not covered under the Medicaid plan.

STATE Oklahoma
DATE RECD 09-03-96
DATE APPVD 10-02-96
DATE EFF 07-01-96
HCFA 179 96-04

A

5. An amount for maintenance of a single individual's home for not longer than six months, if a physician has certified he or she is likely to return home within that period.

____ Yes. Amount for maintenance of home $_____

_X_ No.

1902(1) of the Act. P.L. 99-643 (Section 3(h))

6. SSI benefits paid under Section 1611(e)(1)(E) of the Act to blind or disabled individuals during the initial two months in which the individuals receive care in a hospital, SNF, or ICF if the individuals are allowed to retain benefits under agreement with the facility.

Section 1924 of of Act

7. For Section 1924 policies see Supplement 13, Pages 1, 2, and 3.

435.711 Not these C.
435.721 Not these
435.831 Not applicable

Financial Eligibility - Categorically and Medically Needy and Qualified Medicare Beneficiaries

Except as provided under Section 1924 of the Act, policies reflected in item C, 1-5 apply. See Supplement I3 for additional policies relative to Section 1924.

1. Income disregards - Categorically Medically Needy and Qualified Medicare Beneficiaries

*See Supplement 1 to Attachment 2.6-A, Page 1.

Revised 07-01-96

State: Oklahoma

Citation(s)	Conditions or Requirement

a. In determining countable income for AFDC related individuals, the following disregards are applied:

The disregards and exemptions in the State's approved AFDC plan are applied.

P.L. 100-360
(Section 302(e)(1))

X The agency continues to treat pregnant women eligible under the provisions of section 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, until the end of the 60-day period beginning on the last day of her pregnancy.

435.721, 435.831 and 1902(m)(1)(B) and (m)(4) of the Act, P.L. 99-509 (Sections 9402(a) and (b))

b. In determining countable income for aged individuals, including aged individuals with incomes up to the Federal nonfarm poverty line described in section 1902(m)(1) of the Act, the following disregards are applied:

___ The disregards of the SSI program

___ The disregards of the State supplementary payment program, as follows:

X The disregards of the SSI program, except for the following restrictions, applied under the provisions of section 1902(f) of the Act:

The State does not allow the $20.00 SSI unearned income disregard.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

This page will sunset effective October 1, 2015.

State: Oklahoma

Citation(s)	Conditions or Requirement
	a. In determining countable income for AFDC related individuals, the following disregards are applied: The disregards and exemptions in the State's approved AFDC plan are applied.
P.L. 100-360 (Section 302(e)(1))	X The agency continues to treat pregnant women eligible under the provisions of section 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, until the end of the 60-day period beginning on the last day of her pregnancy.
435.721, 435.831 and 1902(m)(1)(B) and (m)(4) of the Act, P.L. 99-509 (Sections 9402(a) and (b))	b. In determining countable income for aged individuals, including aged individuals with incomes up to the Federal nonfarm poverty line described in section 1902(m)(1) of the Act, the following disregards are applied: X The disregards of the SSI program ___ The disregards of the State supplementary payment program, as follows: ___ The disregards of the SSI program, except for the following restrictions, applied under the provisions of section 1902(f) of the Act:

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

This page will be implemented October 1, 2015.

State: Oklahoma

__X__ Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for mandatory and optional categorically needy poverty level related groups, and for medically needy groups.

__x__ Supplement 7 to ATTACHMENT 2.6-A specifies the income levels for categorically needy aged, blind, and disabled persons who are covered under requirements more restrictive than SSI.

__x__ Supplement 4 to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.

__x__ Supplement 5 to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.

__X__ Supplement 8a to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States that are more liberal than the methods of the cash assistance program, permitted under section 1902(r)(2) of the Act.

____ Supplement 8b to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.

__X__ Supplement 14 to ATTACHMENT 2.6-A specifies income levels used by States for determining eligibility of Tuberculosis-infected individuals whose eligibility is determined under section 1902(z)(1) of the Act.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

This page will sunset effective October 1, 2015.

State: Oklahoma

__X__ Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for mandatory and optional categorically needy poverty level related groups, and for medically needy groups.

___ Supplement 7 to ATTACHMENT 2.6-A specifies the income levels for categorically needy aged, blind, and disabled persons who are covered under requirements more restrictive than SSI.

___ Supplement 4 to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.

___ Supplement 5 to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.

__X__ Supplement 8a to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States that are more liberal than the methods of the cash assistance program, permitted under section 1902(r)(2) of the Act.

__X__ Supplement 8b to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.

__X__ Supplement 14 to ATTACHMENT 2.6-A specifies income levels used by States for determining eligibility of Tuberculosis-infected individuals whose eligibility is determined under section 1902(z)(1) of the Act.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

This page will be implemented October 1, 2015.

State: Oklahoma

Citation(s)	Condition or Requirement
1902(r)(2) Of the Act 42 CFR 435.721 435.831, and 1902(m)(1)(B)(m)(4) and 1902(r)(2) of the Act	1. Methods of Determining Income a. AFDC-related individuals (except for poverty level Related pregnant women, infants, and children) b. Aged individuals. In determining countable income for aged individuals, including aged individuals with incomes up to the Federal poverty level described in section 1902(m)(1) of the Act, the following methods are used: X The methods of the SSI program ___ The methods of the SSI program and/or any more liberal Methods described in Supplement 8a to ATTACHMENT 2.6-A.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

Citation(s)	Condition or Requirement

☒ For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

☒ For institutional couples, the methods specified under section 1611(e)(5) of the Act.

☐ For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A.

☒ For optional State supplement recipients in section 1902(f) States and SSI criteria states without section 1616 or 1634 agreements—

___ SSI methods only

___ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.

__x_ Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A.

In determining relative financial responsibility, the agency considers on the income of spouses living in the same household as available to spouses.

This page will sunset effective October 1, 2015.

Citation(s)	Condition or Requirement

☐ For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

☒ For institutional couples, the methods specified under section 1611(e)(5) of the Act.

☐ For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A.

☒ For optional State supplement recipients in section 1902(f) States and SSI criteria states without section 1616 or 1634 agreements—

_X_ SSI methods only

___ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.

___ Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A.

In determining relative financial responsibility, the agency considers on the income of spouses living in the same household as available to spouses.

This page will be implemented October 1, 2015.

State: Oklahoma

Citation(s)	Condition or Requirement
42 CFR 435.721 and 435.831 1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act	c. Blind individuals. In determining countable income for blind individuals, the following methods are used: ___ The methods of the SSI program only. ___ SSI methods and/or any more liberal methods Described in Supplement 8a to ATTACHMENT 2.6-A. _x_ For individuals other than optional State Supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A, and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. _X_ For institutional couples, the methods specified under section 1611(e)(5) of the Act. ___ For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A. x For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements -- _X_ SSI methods only. ___ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A. __x_ Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A.

This page will sunset effective October 1, 2015.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

State: Oklahoma

Citation(s)	Condition or Requirement
42 CFR 435.721 and 435.831 1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act	c. Blind individuals. In determining countable income for blind individuals, the following methods are used: _X_ The methods of the SSI program only. ___ SSI methods and/or any more liberal methods Described in Supplement 8a to ATTACHMENT 2.6-A. ___ For individuals other than optional State Supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A, and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. _X_ For institutional couples, the methods specified under section 1611(e)(5) of the Act. ___ For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A. _X_ SSI methods only. ___ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A. ___ Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A.

This page will be implemented October 1, 2015.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

STATE OKLAHOMA

CITATION	CONDITION OR REQUIREMENT

7. Maintenance standards for community spouses and other dependent family members used to calculate monthly income allowances under Section 1924 of the Act.

a. Community spouses

___1. A standard based on the formula contained in Section 1924(d) is used.

__X__2. The maximum standard contained in Section 1924(d)(3)(C).

____3. A fixed standard which is greater than the minimum standard described in Section 1924(d) plus actual shelter costs not to exceed the maximum standard contained in Section 1924(d)(3)(C). The standard used is $_____.

b. Other family members who are dependent

__X__1. A standard based on the formula contained in Section 1924(d)(1)(C) is used.

____2. A fixed standard greater than the amount which would be used if the formula described in Section 1924(d)(1)(C) were used. The standard used is $_____.

__X__ c. The standards described above are used for individuals receiving home and community-based waiver services in lieu of services provided in a medical or remedial care institution.

STATE Oklahoma	A
DATE REC'D 12-22-89	
DATE APPV'D 2-11-92	
DATE EFF 9-30-89	
HCFA 179 89-23	

New 09-30-89

TN No. 89-23 Approval Date 2/11/92 Effective Date 9/30/89

Supersedes TN No. None - New Page

STATE OKLAHOMA

CITATION	CONDITION OR REQUIREMENT

d. Definition of dependency

The definition of dependency below is used to define dependent children, parents and siblings for purposes of deducting allowances under Section 1924:

Dependency is defined as a person who is being claimed or could be claimed as a tax dependent for income tax purposes.

STATE	Oklahoma
DATE REC'D	12-22-89
DATE APPV'D	2-11-92
DATE EFF	9-30-89
HCFA 179	89-23
	A

New 09-30-89

TN No. 89-23 Approval Date 2/11/92 Effective Date 9/30/89

Supersedes TN No. None - New Page

State: Oklahoma

Citation(s)		Condition or Requirement
		In determining relative responsibility, the agency considers only the income of spouses living in the same households as available to spouses and the income of parents as available to children living with parents until the children become 21.
42 CFR 435.721, and 435.831 1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act	d.	Disabled individuals. In determining countable income of disabled individuals, including individuals with incomes up to the Federal poverty level described in section 1902(m) of the Act, the following methods are used: __ The methods of the SSI program. ___ SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. _X_ For institutional couples: the methods specified under section 1611(e)(5) of the Act. ___ For optional State supplement recipients under §435.230: income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A. _X__ For individuals other than optional State supplement recipients (except aged and disabled individuals described in section 1903(m)(1) of the Act): more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January 2015
Transmittal Number: 14-0027

This page will sunset effective October 1, 2015.

State: Oklahoma

Citation(s)	Condition or Requirement
	In determining relative responsibility, the agency considers only the income of spouses living in the same households as available to spouses and the income of parents as available to children living with parents until the children become 21.
42 CFR 435.721, and 435.831 1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act	d. Disabled individuals. In determining countable income of disabled individuals, including individuals with incomes up to the Federal poverty level described in section 1902(m) of the Act, the following methods are used: _X_ The methods of the SSI program. ___ SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. _X_ For institutional couples: the methods specified under section 1611(e)(5) of the Act. ___ For optional State supplement recipients under §435.230: income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A. ___ For individuals other than optional State supplement recipients (except aged and disabled individuals described in section 1903(m)(1) of the Act): more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

This page will be implemented October 1, 2015.

State: Oklahoma

Citation(s)	Condition or Requirement
	_X_ For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements—-
	___ SSI methods only.
	___ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.
	_x_ Methods more restrictive and/or more liberal than SSI, except for aged and disabled individuals described in section 1902(m)(1) of the Act. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8a to ATTACHMENT 2.6-A.
	In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

This page will sunset effective October 1, 2015.

State: Oklahoma

Citation(s)	Condition or Requirement

_X_ For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements—-

_X_ SSI methods only.

___ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.

___ Methods more restrictive and/or more liberal than SSI, except for aged and disabled individuals described in section 1902(m)(1) of the Act. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8a to ATTACHMENT 2.6-A.

In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

This page will be implemented October 1, 2015.

Citation		Condition or Requirement
[redacted]		
1902(e)(6) of the Act	X	(3) The agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.
1905(p)(1), 1902(m)(4), and 1902(r)(2) of the Act		f. Qualified Medicare beneficiaries. In determining countable income for qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, the following methods are used:
		X The methods of the SSI program only.
		___ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.
		___ For institutional couples, the methods specified under section 1611(e)(5) of the Act.

STATE Oklahoma
DATE REC'D JAN 27 1992
DATE APPV'D FEB 28 1992
DATE EFF OCT - 1 1991
HCFA 179 92-04
A

Citation Department of Human Services		Condition or Requirement
		If an individual receives a title II benefit, any amounts attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level. For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period. For individuals not receiving title II income, the revised poverty levels are effective no later than the date of publication.
1905(s) of the Act	g.	(1) Qualified disabled and working individuals. In determining countable income for qualified disabled and working individuals covered under 1902(a)(10)(E)(ii) of the Act, the methods of the SSI program are used.
1905(p) of the Act		(2) Specified low-income Medicare beneficiaries. In determining countable income for specified low-income Medicare beneficiaries covered under 1902(a)(10)(E)(iii) of the Act, the same method as in f. is used.

STATE Oklahoma
DATE REC'D APR 06 1993
DATE APP'D MAY 03 1993
DATE EFF JAN 01 1993
HCFA 179 93-08

A

* U.S. G.P.O.:1993-342-239:80032

Citation	Condition or Requirement
1902(k) of the Act	2. Medicaid Qualifying Trusts In the case of a Medicaid qualifying trust described in section 1902(k)(2) of the Act, the amount from the trust that is deemed available to the individual who established the trust (or whose spouse established the trust) is the maximum amount that the trustee(s) is permitted under the trust to distribute to the individual. This amount is deemed available to the individual, whether or not the distribution is actually made. This provision does not apply to any trust or initial trust decree established before April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded. ☐ The agency does not count the funds in a trust as described above in any instance where the State determines that it would work an undue hardship. Supplement 10 of ATTACHMENT 2.6-A specifies what constitutes an undue hardship.
1902(a)(10) of the Act	3. Medically needy income levels (MNILs) are based on family size. Supplement 1 to ATTACHMENT 2.6-A specifies the MNILs for all covered medically needy groups. If the agency chooses more restrictive levels under section 1902(f) of the Act, Supplement 1 so indicates.

STATE Oklahoma JAN 27 1992
DATE REC'D FEB 28 1992
DATE APPV'D OCT - 1 1991
DATE EFF 92-04
HCFA 179

A

State: Oklahoma

Citation(s)	Condition or Requirement
42 CFR 435.831 and 435.914	4. Handling of Excess Income- Spend-down for the Medically Needy in All States and the Categorically Needy in 1902(f) States Only a. Medically Needy (1) Income in excess of the MNIL is considered as available for payment of medical care and services. The Medicaid agency measures available income for periods of either ___ or ___ month(s) (not to exceed 6 months to determine the amount of excess countable income applicable to the cost of medical care and services. (2) If countable income exceeds the MNIL standard, the agency deducts the following incurred expenses in the following order: (a) Health insurance premiums, deductibles and coinsurance charges. (b) Expenses for necessary medical and remedial care not included in the plan. (c) Expenses for necessary medical and remedial care included in the plan. __ Reasonable limits on amounts expenses deducted from income under a.(2)(a) and (b) above are listed below.
1902(a)(17) of the Act	Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

Citation	Condition or Requirement
	b. Categorically Needy - Section 1902 (f) States
42 CFR 435.732	The agency applies the following policy under the provisions of section 1902(f) of the Act. The following amounts are deducted from income to determine the individual's countable income: (1) Any SSI benefit received. (2) Any State supplement received that is within the scope of an agreement described in sections 1616 or 1634 of the Act, or a State supplement within the scope of section 1902(a)(10)(A)(ii)(XI) of the Act. (3) Increases in OASDI that are deducted under §§435.134 and 435.135 for individuals specified in that section, in the manner elected by the State under that section. (4) Other deductions from income described in this plan at Attachment 2.6-A, Supplement 4. (5) Incurred expenses for necessary medical and remedial services recognized under State law.
1902(a)(17) of the Act, P.L. 100-203	Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APPV'D MAR - 3 1992
DATE EFF OCT - 1 1991
HCFA 179 92-02
A

State: OKLAHOMA

Citation	Condition or Requirement

5. Methods for Determining Resources

a. AFDC-related individuals (except for poverty level related pregnant women, infants, and children).

(1) In determining countable resources for AFDC-related individuals, the following methods are used:

___ The methods under the State's approved AFDC plan

___ The methods under the State's approved AFDC plan and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.

_X_ Not applicable. The agency does not consider resources in determining eligibility.

(2) In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

State: Oklahoma

Citation(s)	Condition or Requirement

5. Methods of Determining Resources

1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r) of the Act

b. Aged individuals. For aged individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, the agency used the following methods for treatment of resources:

___ The methods of the SSI program.

___ SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.

_x_ Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describes the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specifies the more liberal methods.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

This page will sunset effective October 1, 2015.

State: Oklahoma

Citation(s)	Condition or Requirement

5. Methods of Determining Resources

1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r) of the Act

b. Aged individuals. For aged individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, the agency used the following methods for treatment of resources:

_X_ The methods of the SSI program.

___ SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.

___ Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describes the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specifies the more liberal methods.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

This page will be implemented October 1, 2015.

State: Oklahoma

Citation(s)	Condition or Requirement
	In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses.
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B), and 1902(r) of the Act	c. Blind individuals. For blind individuals the agency uses the following methods for treatment of resources. __ The methods of the SSI program. ___ SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A. _x_ Methods that are more restrictive and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describe the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specify the more liberal methods. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

This page will sunset effective October 1, 2015.

State: Oklahoma

Citation(s)	Condition or Requirement
	In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses.
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B), and 1902(r) of the Act	c. Blind individuals. For blind individuals the agency uses the following methods for treatment of resources. _X_ The methods of the SSI program. ___ SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A. ___ Methods that are more restrictive and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describe the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specify the more liberal methods.
	In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

This page will be implemented October 1, 2015.

State: Oklahoma

Citation(s)	Condition or Requirement
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r)(2) of the Act	d. Disabled individuals, including individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act. The agency uses the following methods for the treatment of resources: __ The methods of the SSI program ___ SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. _x_ Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those under the SSI program. More restrictive methods are described in Supplement 5 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8b to ATTACHMENT 2.6-A. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

This page will sunset effective October 1, 2015.

State: Oklahoma

Citation(s)	Condition or Requirement
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r)(2) of the Act	d. Disabled individuals, including individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act. The agency uses the following methods for the treatment of resources: _X_ The methods of the SSI program ___ SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. ___ Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those under the SSI program. More restrictive methods are described in Supplement 5 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8b to ATTACHMENT 2.6-A. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

This page will be implemented October 1, 2015.

State: Oklahoma

Citation(s)	Condition or Requirement

1905(p)(1) (C) and (D) and 1902 (r)(2) of the Act

5. h. For Qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act the agency uses the following methods for treatment of resources.

__ The methods of the SSI program only.

_X_ The methods of the SSI program and/or more liberal methods as described in Supplement 8b to ATTACHMENT 2.6-A. Oklahoma uses the same more restrictive and/or liberal resource methodologies as for all Aged, Blind and Disabled individuals.

1905(s) of the Act

i. For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the agency uses SSI program methods for the treatment of resources.

1902(u) of the Act

j. For Cobra continuation beneficiaries, the agency uses the following methods for treatment of resources:

___ The methods of the SSI program only.

___ More restrictive methods applied under section 1902(f) of the Act as described in Supplement 5 to Attachment 2.6-A.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

This page will sunset effective October 1, 2015.

State: Oklahoma

Citation(s)	Condition or Requirement
1905(p)(1) (C) and (D) and 1902 (r)(2) of the Act	5. h. For Qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act the agency uses the following methods for treatment of resources. __ The methods of the SSI program only. _X_ The methods of the SSI program and/or more liberal methods as described in Supplement 8b to ATTACHMENT 2.6-A.
1905(s) of the Act	i. For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the agency uses SSI program methods for the treatment of resources.
1902(u) of the Act	j. For Cobra continuation beneficiaries, the agency uses the following methods for treatment of resources: ___ The methods of the SSI program only. ___ More restrictive methods applied under section 1902(f) of the Act as described in Supplement 5 to Attachment 2.6-A.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

This page will be implemented October 1, 2015.

State: Oklahoma

Citation(s)	Condition or Requirement

1902(a)(10)(E)(iii) of the Act

k. Specified low-income Medicare beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act--

The agency uses the same method as in 5.h. of Attachment 2.6-A

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

6. Resource Standard- Categorically Needy

a. 1902(f) states (except as specified under items 6.c. and d. below) for aged, blind, and disabled individuals:

_x_ Same as SSI resource Standards.

___ More restrictive

The resource standards for other individuals are the same as those in the related cash assistance program.

b. Non-1902(f) states (except as specified under items 6.c. and d. below)

The resource standards are the same as those in the related cash assistance program.

Supplement 8 to ATTACHMENT 2.6-A specifies for 1902(f) the categorically needy resource levels for all covered categorically needs groups.

This page will sunset effective October 1, 2015.

State: Oklahoma

Citation(s)	Condition or Requirement

1902(a)(10)(E)(iii) of the Act

k. Specified low-income Medicare beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act--

The agency uses the same method as in 5.h. of Attachment 2.6-A

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

6. Resource Standard- Categorically Needy

a. 1902(f) states (except as specified under items 6.c. and d. below) for aged, blind, and disabled individuals:

___ Same as SSI resource Standards.

___ More restrictive

b. Non-1902(f) states (except as specified under items 6.c. and d. below)

The resource standards are the same as those in the related cash assistance program.

Supplement 8 to ATTACHMENT 2.6-A specifies for 1902(f) the categorically needy resource levels for all covered categorically needs groups.

This page will be implemented October 1, 2015.

State: OKLAHOMA

Citation	Condition or Requirement
1902(m)(1)(C) and (m)(2)(B) of the Act	e. For aged and disabled individuals described in section 1902(m)(1) of the Act who are covered under section 1902 (a)(10)(A)(ii)(X) of the Act, the resource standard is: _X_ Same as SSI resource standards. ___ Same as the medically needy resource standards, which are higher than the SSI resource standards (if the State covers the medically needy). Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for these individuals.

[redacted]

State: OKLAHOMA

Citation	Condition or Requirement
1902(a)(10)(C)(i) of the Act	7. Resource Standard - Medically Needy a. Resource standards are based on family size. b. A single standard is employed in determining resource eligibility for all groups. c. In 1902(f) States, the resource standards are more restrictive than in 7.b. above for – _____ Aged _____ Blind _____ Disabled Supplement 2 to Attachment 2.6-A specifies the resource standards for all covered medically needy groups. If the agency chooses more restrictive level under 7.c., Supplement 2 so indicates. The state does not have a medically needy program.
1902(a)(10)(E), 1905(p)(1)(D), 1905(p)(2)(B), and 1860D-14 (a)(3)(D) of the Act	8. Resource Standard – Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries and Qualifying Individuals For Qualified Medicare Beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, Specified Low-Income Medicare Beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act, and Qualifying Individuals covered under 1902(a)(10)(E)(iv) of the Act, the resource standard is three times the SSI resource limit, adjusted annually by the increase in the Consumer Price Index (CPI).
1902(a)(10)(E)(ii) and 1905(s) of the Act	9. Resource Standard – Qualified Disabled and Working Individuals For Qualified Disabled and Working Individuals covered under Section 1902(a)(10)(E)(ii) of the Act, the resource standard for an individual or a couple (in the case of an individual with a spouse) is twice the SSI resource standard.

SUPERSEDES: TN- 00-18

STATE Oklahoma
DATE REC'D. 3-31-10
DATE APP'VD 6-25-10
DATE EFF 1-1-10
HCFA 179 10-11

A

State: OKLAHOMA

Citation	Condition or Requirement
1902(u) of the Act	10. Excess Resources

a. Categorically Needy, Qualified Medicare Beneficiaries, Qualified Disabled and Working Individuals, and Specified Low-Income Medicare Beneficiaries

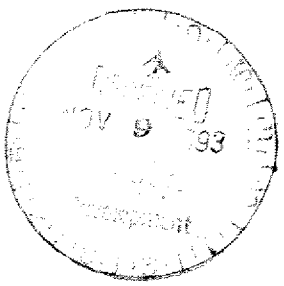
Any excess resources make the individual ineligible.

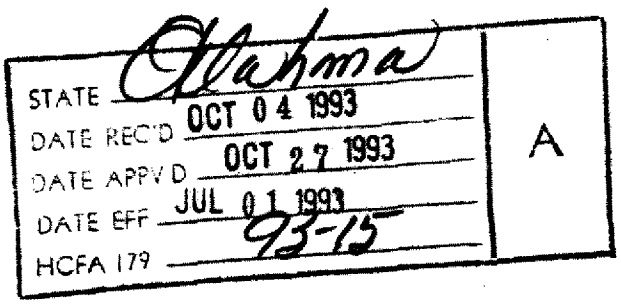
b. Categorically Needy Only

___ This State has a section 1634 agreement with SSI. Receipt of SSI is provided for individuals while disposing of excess resources.

c. Medically Needy

Any excess resources make the individual ineligible.





Citation	Condition or Requirement

42 CFR 435.914

11. Effective Date of Eligibility

a. Groups Other Than Qualified Medicare Beneficiaries

(1) For the prospective period.

Coverage is available for the full month if the following individuals are eligible at any time during the month.

X Aged, blind, disabled.
X AFDC-related.

Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements.

___ Aged, blind, disabled.
___ AFDC-related.

(2) For the retroactive period.

Coverage is available for three months before the date of application if the following individuals would have been eligible had they applied:

___ Aged, blind, disabled.
___ AFDC-related.

Coverage is available beginning the first day of the third month before the date of application if the following individuals would have been eligible at any time during that month, had they applied..

X Aged, blind, disabled.
X AFDC-related.

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APP'D MAR - 3 1992
DATE EFF OCT - 1 1991
HCFA 179 92-02

A

Citation	Condition or Requirement
[redacted]	
1902(e)(8) and 1905(a) of the Act	/X/ b. For qualified Medicare beneficiaries defined in section 1905(p)(1) of the Act, coverage is available beginning with the first day of the month after the month in which the individual is first determined to be a qualified Medicare beneficiary under section 1905(p)(1). The eligibility determination is valid for-- /X/ 12 months / / 6 months / / ___ months (no less than 6 months and no more than 12 months)

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APPV'D MAR - 3 1992
DATE EFF OCT - 1 1991
HCFA 179 92-02
A

Citation	Condition or Requirement
1902(a)(18) and 1902(f) of the Act	12. Pre-OBRA 93 Transfer of Resources - Categorically and Medically Needy, Qualified Medicare Beneficiaries, and Qualified Disabled and Working Individuals The agency complies with the provisions of section 1917 of the Act with respect to the transfer of resources. Disposal of resources at less than fair market value affects eligibility for certain services as detailed in Supplement 9 to Attachment 2.6-A.
1917(c)	13. Transfer of Assets - All eligibility groups The agency complies with the provisions of section 1917(c) of the Act, as enacted by OBRA 93, with regard to the transfer of assets. Disposal of assets at less than fair market value affects eligibility for certain services as detailed in Supplement 9(a) to ATTACHMENT 2.6-A, except in instances where the agency determines that the transfer rules would work an undue hardship.
1917(d)	14. Treatment of Trusts - All eligibility groups The agency complies with the provisions of section 1917(d) of the Act, as amended by OBRA 93, with regard to trusts. ____ The agency uses more restrictive methodologies under section 1902(f) of the Act, and applies those methodologies in dealing with trusts; _X_ The agency meets the requirements in section 1917(d)(4)(B) of the Act for use of Miller trusts. The agency does not count the funds in a trust in any instance where the agency determines that the transfer would work an undue hardship, as described in Supplement 10 to ATTACHMENT 2.6-A.

STATE Oklahoma
DATE REC'D 03-31-95
DATE APPV'D 06-20-95
DATE EFF 01-01-95
HCFA 179 95-09
A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: OKLAHOMA

OPTIONAL CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO THE SUPPLEMENTAL SECURITY INCOME (SSI) FEDERAL BENEFIT RATE

1. Individuals in institutions who are eligible under a special income level (42 CFR 435.231) (I think this is 42 CFR 435.236) bjs (231) is no longer in CFR bjs 1999

435.1008 & 1000

X The State allows eligibility for individuals with income that does not exceed 300 percent of the SSI Federal benefit rate.

___ The State has elected to allow eligibility for individuals with income at an amount lower than 300 percent of the SSI Federal benefit rate.

Effective Date:	Amount
_____	$_____

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APP'V'D MAR - 3 1992
DATE EFF OCT - 1 1991
HCFA 179 92-02

A

New 10-01-91

TN NO. 92-02
Supersedes
TN No. New Page

Approval Date MAR - 3 1992 Effective Date: OCT - 1 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: OKLAHOMA

INCOME ELIGIBILITY LEVELS (Continued)

3. Aged and Disabled Individuals

The levels for determining income eligibility for groups of aged and disabled individuals under the provisions of Section 1902 (m)(1) of the Act are as follows:

Based on 100 percent of the official Federal income poverty line.

Family Size	Income Level
1	$_____*
2	$_____*
3	$_____*
4	$_____*
5	$_____*

(*as published annually)

STATE Oklahoma DATE REC'D 12-22-00 DATE APPV'D 3-22-01 DATE EFF 11-01-00 HCFA 179 00-18	A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: OKLAHOMA

INCOME ELIGIBILITY LEVELS (Continued)

C. QUALIFIED MEDICARE BENEFICIARIES WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

The levels for determining income eligibility for groups of qualified Medicare beneficiaries under the provisions of section 1905(p)(2)(A) of the Act are as follows:

a. Based on the following percent of the official Federal income poverty level:

Eff. Jan 1, 1989: ☐ 85 percent ☒ 90 percent (no more than 100)

Eff. Jan 1, 1990: ☒ 90 percent ☐ ___percent (no more than 100)

Eff. Jan 1, 1991: 100 percent

Eff. Jan 1, 1992: 100 percent

b. Levels:

*

CA. QUALIFIED DISABLED WORKING INDIVIDUALS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

As of July 1990, the levels for determining income eligibility for groups of qualified disabled working individuals under the provisions of section 1905(s) of the Act are 200% of federal poverty level.

*

STATE Oklahoma
DATE REC'D MAY 26 1995
DATE APPV'D AUG 24 1995
DATE EFF APR 01 1995
HCFA ID 95-10
A

Revised 04-01-95

TN No. 95-10
Supersedes TN No. 94-04
Approval Date AUG 24 1995
Effective Date APR 01 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: OKLAHOMA

INCOME LEVELS (Continued)

D. MEDICALLY NEEDY

___ Applicable to all groups. ____ Applicable to all groups except those specified below. Excepted group income levels are also listed on an attached page 3.

(1) Family Size	(2) Net income level protected for maintenance for one month __urban only ___ urban & rural	(3) Amount by which Column (2) exceeds limits specified in 42 CFR 435.1007*	(4) Net income level for persons living in rural areas for ____months	(5) Amount by Column (4) exceeds limits specified in 42 CFR 435.1007*
1	$	$	$	$
2	$	$	$	$
3	$	$	$	$
4	$	$	$	$
For each additional person, add:	$	$	$	$

*The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

STATE Oklahoma
DATE REC'D 3-26-03
DATE APPV'D 6-17-03
DATE EFF 2-1-03
HCFA 179 OK 03-07

A

SUPERSEDES: TN- 95-16

Revised 02-01-03

TN# 03-07 Approval Date 6-17-03 Effective Date 2-1-03
Supersedes
TN# 95-16

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: OKLAHOMA

INCOME LEVELS (Continued)

D. MEDICALLY NEEDY

(1) Family Size	(2) Net income level protected for maintenance for one month ___ urban only ___ urban & rural	(3) Amount by which Column (2) exceeds limits specified in 42 CFR 435.1007*	(4) Net income level for persons living in rural areas for ___months	(5) Amount by which Column (4) exceeds limits specified in 42 CFR 435.1007*
5	$	$	$	$
6	$	$	$	$
7	$	$	$	$
8	$	$	$	$
9	$	$	$	$
10	$	$	$	$
For each additional person, add:	$ 50.00	$	$	$

*The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

SUPERSEDES: TN- 95-16

STATE Oklahoma
DATE REC'D 3-26-03
DATE APPV'D 6-17-03
DATE EFF 2-1-03
HCFA 179 OK 03-07

A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Oklahoma

b. Aged and Disabled Individuals

☐ Same as SSI resource levels.

☐ More restrictive than SSI levels and are as follows:

Family Size	Resource Level
1	
2	
3	
4	
5	

☐ Same as medically needy resource levels (applicable only if State has a medically needy program

Not applicable.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

This page will sunset effective October 1, 2015.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Oklahoma

b. Aged and Disabled Individuals

☒ Same as SSI resource levels.

☐ More restrictive than SSI levels and are as follows:

Family Size	Resource Level
1	
2	
3	
4	
5	

☐ Same as medically needy resource levels (applicable only if State has a medically needy program

Not applicable.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January 2015
Transmittal Number: 14-0027

This page will be implemented October 1, 2015.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: OKLAHOMA

RESOURCE LEVELS (Continued)

APPLICABLE TO ALL GROUPS

B. MEDICALLY NEEDY

Family Size	Resource Level
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

For each additional person:

NOT APPLICABLE

STATE Oklahoma
DATE REC'D 3-26-03
DATE APPV'D 6-17-03
DATE EFF 2-1-03
HCFA 179 OK 03-07

A

SUPERSEDES: TN- 97-20

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Oklahoma

METHODS FOR TREATMENT OF INCOME THAT DIFFER
FROM THOSE OF THE SSI PROGRAM

(Section 1902(f) more restrictive methods and criteria and State supplement criteria in SSI criteria States without section 1634 agreements and in section 1902(f) States. Use to reflect more liberal methods only if you limit to State supplement recipients.DO NOT USE this supplement to reflect more liberal policies that you elect under the authority of section l902(r)(2) of the Act. Use Supplement 8a for section 1902(r)(2) methods.)

Oklahoma does not allow the $20.00 SSI unearned income disregard.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

This page will sunset effective October 1, 2015.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Oklahoma

MORE RESTRICTIVE METHODS OF TREATING RESOURCES THAN THOSE
OF THE SSI PROGRAM – Section 1902(f) States Only

Irrevocable Burial Contracts. When an applicant elects to make an irrevocable burial contract or applies for assistance on or after November 1, 2009, the amount in any combination of an irrevocable burial contract, revocable prepaid burial contract/trust and the face value of life insurance policies which is in excess of $10,000.00 will render the applicant ineligible for Medicaid.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

This page will sunset effective October 1, 2015.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: OKLAHOMA

METHODS FOR TREATMENT OF RESOURCES FOR INDIVIDUALS
WITH INCOMES RELATED TO FEDERAL POVERTY LEVELS

(Do not complete if you are electing more liberal methods under the authority of section 1902(r)(2) of the Act instead of the authority specific to Federal poverty levels. Use Supplement 8b for section 1902(r)(2) methods.)

*

Revised 07-01-93

TN No. 93-13
Supersedes TN No. 92-02
Approval Date SEP 08 1993
Effective Date JUL 01 1993

HCFA ID: 7985E

STATE Oklahoma
DATE REC'D AUG 18 1993
DATE APPV'D SEP 08 1993
DATE EFF JUL 01 1993
HCFA 179 93-13
A

State: OKLAHOMA

Supplement 6 to Attachment 2.6-A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STANDARDS FOR OPTIONAL STATE SUPPLEMENTARY PAYMENTS

Payment Category (Reasonable Classification)	Administered by		Income Level				Income Disregards Employed
			Gross		Net		
	Federal	State	1 Person	Couple	1 Person	Couple	
(1)	(2)		(3)		(4)		(5)
Aged		X	Does not exceed 300% of SSI FBR		$716	$1095	SSI
Blind		X	Does not exceed 300% of SSI FBR		$716	$1095	SSI
Disabled		X	Does not exceed 300% of SSI FBR		$716	$1095	SSI

SUPERSEDES: TN- 09-02

STATE Oklahoma
DATE REC'D. 2-12-10
DATE APPV'D 5-12-10
DATE EFF 2-1-10
HCFA 179 10-06

A

Revised 02-01-10

TN# 10-06 Approval Date 5-12-10 Effective Date 2-1-10
Supersedes
TN# 09-02

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Oklahoma

INCOME LEVELS FOR 1902(f) STATES - CATEGORICALLY NEEDY
WHO ARE COVERED UNDER REQUIREMENTS MORE RESTRICTIVE THAN SSI

Payment Category Reasonable Classification	Income Level		Income Disregards Employed
	1 Person	Couple	
Aged	$674	$1011	SSI
Blind	$674	$1011	SSI
Disabled	$674	$1011	SSI

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

This page will sunset effective October 1, 2015.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Oklahoma

RESOURCE STANDARDS FOR 1902(F) STATES- CATEGORICALLY NEEDY

Family Size	Resource Level
1	$2000.00
2	3000.00
3	3100.00
4	3200.00
5	3300.00
6	3400.00
7	3500.00
8	3600.00
9	3700.00
10	3800.00

For each additional person $100.00

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

This page will sunset effective October 1, 2015.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Oklahoma

RESOURCE STANDARDS FOR 1902(F) STATES- CATEGORICALLY NEEDY

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State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

This page will be implemented October 1, 2015.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: OKLAHOMA

**MORE LIBERAL METHODS OF TREATING INCOME
UNDER SECTION 1902(r)(2) OF THE ACT**

All wages paid by the Census Bureau for temporary employment related to Census activities are excluded as income for the eligibility groups listed below:

[redacted]

- 1902(a)(10)(A)(i)(VI) – Poverty level children under age 6 (133% FPL).
- 1902(a)(10)(A)(i)(VII) – Poverty level children under age 19 (100% FPL).
- 1905(p) – QMBs.
- 1902(a)(10)(E)(iii) – SLMBs.
- 1902(a)(10)(E)(iv)(I) – QIs.

TN# 08-16 Approval Date DEC 19 2008 Effective Date [illegible]
Supersedes
TN# None-Was Page

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Oklahoma

MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER SECTION 1902(r)(2) OF THE ACT.

_x___ Section 1902(f) ___ Non-Section 1902(f) State

This methodology applies to the poverty level group (100% of FPL), at 1902(a)(10)(A)(ii)(X) who are described in 1902(m)(1). The state disregards the difference between $2,000.00 for individuals and $3,000 for couples and the QMB resource levels for individuals and couples, as appropriate.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

This page will sunset effective October 1, 2015.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Oklahoma

MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER SECTION 1902(r)(2) OF THE ACT.

____ Section 1902(f) __X__ Non-Section 1902(f) State

This methodology applies to the poverty level group (100% of FPL), at 1902(a)(10)(A)(ii)(X) who are described in 1902(m)(1). The state disregards the difference between $2,000.00 for individuals and $3,000 for couples and the QMB resource levels for individuals and couples, as appropriate.

State: Oklahoma
Date Received: 22 August, 2014
Date Approved: 1 May, 2015
Date Effective: 1 January, 2015
Transmittal Number: 14-0027

This page will be implemented October 1, 2015.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Oklahoma

STATE LONG-TERM CARE INSURANCE PARTNERSHIP

1902(R)(2)
1917(b)(1)(C)

The following more liberal methodology applies to individuals who are eligible for medical assistance under one of the following eligibility groups:

1902(a)(10)(A)(ii)(V)

An individual who is a beneficiary under a long-term care insurance policy that meets the requirements of a "qualified State long-term care insurance partnership" policy (partnership policy) as set forth below, is given a resource disregard as described in this amendment. The amount of the disregard is equal to the amount of the insurance benefit payments made to or on behalf of the individual. The term "long-term care insurance policy" includes a certificate issued under a group insurance contract.

X

The State Medicaid Agency (agency) stipulates that the following requirements will be satisfied in order for a long-term care policy to qualify for a disregard. Where appropriate, the Agency relies on attestations by the State Insurance Commissioner (Commissioner) or other State official charged with regulation and oversight of insurance policies sold in the state, regarding information within the expertise of the State's Insurance Department.

- The policy is a qualified long-term care insurance policy as defined in section 7702B(b) of the Internal Revenue Code of 1986.

- The policy meets the requirements of the long-term care insurance model regulation and long-term care insurance model Act promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000) as those requirements are set forth in section 1917(b)(5)(A) of the Social Security Act.

New Page 07-14-08

STATE Oklahoma
DATE REC'D 11-28-07
DATE APP'VD 1-10-08
DATE EFF 7-14-08
HCFA 179 07-16

A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Oklahoma

STATE LONG-TERM CARE INSURANCE PARTNERSHIP

- The policy, if issued in this State, was issued no earlier than the effective date of this State plan amendment.

- The insured individual was a resident of a Partnership State when coverage first became effective under the policy. If the policy is later exchanged for a different long-term care policy, the individual was a resident of a Partnership State when coverage under the earliest policy became effective.

- The policy meets the inflation protection requirements set forth in section 1917(b)(1)(C)(iii)(IV) of the Social Security Act.

- The Commissioner requires the issuer of the policy to make regular reports to the Secretary that include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.

- The State does not impose any requirement affecting the terms or benefits of a partnership policy that the state does not also impose on non-partnership policies.

- The State Insurance Department assures that any individual who sells a partnership policy in Oklahoma receives training, and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.

- The Agency provides information and technical assistance to the Oklahoma Insurance Department regarding the training described above.

New Page 07-14-08

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: OKLAHOMA

TRANSFER OF RESOURCES

1902(f) and 1917 of the Act

The agency provides for the denial of eligibility by reason of disposal of resources for less than fair market value.

A. Except as noted below, the criteria for determining the period of ineligibility are the same as criteria specified in section 1613(c) of the Social Security Act (Act).

1. Transfer of resources other than the home of an individual who is an inpatient in a medical institution.

a. ☑ The agency uses a procedure which provides for a total period of ineligibility greater than 24 months for individuals who have transferred resources for less than fair market value when the uncompensated value of disposed of resources exceeds $12,000. This period bears a reasonable relationship to the uncompensated value of the transfer. The computation of the period and the reasonable relationship of this period to the uncompensated value is described as follows:

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APPV'D MAR - 3 1992
DATE EFF OCT - 1 1991
HCFA 179 TB-22
A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: OKLAHOMA

b. ☑ The period of ineligibility is less than 24 months, as specified below:

c. ☑ The agency has provisions for waiver of denial of eligibility in any instance where the State determines that a denial would work an undue hardship.

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APP'D MAR - 3 1992
DATE EFF OCT - 1 1991
HCFA 179 92-02
A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: OKLAHOMA

2. Transfer of the home of an individual who is an inpatient in a medical institution.

☑ A period of ineligibility applies to inpatients in an SNF, ICF or other medical institution as permitted under section 1917(c)(2)(B)(i).

a. Subject to the exceptions on page 2 of this supplement, an individual is ineligible for 24 months after the date on which he disposed of the home. However, if the uncompensated value of the home is less than the average amount payable under this plan for 24 months of care in an SNF, the period of ineligibility is a shorter time, bearing a reasonable relationship (based on the average amount payable under this plan as medical assistance for care in an SNF) to the uncompensated value of the home as follows:

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APP'D MAR - 3 1992
DATE EFF OCT - 1 1991
HCFA 179 92-02
A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: OKLAHOMA

b. ☑ Subject to the exceptions on page 2 of this supplement, if the uncompensated value of the home is more than the average amount payable under this plan as medical assistance for 24 months of care in an SNF, the period of ineligibility is more than 24 months after the date on which he disposed of the home. The period of ineligibility bears a reasonable relationship (based upon the average amount payable under this plan as medical assistance for care in an SNF) to the uncompensated value of the home as follows:

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APP'D MAR - 3 1992
DATE EFF OCT - 1 1991
HCFA 179 92-02
A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: OKLAHOMA

No individual is ineligible by reason of item A.2 if--

(i) A satisfactory showing is made to the agency (in accordance with any regulations of the Secretary of Health and Human Services) that the individual can reasonably be expected to be discharged from the medical institution and to return to that home;

(ii) Title to the home was transferred to the individual's spouse or child who is under age 21, or (for States eligible to participate in the State program under title XVI of the Social Security Act) is blind or permanently and totally disabled or (for States not eligible to participate in the State program under title XVI of the Social Security Act) is blind or disabled as defined in section 1614 of the Act;

(iii) A satisfactory showing is made to the agency (in accordance with any regulations of the Secretary of Health and Human Services) that the individual intended to dispose of the home either at fair market value or for other valuable consideration; or

(iv) The agency determines that denial of eligibility would work an undue hardship.

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APPV'D MAR - 3 1992
DATE EFF OCT - 1 1991
HCFA 179 92-02
A

State OKLAHOMA

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

3. 1902(f) States

[X] Under the Provisions of section 1902(f) of the Social Security Act Act, the following transfer of resource criteria more restrictive than those established under section 1917(c) of the Act, apply:

a. Effective July 1, 1988, no period of ineligibility will be imposed on an individual for uncompensated transfers unless the individual is institutionalized (institutionalized means the individual resides in a nursing facility, intermediate care facility for the mentally retarded or is receiving waiver services) and transferred resources without compensation 30 months prior to institutionalization, if a Medicaid recipient at the beginning of institutionalization, or 30 months prior to application, if not Medicaid eligible at the beginning of institutionalization.

i. The agency uses a procedure which provides for a period of ineligibility (whole number of months) that will be the lesser of:

(a) 30 months, or

(b) a number of months equal to the uncompensated value of the transferred resources divided by the average monthly cost to a private patient in a NF in Oklahoma. Any remainder from the division will be disregarded.

ii. No individual is ineligible by the above reasons if:

(a) the transfer was prior to July 1, 1988;

(b) the resource transferred was a home and title to the home was transferred to:

(i) the spouse;

(ii) the individual's child under age 21 or who is blind or totally disabled (SSA/SSI definition);

STATE Oklahoma
DATE REC'D 1-4-94
DATE APPV'D 2-3-94
DATE EFF 10-1-93
HCFA 179 93-24
A

State OKLAHOMA

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

(iii) a sibling who has equity interest in the home and resided in the home for at least one year prior to the individual's institutionalization; or

(iv) the individual's son or daughter who resided in the home, and provided care, for at least two years prior to the individual's institutionalization

(c) The individual can show satisfactorily that the intent was to dispose of resources at fair market value or that the transfer was for a purpose other than eligibility.

(d) The transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's resource allowance.

(e) The resource was transferred to the individual's minor child who is blind or totally disabled (SSA/SSI definition).

(f) The resource was transferred to the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the resources are not subsequently transferred to still another person for less than fair market value.

(g) The denial would result in undue hardship.

b. Effective for services provided on and after October 1, 1993, and with respect to transfers of assets on and after August 11, 1993, the transfer of assets provisions are as follows:

i. For an institutionalized individual, the look-back date is 36 months before the first day the individual is both institutionalized and has applied for medical assistance. However, in the case of payments from a trust or portions of a trust that are treated as transfers of assets, the look back date is 60 months.

ATE Oklahoma
ATE REC'D 1-4-94
ATE APP'D 2-3-94
ATE EFF 10-1-93
CFA 179 93-24

A

Revised 10-01-93

TN# 93-24 Approval Date 2/3/94 Effective Date 10/1/93
Supersedes
TN# 92-02

State OKLAHOMA

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

ii. The penalty period begins the first day of the first month during or after which assets have been transferred and which does not occur in any other period of ineligibility due to an asset transfer. When there have been multiple transfers, all transferred assets are added together to determine the penalty.

iii. The penalty period consists of a period of ineligibility (whole number of months) determined by dividing the total uncompensated value of the assets by the average monthly cost to a private patient in a nursing facility in Oklahoma. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.

iv. Assets are defined as all income and resources of the individual and the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action:

(a) by the individual or such individual's spouse;

(b) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse; or

(c) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.

v. A penalty would not apply if:

(a) The title to the individual's home was transferred to:

(i) the spouse;

STATE Oklahoma
DATE REC'D 1-4-94
DATE APPV'D 2-3-94
DATE EFF 10-1-93
CFA 179 93-24

A

State OKLAHOMA

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

(ii) the individual's child under age 21 who is blind or totally disabled (SSA/SSI definition);

(iii) a sibling who has equity interest in the home and resided in the home for at least one year prior to the institutionalization of the individual;

(iv) the individual's son or daughter who resided in the home and provided care for at least two years prior to the individual's institutionalization.

(b) The individual can show satisfactorily that the intent was to dispose of assets at fair market value or that the transfer was exclusively for a purpose other than eligibility. It is presumed that any transfer of assets made for less than fair market value was made in order to qualify the individual for Medicaid. In order to rebut this presumption, the individual must present compelling evidence that a transfer was made for reasons other than to qualify for Medicaid. It is not sufficient for an individual to claim that assets were transferred solely for the purposes of allowing another to have them with ostensibly no thought of Medicaid if the individual qualifies for Medicaid as a result of the transfer.

(c) The transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's asset allowance.

(d) The asset was transferred to the individual's minor child who is blind or totally disabled (SSA/SSI definition). The transfer may be to a trust established for the benefit of the individual's child.

STATE Oklahoma
DATE REC'D 1-4-94
DATE APPV'D 2-3-94
DATE EFF 10-1-93
HCFA 179 93-24

A

New 10-01-93

TN# 93-24 Approval Date 2/3/94 Effective Date 10/1/93
Supersedes
TN# One New Page

State OKLAHOMA

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

(e) The asset was transferred to or from the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the assets are not subsequently transferred to still another person for less than fair market value.

(f) The asset is transferred to a trust established solely for the benefit of a disabled individual under the age of 65.

(g) The denial would result in undue hardship.

STATE Oklahoma
DATE REC'D 1-4-94
DATE APPV'D 2-3-94
DATE EFF 10-1-93
HCFA 179 93-24

A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: OKLAHOMA

TRANSFER OF ASSETS

1917(c) The agency provides for the denial of certain Medicaid services by reason of disposal of assets for less than fair market value.

1. Institutionalized individuals may be denied certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

The agency withholds payment to institutionalized individuals for the following services:

Payments based on a level of care in a nursing facility;

Payments based on a nursing facility level of care in a medical institution;

Home and community-based services under a 1915 waiver.

2. Non-institutionalized individuals:

___ The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive than those set forth in section 1905(a) of the Social Security Act:

The agency withholds payment to non-institutionalized individuals for the following services:

Home health services (section 1905(a)(7));

Home and community care for functionally disabled and elderly adults (section 1905(a)(22));

Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(24).

___ The following other long-term care services for which medical assistance is otherwise under the agency plan:

STATE Oklahoma	A
DATE REC'D 03-31-95	
DATE APP'D 06-20-95	
DATE EFF 01-01-95	
HCFA 179 95-09	

New 01-01-95

TN No. 95-09
Supersedes Approval Date 6/20/95 Effective Date 1/1/95
TN No. ~~SUPERSEDES~~: NONE - NEW PAGE

State: OKLAHOMA

TRANSFER OF ASSETS

3. Penalty Date--The beginning date of each penalty period imposed for an uncompensated transfer of assets is:

X the first day of the month in which the asset was transferred;

___ the first day of the month following the month of transfer.

4. Penalty Period - Institutionalized Individuals--
In determining the penalty for an institutionalized individual, the agency uses:

X the average monthly cost to a private patient of nursing facility services in the ~~agency~~ State;

___ the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized.

5. Penalty Period - Non-institutionalized Individuals--
The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services;

___ imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

STATE Oklahoma DATE RECD 03-31-95 DATE APPVD 06-20-95 DATE EFF 01-01-95 HCFA 179 95-09	A

State: OKLAHOMA

TRANSFER OF ASSETS

6. Penalty period for amounts of transfer less than cost of nursing facility care--

a. Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency:

_X_ does not impose a penalty;

___ imposes a penalty for less than a full month, based on the proportion of the agency's private nursing facility rate that was transferred.

b. Where an individual makes a series of transfers, each less than the private nursing facility rate for a month, the agency:

___ does not impose a penalty;

_X_ imposes a series of penalties, each for less than a full month.

7. Transfers made so that penalty periods would overlap--
The agency:

_X_ totals the value of all assets transferred to produce a single penalty period;

___ calculates the individual penalty periods and imposes them sequentially.

8. Transfers made so that penalty periods would not overlap--
The agency:

_X_ assigns each transfer its own penalty period;

___ uses the method outlined below:

STATE Oklahoma
DATE REC'D 03-31-95
DATE APPV'D 06-20-95
DATE EFF 01-01-95
HCFA 179 95-09
A

Revision: HCFA-PM-95-1 (MR) Corrected
March 1995 SUPPLEMENT 9(a) to ATTACHMENT 2.6-A
Page 4

State: OKLAHOMA

TRANSFER OF ASSETS

9. Penalty periods - transfer by a spouse that results in a penalty period for the individual—

(a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

Penalty will be assessed as outlined in OAC 317:35-9-66 (4) (L) which states "when a transfer of assets by the spouse of an individual and the spouse who made such transfer subsequently becomes institutionalized, the period of ineligibility will be apportioned between the two institutionalized spouses."

(b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

10. Treatment of income as an asset—
When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

___ The agency will impose partial month penalty periods.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

___ For transfers of individual income payments, the agency will impose partial month penalty periods.

_X_ For transfers of the right to an income stream, the agency will use the actuarial value of all payments transferred.

___ The agency uses an alternate method to calculate penalty periods, as described below:

TN No. 95-09 Supersedes Approval Date 6/20/95 Effective Date 4/1/95
TN No SUPERSEDES: NONE - NEW PAGE

Now 01-01-95

STATE Oklahoma
DATE RECD 03-31-95
DATE APPVD 06-20-95
DATE EFF 01-01-95
HCFA 179 95-09

P.04 A

State: OKLAHOMA

TRANSFER OF ASSETS

11. Imposition of a penalty would work an undue hardship--
The agency does not apply the transfer of assets provisions in any case in which the agency determines that such an application would work an undue hardship. The agency will use the following procedures in making undue hardship determinations:

State Medicaid Manual Section 3258.10, Item 5, 3-3-109.22 will be followed, which references the following administrative requirements:

- Notice to recipients that an undue hardship exception exists;
- a timely process for determining whether an undue hardship waiver will be granted;
- a process under which an adverse determination can be appealed.

STATE Oklahoma	A
DATE RECD 03-31-95	
DATE APPVD 06-30-95	
DATE EFF 01-01-95	
HCFA 179 95-09	

The following criteria will be used to determine whether the agency will not count assets transferred because the penalty would work an undue hardship:

Decisions for undue hardship are made by Program Specialist in Department of Human Services.

Aspects considered are:

1. Was asset ever in the control of the client?
2. Does action create actual undue hardship versus inconvenience (i.e., will client be denied food, clothing, shelter, etc.)?
3. Have avenues such as referral for Adult Protective Services (APS) been explored and/or can legal action be taken on APS referral?
4. Are there any other verifiable legal impediments to prevent return of Transfer of Assets?

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: OKLAHOMA

TRANSFER OF ASSETS

1917(c) FOR TRANSFERS OF ASSESTS FOR LESS THAN FAIR MARKET VALUE MADE ON OR AFTER FEBRUARY 8, 2006, the agency provides for the denial of certain Medicaid services.

1. Institutionalized individuals are denied coverage of certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

   The agency does not provide medical assistance coverage for institutionalized individuals for the following services:

   Nursing facility services;

   Nursing facility level of care provided in a medical institution;

   Home and community-based services under a 1915(c) or (d) waiver.

STATE Oklahoma DATE REC'D 1-5-06 DATE APPV'D 8-22-07 DATE EFF 2-8-06 HCFA 179 06-04	A

SUPERSEDES: NONE - NEW PAGE

New Page 02-08-06

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: OKLAHOMA

TRANSFER OF ASSETS

2. Non-institutionalized individuals:

___ The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive than those set forth in section 1905(a) of the Social Security Act.

The agency withholds payment to non-institutionalized individuals for the following services:

Home health services (section 1905(a)(7));

Home and community care for functionally disabled elderly adults (section 1905(a)(22));

Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(24).

___ The following other long-term care services for which payment for medical assistance is otherwise made under the agency plan.

STATE Oklahoma DATE REC'D 4-5-06 DATE APP'D 8-22-07 DATE EFF 2-8-06 HCFA 179 06-04	A

SUPERSEDES: NONE - NEW PAGE

New Page 02-08-06

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: OKLAHOMA

TRANSFER OF ASSETS

3. Penalty Date - The beginning date of each penalty period imposed for an uncompensated transfer of assets is the later of:

- the first day of a month during or after which assets have been transferred for less than fair market value;

_X_ The State uses the first day of the month in which the assets were transferred

____ The State uses the first day of the month after the month in which the assets were transferred

or

- the date on which the individual is eligible for medical assistance under the State plan and is receiving institutional level of care services described in paragraphs 1 and 2 that, were it not for the imposition of the penalty period, would be covered by Medicaid;

AND

which does not occur during any other period of ineligibility for services by reason of a transfer of assets penalty.

STATE Oklahoma DATE REC'D 4-5-06 DATE APP'V'D 8-22-07 DATE EFF 2-8-06 HCFA 179 06-04	A

SUPERSEDES: NONE - NEW PAGE

New Page 02-08-06

SUPERSEDES: NONE - NEW PAGE

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: OKLAHOMA

TRANSFER OF ASSETS

4. Penalty Period – Institutionalized Individuals –
In determining the penalty for an institutionalized individual, the agency uses:

X the average monthly cost to a private patient of nursing facility services in the State at the time of application;

___ the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized at the time of application.

5. Penalty Period – Non-institutionalized Individuals—
The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services;

___ imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

6. Penalty period for amounts of transfer less than cost of nursing facility care—

X Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency imposes a penalty for less than a full month, based on the option selected in item 4.

X The state adds together all transfers for less than fair market value made during the look-back period in more than one month and calculates a single period of ineligibility, that begins on the earliest date that would otherwise apply is the transfer had been made in a single lump sum.

STATE Oklahoma
DATE REC'D 4-5-06
DATE APP'D 8-22-07
DATE EFF 2-8-06
HCFA 179 06-04
A

SUPERSEDES: NONE - NEW PAGE

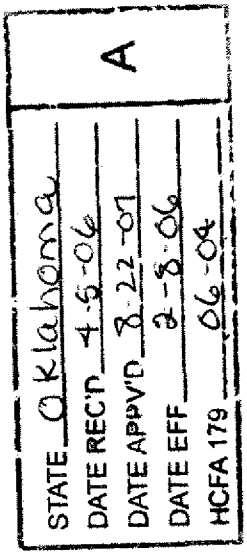
New Page 02-08-06

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: OKLAHOMA

TRANSFER OF ASSETS

7. Penalty periods – transfer by a spouse that results in a penalty period for the individual –



(a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

Penalty will be assessed as outlined in OAC 317:35 which states "when a transfer of assets by the spouse of an individual results in a period of ineligibility and the spouse who made such transfer subsequently becomes institutionalized, the period of ineligibility will be apportioned between the two institutionalized spouses."

(b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

8. Treatment of a transfer of income --

When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

X For transfers of individual income payments, the agency will calculate the penalty period on the lump sum value.

X For transfers of the right to an income stream, the agency will base the penalty period on the combined actuarial value of all payments transferred.

SUPERSEDES: NONE - NEW PAGE New Page 02-08-06

SUPERSEDES: NONE - NEW PAGE

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: OKLAHOMA

TRANSFER OF ASSETS

9. Imposition of a penalty would work an undue hardship –

The agency does not impose a penalty for transferring assets for less than fair market value in any case in which the agency determines that such imposition would work an undue hardship. The agency will use the following criteria in making undue hardship determinations:

Application of a transfer of assets penalty would deprive the individual:

(a) Of medical care such that the individual's health or life would be endangered; or

(b) Of food, clothing, shelter, or other necessities of life.

10. Procedures for Undue Hardship Waivers

The agency has established a process under which hardship waivers may be requested that provides for:

(a) Notice to a recipient subject to a penalty that an undue hardship exception exists;

(b) A timely process for determining whether an undue hardship waiver will be granted; and

(c) A process, which is described in the notice, under which an adverse determination can be appealed.

These procedures shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the individual's personal representative.

STATE Oklahoma
DATE REC'D 7-5-06
DATE APPV'D 8-22-07
DATE EFF 2-8-06
HCFA 179 06-04

A

New Page 02-08-06

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: OKLAHOMA

TRANSFER OF ASSETS

11. Bed Hold Waivers For Hardship Applicants

The agency provides that while an application for an undue hardship waiver is pending in the case of an individual who is a resident of a nursing facility:

___ Payments to the nursing facility to hold the bed for the individual will be made for a period not to exceed ____ days (may not be greater than 30).

SUPERSEDES: NONE - NEW PAGE

STATE Oklahoma
DATE REC'D 4-5-06
DATE APPV'D 8-22-07
DATE EFF 2-8-06
HCFA 179 06-04

A

New Page 02-08-06

Revision: HCFA-PM-95-1 (MB)
March 1995

Corrected
SUPPLEMENT 10 to ATTACHMENT 2.6-A
Page 1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: OKLAHOMA

The agency does not apply the trust provisions in any case in which the agency determines that such application would work an undue hardship.

The following criteria will be used to determine whether the agency will not count assets transferred because doing so would work an undue hardship:

See criteria on lower half of Supplement 9(a) to Attachment 2.6-A, Page 5.

STATE Oklahoma
DATE REC'D 03-31-95
DATE APPV'D 06-26-95
DATE EFF 01-01-95
HCFA 179 95-09
A

Under the agency's undue hardship provisions, the agency exempts the funds in an irrevocable burial trust.

The maximum value of the exemption for an irrevocable burial trust is $ N/A .

TN No. 95-09 Revised 01-01-95
Supersedes TN No. 92-02 Approval Date 6/20/95 Effective Date 1/1/95

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: OKLAHOMA

SECTION 1924 PROVISIONS

A. Income and resource eligibility policies used to determine eligibility for institutionalized individuals who have spouses living in the community are consistent with Section 1924.

B. In the determination of resource eligibility the State resource standard is $ 25,000.00 .

C. The definition of undue hardship for purposes of determining if institutionalized spouses receive Medicaid in spite of having excess countable resources is described below:

The countable resources are under the control of community spouse and the community spouse refuses to use the resources for the care of the institutionalized spouse. This refusal places the institutionalized spouse in a life endangering situation with no alternative for care available.

STATE Oklahoma	A
DATE REC'D 12-22-89	
DATE APPV'D 2-11-92	
DATE EFF 10-1-89	
HCFA 179 89-23	

New 10-01-89

TN NO. 89-23 Approval Date 2/11/92 Effective Date 10/1/89

Supersedes TN No. None New Page

State OKLAHOMA

Citation	Condition or Requirement

7. Maintenance standards for community spouses and other dependent family members used to calculate monthly income allowances under Section 1924 of the Act.

a. Community spouses

_____ 1. A standard based on the formula contained in Section 1924(d) is used.

_X_ 2. The maximum standard contained in Section 1924(d)(3)(C).

_____ 3. A fixed standard which is greater than the minimum standard described in section 1924(d) plus actual shelter costs not to exceed the maximum standard contained in Section 1924(d)(3)(C). The standard used is $_____.

b. Other family members who are dependent.

_X_ 1. A standard based on the formula contained in Section 1924(d)(1)(C) is used.

_____ 2. A fixed standard greater than the amount which would be used if the formula described in Section 1924(d)(1)(C) were used. The standard used is $_____.

_X_ c. The standards described above are used for individuals receiving home and community-based waiver services in lieu of services provided in a medical or remedial care institution.

STATE Oklahoma	A
DATE RECD 09-03-96	
DATE APP 10-02-96	
DATE EFF 07-01-96	
HCFA I/S 96-04	

State OKLAHOMA

Citation	Condition or Requirement

d. Definition of dependency

The description of dependency below is used to define dependent children, parents and siblings for purposes of deducting allowances under Section 1924:

Dependency is defined as a person who is being claimed or could be claimed as a tax dependent for income tax purposes.

Oklahoma
STATE
09-03-96
DATE
10-02-96
DATE
07-01-96
DATE
96-04
HCFA 179
A

STATE Oklahoma
DATE REC'D 3-31-10
DATE APP'D 6-29-10
DATE EFF 9-30-10
HCFA 179 10-12

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **OKLAHOMA**

ASSET VERIFICATION SYSTEM

1940(a) 1. The Agency will provide for the verification of assets for purposes of determining or redetermining Medicaid eligibility for aged, blind and disabled Medicaid applicants and recipients using an Asset Verification System (AVS) that meets the following minimum requirements.

A. The request and response system must be electronic:

(1) Verification inquiries must be sent electronically via the internet or similar means from the Agency to the financial institution (FI).
(2) The system cannot be based on mailing paper-based requests.
(3) The system must have the capability to accept responses electronically.

B. The system must be secure, based on a recognized industry standard of security (e.g., as defined by the U.S. Commerce Department's National Institute of Standards and Technology, or NIST).

C. The system must establish and maintain a database of FIs that participate in the Agency's AVS.

D. Verification requests also must be sent to FIs other than those identified by applicants and recipients, based on some logic such as geographic proximity to the applicant's home address, or other reasonable factors whenever the Agency determines that such requests are needed to determine or redetermine the individual's eligibility.

E. The verification requests must include a request for information on both open and closed accounts, going back up to 5 years.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **OKLAHOMA**

ASSET VERIFICATION SYSTEM

2. System Development

A. _____ The Agency itself will build and maintain an AVS.

In 3 below, describe how the system will meet the requirements in Section 1.

B. __X__ The Agency will hire a contractor to build and maintain an AVS.

In 3 below, identify the contractor, if known, and describe how the system will meet the requirements in Section 1.

C. _____ The Agency will be joining a consortium to develop an AVS.

In 3 below, identify the States participating in the consortium. Also identify the contractor, if known, who will build and maintain the consortium's AVS, and how the system will meet the requirements in Section 1.

D. _____ The Agency already has a system in place that meets the requirements for an acceptable AVS:

In 3 below, describe how the system meets the requirements in Section 1.

E. _____ Other alternative not included in A. – D. above.

In 3 below, describe this alternative approach how it will meet the requirements in Section 1.

STATE Oklahoma
DATE REC'D 3-31-10
DATE APP'VD 6-29-10
DATE EFF 9-30-10
HCFA 179 10-12
A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **OKLAHOMA**

ASSET VERIFICATION SYSTEM

3. Provide the AVS implementation description and other information requested for the implementation approach checked in Section 2.

The contractor is not known at this time. The system and entity chosen will be able to comply with the following requirements:

1. An electronic process for asset verification;
2. A database of financial institutions that provide data to the entity;
3. A 5-year look back of the assets on individual applicants, recipients, spouses and partners;
4. A secure system based on a recognized industry standard as defined by the U.S. Commerce Department's National Institute;
5. Verification requests will include both open and closed asset account information;
6. The acceptable asset verification entity will provide adequate data for the generation of all required reports expected to meet federal reporting requirements such as the number of requests, number of responses and amounts of undisclosed assets found.

STATE Oklahoma
DATE REC'D 3-31-10
DATE APPV'D 6-29-10
DATE EFF 9-30-10
HCFA 179 10-12
A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: OKLAHOMA

DISQUALIFICATION FOR LONG-TERM CARE ASSISTANCE FOR INDIVIDUALS WITH SUBSTANTIAL HOME EQUITY

1917(f) The State agency denies reimburssement for nursing facility services and other long-term care services covered under the State plan for an individual who does not have a spouse, child under 21 or adult disabled child residing in the individual's home, when the individual's equity interest in the home exceeds the following amount:

X $500,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest $1,000).

___ An amount that exceeds $500,000 but does not exceed $750,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest $1,000).

The amount chosen by the State is _____.

___ This higher standard applies statewide.

___ This higher standard does not apply statewide. It only applies in the following areas of the State:

___ This higher standard applies to all eligibility groups.

___ This higher standard only applies to the following eligibility groups:

STATE Oklahoma DATE REC'D 4-5-06 DATE APP'V'D 8-22-07 DATE EFF 2-8-06 HCFA 179 06-04	A

The State has a process under which this limitation will be waiver in cases of undue hardship.

SUPERSEDES: NONE - NEW PAGE

New Page 02-08-06

State Plan Under Title XIX of the Social Security Act

State: Oklahoma

METHODOLOGY FOR IDENTIFICATION OF APPLICABLE FMAP RATES

The State will determine the appropriate FMAP rate for expenditures for individuals enrolled in the adult group described in 42 CFR 435.119 and receiving benefits in accordance with 42 CFR Part 440 Subpart C. The adult group FMAP methodology consists of two parts: an individual-based determination related to enrolled individuals, and as applicable, appropriate population-based adjustments.

Part 1 – Adult Group Individual Income-Based Determinations

For individuals eligible in the adult group, the state will make an individual income-based determination for purposes of the adult group FMAP methodology by comparing individual income to the relevant converted income eligibility standards in effect on December 1, 2009, and included in the MAGI Conversion Plan (Part 2) approved by CMS on 05/14/2020 . In general, and subject to any adjustments described in this SPA, under the adult group FMAP methodology, the expenditures of individuals with incomes below the relevant converted income standards for the applicable subgroup are considered as those for which the newly eligible FMAP is not available. The relevant MAGI-converted standards for each population group in the new adult group are described in Table 1.

Table 1: Adult Group Eligibility Standards and FMAP Methodology Features

Covered Populations Within New Adult Group		Applicable Population Adjustment			
Population Group	**Relevant Population Group Income Standard** For each population group, indicate the lower of: • The reference in the MAGI Conversion Plan (Part 2) to the relevant income standard and the appropriate cross-reference, or • 133% FPL. If a population group was not covered as of 12/1/09, enter "Not covered".	**Resource Proxy**	**Enrollment Cap**	**Special Circumstances**	**Other Adjustments**
		Enter "Y" (Yes), "N" (No), or "NA" in the appropriate column to indicate if the population adjustment will apply to each population group. Provide additional information in corresponding attachments.			
A	B	C	D	E	F
Parents/Caretaker Relatives	Attachment A, Column C, Line 1 of Part 2 of the CMS approved MAGI conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan	No	No	No	No
Disabled Persons, non-institutionalized	Attachment A, Column C, Line 2 of Part 2 of the CMS approved MAGI conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan	No	No	No	No
Disabled Persons, institutionalized	Attachment A, Column C, Line 3 of Part 2 of the CMS approved MAGI conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan	No	No	No	No
Children Age 19 or 20	Attachment A, Column C, Line 4 of Part 2 of the CMS approved MAGI conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan	No	No	No	No
Childless Adults	Attachment A, Column C, Line 5 of Part 2 of the CMS approved MAGI conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan	N/A	N/A	N/A	N/A

Part 2 – Population-based Adjustments to the Newly Eligible Population Based on Resource Test, Enrollment Cap or Special Circumstances

A. Optional Resource Criteria Proxy Adjustment (42 CFR 433.206(d))

1. The state:

   ☐ Applies a resource proxy adjustment to a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

   ☒ Does NOT apply a resource proxy adjustment (Skip items 2 through 3 and go to Section B).

   Table 1 indicates the group or groups for which the state applies a resource proxy adjustment to the expenditures applicable for individuals eligible and enrolled under 42 CFR 435.119. A resource proxy adjustment is only permitted for a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

   The effective date(s) for application of the resource proxy adjustment is specified and described in Attachment B.

2. Data source used for resource proxy adjustments:

   The state:

   ☐ Applies existing state data from periods before January 1, 2014.

   ☐ Applies data obtained through a post-eligibility statistically valid sample of individuals.

   Data used in resource proxy adjustments is described in Attachment B.

3. Resource Proxy Methodology: Attachment B describes the sampling approach or other methodology used for calculating the adjustment.

B. Enrollment Cap Adjustment (42 CFR 433.206(e))

1. ☐ An enrollment cap adjustment is applied by the state (complete items 2 through 4).

   ☒ An enrollment cap adjustment is not applied by the state (skip items 2 through 4 and go to Section C).

2. Attachment C describes any enrollment caps authorized in section 1115 demonstrations as of December 1, 2009 that are applicable to populations that the state covers in the eligibility group described at 42 CFR 435.119 and received full benefits, benchmark benefits, or benchmark equivalent benefits as determined by CMS. The enrollment cap or caps are as specified in the applicable section 1115 demonstration special terms and conditions as confirmed by CMS, or in alternative authorized cap or caps as confirmed by CMS. Attach CMS correspondence confirming the applicable enrollment cap(s).

3. The state applies a combined enrollment cap adjustment for purposes of claiming FMAP in the adult group:

   ☐ Yes. The combined enrollment cap adjustment is described in Attachment C

   ☐ No.

4. Enrollment Cap Methodology: Attachment C describes the methodology for calculating the enrollment cap adjustment, including the use of combined enrollment caps, if applicable.

C. Special Circumstances (42 CFR 433.206(g)) and Other Adjustments to the Adult Group FMAP Methodology

1. The state:

   ☐ Applies a special circumstances adjustment(s).

   ■ Does not apply a special circumstances adjustment.

2. The state:

   ☐ Applies additional adjustment(s) to the adult group FMAP methodology (complete item 3).

   ■ Does not apply any additional adjustment(s) to the adult group FMAP methodology (skip item 3 and go to Part 3).

3. Attachment D describes the special circumstances and other proxy adjustment(s) that are applied, including the population groups to which the adjustments apply and the methodology for calculating the adjustments.

Part 3 – One-Time Transitions of Previously Covered Populations into the New Adult Group

A. Transitioning Previous Section 1115 and State Plan Populations to the New Adult Group

☒ Individuals previously eligible for Medicaid coverage through a section 1115 demonstration program or a mandatory or optional state plan eligibility category will be transitioned to the new adult group described in 42 CFR 435.119 in accordance with a CMS-approved transition plan and/or a section 1902(e)(14)(A) waiver. For purposes of claiming federal funding at the appropriate FMAP for the populations transitioned to new adult group, the adult group FMAP methodology is applied pursuant to and as described in Attachment E, and where applicable, is subject to any special circumstances or other adjustments described in Attachment D.

☐ The state does not have any relevant populations requiring such transitions.

Part 4 - Applicability of Special FMAP Rates

A. Expansion State Designation

The state:

☒ Does NOT meet the definition of expansion state in 42 CFR 433.204(b). (Skip section B and go to Part 5)

☐ Meets the definition of expansion state as defined in 42 CFR 433.204(b), determined in accordance with the CMS letter confirming expansion state status, dated _____.

B. Qualification for Temporary 2.2 Percentage Point Increase in FMAP.

The state:

☒ Does NOT qualify for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7).

☐ Qualifies for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7), determined in accordance with the CMS letter confirming eligibility for the temporary FMAP increase, dated _____ . The state will not claim any federal funding for individuals determined eligible under 42 CFR 435.119 at the FMAP rate described in 42 CFR 433.10(c)(6).

Part 5 - State Attestations

The State attests to the following:

A. The application of the adult group FMAP methodology will not affect the timing or approval of any individual's eligibility for Medicaid.

B. The application of the adult group FMAP methodology will not be biased in such a manner as to inappropriately establish the numbers of, or medical assistance expenditures for, individuals determined to be newly or not newly eligible.

ATTACHMENTS

Not all of the attachments indicated below will apply to all states; some attachments may describe methodologies for multiple population groups within the new adult group. Indicate those of the following attachments which are included with this SPA:

- ☒ Attachment A – Conversion Plan Standards Referenced in Table 1
- ☐ Attachment B – Resource Criteria Proxy Methodology
- ☐ Attachment C – Enrollment Cap Methodology
- ☐ Attachment D – Special Circumstances Adjustment and Other Adjustments to the Adult Group FMAP Methodology
- ☒ Attachment E – Transition Methodologies

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 4 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Attachment A: Most Recent Updated Summary Information for Part 2 of Modified Adjusted Gross Income (MAGI) Conversion Plan*

OKLAHOMA

CMS Approved: 5/14/2020

	Population Group	Net standard as of 12/1/09	Converted standard for FMAP claiming	Same as converted eligibilty standard? (yes, no, or n/a)	Source of information in Column C (New SIPP conversion or Part 1 of approved state MAGI conversion plan)	Data source for Conversion (SIPP or state data)
	A	B	C	D	E	F
1	**Parents/Caretaker Relatives**	73% AFDC need standard	1 $407 2 $521 3 $668 4 $820 5 $958 6 $1098 7 $1236 8 $1364 9 $1486	yes	MAGI SIPP Conversion	SIPP
2	**Noninstitutionalized Disabled Persons** FPL %	100%	100%	n/a	New SIPP conversion	SIPP
3	**Institutionalized Disabled Persons** SSI FBR%	300%	300%	n/a	ABD conversion template	n/a
4	**Children Age 19-20**	212%	n/a	yes	MAGI SIPP Conversion	SIPP
5	**Childless Adults** FPL %	200%	n/a	yes	MAGI SIPP Conversion	SIPP

n/a: Not applicable.

***The contents of this table will be updated automatically in case of modifications to the CMS approved MAGI Conversion Plan.**

Attachment E: Adult Population Reprocess Plan

Counts of current members as of 11/11/2020

Type of Recipient	Recipients	Cases
Insure Oklahoma – Individual Plan	19,273	16,222
Insure Oklahoma – Employer Sponsored Insurance (ESI) with FPL 138% or less	4,055	3,312
SoonerPlan	41,377	36,639
Adults not eligible as Needy Caretakers	31,153	26,747
Not Categorically Related Adults	4,163	3,918
Totals	**100,021**	**86,838**

Any members that do not have current eligibility must have applied within the last 90 days.

Plan for Reprocess
OHCA will reprocess each group in 06/2021 for an expansion eligibility start date of 07/01/2021.
OHCA will reprocess each group in a manner that will create the least operational impact, most likely one per week. Some groups, depending on volume, may be reprocessed over multiple days.

Suggested Order of reprocesses:

- Insure Oklahoma
    - Individual Plan
    - Individuals in the ESI plan with FPL less than 138%
- SoonerPlan
- Adults not eligible as Needy Caretakers
- Not Categorically Related Adults

Program Definitions
Insure Oklahoma – Individual Plan: Insure Oklahoma's Public option
Insure Oklahoma – ESI: Insure Oklahoma's Employee Sponsored Insurance plan helps employers provide their eligible employees with affordable health care.
SoonerPlan: benefit plan covering limited services related to family planning, to women and men ages 19 and older, in an effort to reduce unwanted pregnancies.

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

1. Inpatient hospital services other than those provided in an institution for mental diseases..

Provided: [ ] No limitations [X] With limitations* .

2.a. Outpatient hospital services.

Provided: [ ] No limitations [X] With limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic and covered under the Plan.

[X] Provided [ ] No limitations [X] With limitations*

[ ] Not Provided.

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the Plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual.

Provided: [X] [] No limitations [X] With limitations*

3. Other laboratory and x-ray services.

Provided: [ ] No limitations [X] With limitations*

*Description provided on attachment.

State: Oklahoma
Date Received: 30 September, 2019
Date Approved: 10 December, 2019
Effective Date: 1 September, 2019
Transmittal Number: 19-0016

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

1. Inpatient hospital services other than those provided in an institution for mental diseases

Payment is made for compensable inpatient medical and surgical services to those hospitals which have a contract with this Agency. Freestanding inpatient rehabilitation hospital services are limited to 90 days per individual per state fiscal year. The 90-day limitation per state fiscal year can be extended based on medical necessity.

The limitation is not applicable to services received by children (see 4.b., Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)).

Medical necessity for hospital services is subject to review and determination that a period of hospitalization is not medically necessary will result in a non-compensable service.

Original misplaced filed 5/17/05

State: OKLAHOMA

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

2.a. Outpatient hospital services

Emergency Room Services – Emergency department services are covered. Payment is made at a case rate, which is an all-inclusive rate for all non-physician services provided during the visit.

Dialysis

Therapeutic radiology or chemotherapy – Outpatient chemotherapy is compensable for proven malignancies and opportunistic infections. Outpatient radiation is covered for the treatment of proven malignancies or when treating benign conditions utilizing stereotactic radiosurgery (e.g., gamma knife).

Outpatient hospital services – Outpatient hospital services, not specifically addressed, are covered when prior authorized.

Outpatient surgical services - Facility payments for selected surgical procedures on an outpatient basis will be made to hospitals which have a contract with the Agency.

STATE Oklahoma DATE REC'D 2 Jan 04 DATE APPV'D 22 Nov 04 DATE EFF 1 JAN 04 HCFA 179 03-27	A

SUPERSEDES: TN: 01-01

Revised 01-01-04

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

2.b. Rural health clinic (RHC) services and other ambulatory services furnished by rural health clinic

Payment is made for services provided in rural health clinics (RHCs) that are certified for participation in the Medicare program.

A clinic must be in:

- A U.S. Census Bureau-defined non-urbanized area;
- An area currently designated or certified by the Health Resources and Services Administration within the previous 4 years as one of these types of areas:
- Primary Care Geographic Health Professional Shortage Area (HPSA) under Section 332(a)(1)(A) of the Public Health Service (PHS) Act ;
- Primary Care Population-Group HPSA under Section 332(a)(1)(B) of the PHS Act;
- Medically Underserved Area under Section 330(b)(3) of the PHS Act; and,
- Governor-designated and Secretary-certified shortage area under Section 6213(c) of the Omnibus Budget Reconciliation Act (OBRA) of 1989

RHC services include:

- Physician services;
- Services and supplies furnished “incident to” physician services;
- Nurse practitioner (NP), physician assistant (PA), certified nurse-midwife (CNM), clinical psychologist (CP), and clinical social worker (CSW) services;
- Services and supplies furnished “incident to” NP, PA, CNM, CP or CSW services;
- Visiting nurse services to the homebound where the Centers for Medicare & Medicaid Services (CMS) certified there is a shortage of home health agencies and certain criteria are met; and
- Certain virtual communication services.

Payment is limited to four (4) visits per month for adults. Payment is made for one visit/encounter per member per day.

More than one visit with an RHC practitioner on the same day, or multiple visits with the same RHC practitioner on the same day, counts as a single visit, except for the following:

- The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day (for example, a patient sees their practitioner in the morning for a medical condition and later in the day has a fall and returns to the RHC);
- A qualified medical visit and a qualified mental health visit on the same day; and,
- An Initial Preventive Physical Examination (IPPE) and a separate medical and/or mental health visit on the same day.

State: Oklahoma
Date Received: 30 September, 2019
Date Approved: 10 December, 2019
Effective Date: 1 September, 2019
Transmittal Number: 19-0016

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

2.c. Federally qualified health center (FQHC) services and other ambulatory services furnished by an FQHC

State: Oklahoma
Date Received: 30 September, 2019
Date Approved: 10 December, 2019
Effective Date: 1 September, 2019
Transmittal Number: 19-0016

Payment is made for services provided in FQHCs that qualify by one of the following methods:

- The entity receives a grant under Section 330 of the Public Health Service (PHS) Act (42 United States Code 254a), or is receiving funding from such a grant and meets other requirements;
- Is not receiving a grant under Section 330 of the PHS Act but is determined by the Secretary of the Department of Health & Human Services (HHS) to meet the requirements for receiving such a grant (qualifies as a "FQHC look-alike") based on the recommendation of the Health Resources and Services Administration;
- Was treated by the Secretary of HHS for purposes of Medicare Part B as a comprehensive Federally-funded health center as of January 1, 1990; or
- Is operating as an outpatient health program or facility of a tribe or tribal organization under the Indian Self-Determination Act or as an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1991.

For certification as an FQHC, the entity must meet all of these requirements:

- Provides comprehensive services and carries out, or arranges for, an annual evaluation of its total program;
- Meets other health and safety requirements; and,
- Is not concurrently approved as a Rural Health Clinic.

FQHCs that receive a Section 330 grant or are determined to be an FQHC look-alike must meet all requirements contained in Section 330 of the PHS Act, including:

- Serve a designated medically-underserved area or medically-underserved population;
- Offer a sliding fee scale to persons with incomes below 200 percent of the Federal poverty level; and,
- Be governed by a board of directors, of whom a majority of the members receive care at the FQHC.

FQHC services include:

- Physician services;
- Services and supplies “incident to” the services of physicians;
- Nurse practitioner (NP), physician assistant (PA), certified nurse-midwife (CNM), clinical psychologist (CPs), and clinical social worker (CSW) services;
- Services and supplies “incident to” the services of NPs, PAs, CNMs, and CPs; and
- Visiting nurse services to the homebound in an area where CMS determined there is a shortage of home health agencies.

Payment is limited to four (4) encounters per month for adults. Payment is made for one encounter per member per day.

Encounters with more than one FQHC practitioner on the same day, regardless of the length or complexity of the visit, or multiple encounters with the same FQHC practitioner on the same day, constitute a single visit, except when the patient has either or both of these:

- An illness or injury requiring additional diagnosis or treatment subsequent to the first encounter (distinctly different diagnosis);
- A qualified medical visit and a qualified mental health visit on the same day.

State OKLAHOMA

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

3. Other Laboratory and X-ray Services

- Medically necessary outpatient diagnostic x-rays and laboratory work.

STATE Oklahoma
DATE RECD 12-30-99
DATE APPVD 3-14-00
DATE EFF 12-1-99
HCFA 179 99-23

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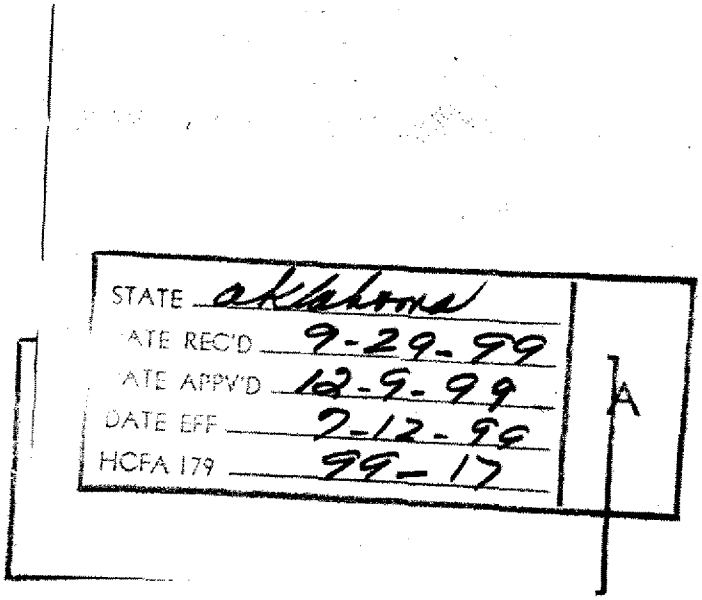
Revised 12-01-99

State OKLAHOMA

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

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older

Payment is made for nursing facility services after approval by the Agency for such care. Nursing facility services include coverage of all medically necessary prescriptions not otherwise covered under the Plan.



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

4b. Early and Periodic Screening, Diagnosis and Treatment of Conditions Found

A. Screening Services

1. Initial Screen. Periodic, comprehensive child health assessments are provided by a licensed medical or osteopathic physician, physician assistant, or advanced practice nurse practitioner to each eligible individual under the age of 21. An initial EPSDT screening may be requested by an eligible individual at any time and must be provided without regard to whether the individual's age coincides with the established periodicity schedule. At a minimum these assessments must include the following components:

(a) Comprehensive Health and/or Developmental history;
(b) Comprehensive unclothed physical exam;
(c) Appropriate Immunizations;
(d) Health Education;
(e) Appropriate Laboratory Tests;
(f) Lead Toxicity Screening;
(g) Vision Services; and
(h) Dental Services.

State: Oklahoma
Date Received: 30 May, 2018
Date Approved: 12 July, 2018
Effective Date: 1 September, 2018
Transmittal Number: 18-06

2. Periodicity Schedule(s). The preventive pediatric health care periodicity schedule recommended by the American Academy of Pediatrics (AAP) has been adopted for use by the State for eligible individuals from age birth through 20. Immunizations are to be checked and provided as needed according to the Advisory Committee on Immunization Practices (ACIP) schedule. Vision and Hearing screens are subject to their own periodicity schedule. However, age appropriate vision and hearing screens must be performed. Dental screens begin at the first sign of tooth eruption by the primary care provider and with each subsequent visit to determine if the child needs a referral to a dental provider. Dental services, including the initial direct referral to a dentist, must occur according to the periodicity of examination, preventive dental services, anticipatory guidance, and oral treatment for infants, children, and adolescents recommended by the American Academy of Pediatric Dentistry (AAPD).

3. Optional Screens. Periodic screening must be provided in accordance with the recommended AAP periodicity schedule following the initial screening. Interperiodic screenings must be provided when medically necessary to determine the existence of suspected physical or mental illnesses or conditions. A partial screening may be paid if the provider cannot provide all of the minimum components of the screening.

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

4b. Early and Periodic Screening, Diagnosis and Treatment of Conditions Found *(continued)*

B. Diagnosis and Treatment

The following diagnosis and treatment services are provided in addition to any diagnosis and treatment services covered elsewhere in the plan:

1. Medical or Other Remedial Care by Licensed Practitioners (42 CFR 440.60)

(a) Optometric Services – Services for defects in vision including eyeglasses by State licensed optometrist.

(b) Podiatrists Services – Payment is made for medically necessary surgical procedures and medically necessary outpatient visits and procedures generally considered as preventive foot care provided by a Doctor of Podiatric Medicine (DPM). Services beyond this limitation are available if as a result of a screening they are determined to be medically necessary and prior authorized.

(c) Nursing Services – Nursing services must be provided by a registered nurse or licensed practical nurse under supervision of a registered nurse. Services may include medically necessary procedures rendered in the child's home.

(d) Licensed Behavioral Health Practitioner Services – Services provided under the scope of their licensure by clinical psychologists and master's level behavioral practitioners who can bill independently using the appropriate Physician's Current Procedure Terminology (CPT) codes in an outpatient setting**.**

(e) Applied Behavior Analysis (ABA) – ABA services must be medically necessary and prior authorized by OHCA or its designated agent. Eligible ABA provider types include:

i. **Board Certified Behavior Analyst® (BCBA®) –** A master's or doctoral level independent practitioner who is certified by the national-accrediting Behavior Analyst Certification Board® (BACB) and licensed by Oklahoma Department of Human Services (DHS) Developmental Disabilities Services (DDS) provide behavior analysis services. A BCBA may supervise the work of a Board Certified Assistant Behavior Analyst® (BCaBA) and a Registered Behavior Technician (RBT) implementing behavior analytic interventions within their scope of practice and assumes professional responsibility for services rendered by the non-licensed practitioner.

ii. **Board Certified Assistant Behavior Analyst® (BCaBA®) –** A bachelor's level practitioner who is certified by the national-accrediting BACB and is certified by the Oklahoma DHS DDS to provide behavior analysis services under the supervision of a licensed BCBA.

iii. **Registered Behavior Technician™ (RBT®) –** A high school level or higher paraprofessional who is certified by the national-accrediting BACB and practices under the close and ongoing supervision of a BCBA. A RBT® is primarily responsible for the direct implementation of BCBA® designed behavior-analytic services.

iv. **State-licensed Psychologist** – An Oklahoma state-licensed individual who is in good standing with the Oklahoma Board of Examiners of Psychologists providing ABA services within their scope of practice as defined under State law.

v. **State-licensed human services professional –** An Oklahoma state-licensed individual practicing within the scope of their human service profession as defined by State law and who is certified by the national-accrediting BACB, to include:

(A) A licensed physical therapist;
(B) A licensed occupational therapist;
(C) A licensed clinical social worker or social worker candidate under the supervision of a licensed clinical social worker
(D) A licensed speech-language pathologist or licensed audiologist;
(E) A licensed professional counselor or professional counselor candidate under the supervision of a licensed professional counselor;
(F) A licensed marital and family therapist or marital and family therapist candidate under the supervision of a licensed marital and family therapist; or
(G) A licensed behavioral practitioner or behavioral practitioner candidate under the supervision of a licensed behavioral practitioner.

State: Oklahoma
Date Received: 27 November, 2019
Date Approved: 26 December, 2019
Effective Date: 1 January, 2020
Transmittal Number: 20-0013

2. Medical supplies, equipment, appliances and prosthetic devices (42 CFR 440.70 & 42 CFR 440.120). Services and supplies not otherwise available to Medicaid clients in the state under the state plan when prior authorized.

3. Diagnostic Services (42 440.130(a))
(a) Investigations to Determine Source of Lead. A one-time investigation to determine the source of lead for a child diagnosed with elevated blood lead levels. Reimbursement does not include testing the water, soil, or paint. In accordance with the rules established by the Oklahoma Department of Environmental Quality (DEQ)**,** a qualified Risk Assessor must perform the service.

4. Clinic Services (42 CFR 440.90)
(a) Public Health Clinic Services

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

4b. Early and Periodic Screening, Diagnosis and Treatment of Conditions Found (continued)

B. Diagnosis and Treatment

5. Dental Services - **(42 CFR 440.100)**

At a minimum, dental services include relief of pain and infection; limited restoration of teeth and maintenance of dental health; and oral prophylaxis every 6 months. Dental care includes emergency and preventive services and therapeutic services for dental disease, which, if left untreated, may become acute dental problems or may cause irreversible damage to the teeth or supporting structures. Other dental services may be provided based on medical necessity, including inpatient services in an eligible participating hospital and must be prior authorized.

6. Physical therapy, Occupational therapy, and Services for individuals with Speech, Hearing, and Language Disorders (42 CFR 440.110)

(a) Physical Therapy Services– Services are: 1) prescribed by a physician or other licensed provider of the healing arts; and 2) provided by a licensed physical therapist or a licensed physical therapist assistant under the supervision of a fully licensed physical therapist, working within the scope of his or her practice, in accordance with State law and 42 CFR 440.110(a).

(b) Occupational Therapy Services– Services are: 1) prescribed by a physician or other licensed provider of the healing arts; and 2) provided by a fully licensed occupational therapist or a licensed occupational therapist assistant under the supervision of a fully licensed occupational therapist, working within the scope of his or her practice, in accordance with State law and 42 CFR 440.110(b).

(c) Speech and Language Pathology Services– Services are: 1) referred by a physician or other licensed provider of the healing arts; and 2) provided by one of the following types of licensed practitioners working within the scope of his or her practice, in accordance with State law and 42 CFR 440.110(c):

- A fully licensed speech language pathologist; or
- A licensed speech language pathology assistant under supervision of a speech language pathologist; or
- A provisionally licensed clinical fellow under the supervision of a licensed speech language pathologist.

(d) Hearing Services - Hearing and hearing aid evaluations as appropriate when provided by a State licensed audiologist who meets the Federal qualifications specified at 42 CFR 440.110(c)(3).

(e) Assistive Technology Services/ Devices - The evaluation of a child with disabilities in order to recommend the proper assistive technology device. Services must be provided by a fully licensed speech language pathologist, fully licensed physical therapist or fully licensed occupational therapist [42 CFR 440.70(b)(3)].

7. Prescribed Drugs - (42 CFR 440.120)

Prescription drugs above the State plan limitation are provided when medically necessary.

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

4b. Early and Periodic Screening, Diagnosis and Treatment of Conditions Found (continued)

B. Diagnosis and Treatment (cont'd**)**

8. Rehabilitative Services: Outpatient Behavioral Health - (42 CFR 440.130 (d)).

Services provided to children, youth and young adults with significant emotional, behavioral and mental health needs, including substance abuse. The intent of these services is to provide the clinical intervention and support necessary to successfully maintain each individual in his or her home or community and to enable individuals that have traditionally been served in more restrictive settings to live in community settings and participate fully in family and community life.

(a) Agency Requirements

All rehabilitative services are provided by the provider organizations listed in Attachment 3.1 A, Page 6a-1.1. In addition to the agency accreditation requirements, specific certifications/ participation standards are required to provide the following services:

i. **Children's Psychosocial Rehabilitation (CPSR) -** Children and families will have free choice to obtain services from any willing and qualified provider.

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ii. **Crisis Intervention Services –** Agencies with mobile teams and facility-based crisis stabilization programs must be contracted with the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS). Facility-based crisis programs must have less than 17 beds.

iii. **Multi-Systemic Therapy (MST) –** Individual providers must be licensed and trained by MST, Inc. and receive regular consultation from them**.**

iv. **Partial Hospitalization (PHP)/Intensive Outpatient (IOP) Treatment; Therapeutic Day Treatment (TDT) -** PHP/IOP and TDT must have outpatient behavioral health accreditation specific to PHP/IOP or day treatment programs.

State: Oklahoma
Date Received: June 30, 2013
Date Approved: November 18, 2015
Date Effective: April 1, 2013
Transmittal Number: 13-12

Revised 04-01-13

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

4b. Early and Periodic Screening, Diagnosis and Treatment of Conditions Found (continued)

B. Diagnosis and Treatment (cont'd)

(b) Individual Provider Qualifications

For purposes of this plan, each eligible practitioner type is grouped consistent with specific credentials in the tables listed on Attachment 3.1-A, pages 1a 6.4 through 1a 6.4b. There are four (4) qualifying groups: Behavioral Health Practitioners, (BHPs), Qualified Behavioral Health Technicians (QBHTs), Qualified Behavioral Health Assistants (QBHAs) and Certified Peer Support Specialists (CPSPs).

Individual Provider Qualifications
Outpatient Behavioral Health and Rehabilitative Services

Practitioner Group	Qualifications
Behavioral Health Practitioners	***Level 1:*** **(A) Psychiatrists** - Allopathic or Osteopathic physicians with a current license and board certification in psychiatry or board eligible in the state in which services are provided, **or** **(B) Advanced Practice Registered Nurse (APRN) -** Registered nurse with current licensure and certification of recognition from the board of nursing in the state in which services are provided and certified in a psychiatric mental health specialty; **or** **(C) Clinical Psychologists -** A clinical psychologist who is duly licensed to practice by the State Board of Examiners of Psychologists; **or** **(D) Current resident in psychiatry; or** **(E) Physician Assistants (PA) -** An Individual licensed in good standing in Oklahoma and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions
	Level 2: **(A) Licensed, Master's Prepared** - Practitioners with a Master's degree and fully licensed to practice in the state in which services are provided, as determined by one of the licensing boards listed below: (1) Clinical Social Workers; (2) Professional Counselors; (3) Marriage & Family Therapists; (4) Behavioral Practitioners; or (5) Alcohol or Drug Counselor; **(B) Licensure Candidates** - An individual with a Master's degree or higher, actively and regularly receiving board approved clinical supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met by one of the licensing boards listed in Level 1 (C) or Level 2 (A) above, **or** **(C) Psychological Clinicians** – Professionals with a Master's degree or higher with certification to provide behavioral health services.

Revised 04-01-13

State: Oklahoma
Date Received: June 30, 2013
Date Approved: November 18, 2015
Date Effective: April 1, 2013
Transmittal Number: 13-12

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

4b. Early and Periodic Screening, Diagnosis and Treatment of Conditions Found (continued)

B. Diagnosis and Treatment (cont'd)

Individual Provider Qualifications
Outpatient Behavioral Health Rehabilitative Services

Practitioner Group	Qualifications
Qualified Behavioral Health Technicians (QBHTs)	**(A)** ***Behavioral Health Rehabilitation Specialist (BHRS):*** • An individual that possesses a Bachelor's degree earned from a regionally accredited college or university recognized by the Department of Education and completion of the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) training for BHRS; **or** • **A Registered Nurse -** A registered nurse that has behavioral health experience, and current licensure in the state where services are provided, and training by ODMHSAS as a BHRS; **or** • **A Certified Alcohol and Drug Counselor** (CADC)**; or** • **A Certified Psychiatric Rehabilitation Practitioner** (CPRP). **(B)** ***Effective July 1, 2013, a BHRS must meet the following***: • Currently certified as a Behavioral Health Case Manager II (CM II) through the ODMHSAS; **or** • Currently Certified Alcohol and Drug Counselor (CADC). *A BHRS designation between July 1, 2010 and June 30, 2013 will be recognized until June 30, 2014, at which point individuals must meet qualifications in (B) above. **(C) Psychological Technician** • Must be actively involved in a Master level program that has already trained the applicant specifically to provide the service under the direct supervision of the psychologist.
Qualified Behavioral Health Aide I (QBHA I)	**QBHA minimum requirements:** • Must have a high school diploma or equivalent; and • Must complete required training and continuing education; and • Be appropriately supervised.
Qualified Behavioral Health Aide II (QBHA II)	**QBHA II minimum requirements:** • Must meet the minimum qualifications of a QBHA I; and, • Have either some post-secondary education or a combination of at least two (2) years of personal/professional experience working with children with significant needs; and, • Must serve as a full-time stay at home parent in order to meet the significant needs of the child placed in the ITFC foster home.

State: Oklahoma
Date Received: 30 August, 2019
Date Approved: 18 October, 2019
Effective Date: 1 September, 2019
Transmittal Number: 19-0018

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

4b. Early and Periodic Screening, Diagnosis and Treatment of Conditions Found (continued)

B. Diagnosis and Treatment (cont'd)

Individual Provider Qualifications
Outpatient Behavioral Health Rehabilitative Services

Practitioner Group	Qualifications
Certified Peer Support Providers (CPSP)	**Minimum Qualifications** • Self- identified consumers who are in recovery from mental illness and/or substance use; or • A parent of a child with a similar mental illness and/or substance use disorder, or • An adult with an on- going and/or personal experience with a family member with a similar mental illness and/or substance use disorder; and • Have a high school diploma or equivalent; • Successful completion of required training according to a curriculum approved by the ODMHSAS prior to providing the service. • Pass certification examination. I. **Family Support Provider (FSP)** • Be 21 years of age and have successful experience as a family member of a child or youth with serious emotional disturbance; or • Have a minimum of 2 years experience working with children with serious emotional disturbance or be equivalently qualified by education in the human services field or a combination of work experience and education with one year of education substituting for one year of experience (preference is given to parents or care givers of child with SED); • Pass OSBI and OKDHS child abuse check as well as adult abuse registry and motor vehicle screens; and • Receive ongoing and regular supervision by a person meeting the qualifications of a BHP. A BHP must be available at all times to provide back up, support, and/or consultation. II. **Peer Recovery Support Specialist (PRSS)** • Be at least 18 years of age; • Have demonstrated recovery from a mental illness, substance abuse disorder or both Be willing to self disclose about their own recovery.

State: Oklahoma
Date Received: June 30, 2013
Date Approved: November 18, 2015
Date Effective: April 1, 2013
Transmittal Number: 13-12

NEW 04-01-13

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

4b. Early and Periodic Screening, Diagnosis and Treatment of Conditions Found (continued)

B. Diagnosis and Treatment (continued)

8. Rehabilitative Services: Outpatient Behavioral Health (cont'd)

(c) Covered Services

i. **Comprehensive Assessment** –The comprehensive assessment is an in-depth, detailed assessment of the child, youth or young adult's emotional, social, behavioral and developmental functioning within the home, school and community, including the direct observation of the individual in those settings. It must identify a behavioral health diagnosis or complex trauma and recommend services. It includes a history of psychiatric symptoms, concerns and problems, mental health status, psychosocial history, a classification of the diagnosis from the current edition of the DSM, an evaluation of alcohol and other drug use, as well as the client's strengths and needs. It serves as the factual basis to develop the individualized care plan. Service components include a psychiatric diagnostic assessment and/or a functional assessment by a BHP to objectively determine the service intensity needs of children and adolescents with (or significant risk for) Severe Emotional Disturbance (SED) or with Substance Abuse Disorders, using a national standardized tool, such as CANS, CASII or ASAM.

ii. **Development of Individualized Care Plan (ICP) and Review** - This is a process by which the information obtained in the assessment is evaluated and used to develop a plan of care that has individualized goals, objectives, activities and services that will enable a client to improve. It is to focus on recovery and must include a discharge plan. This service is conducted by a BHP. A Wraparound planning process supports children and youth in returning to or remaining in the community. Refer to Supplements to Attachment 3.1-A, page 1d and page 1f for coverage and provider qualifications.

iii. **Crisis Intervention Services (CIS).** CIS are for the purpose of responding to acute behavioral or emotional dysfunction as evidenced by psychotic, suicidal, or homicidal or severe psychiatric distress. CIS components include:

(A) Crisis Assessment - Crisis Assessment is an immediate face-to-face evaluation by a physician or BHP to determine the client's immediate presenting situation and identifying any immediate need for emergency services. The crisis assessment is a facility-based service provided by a BHP, and may include up to 23 hours and 59 minutes of observation.

(B) Crisis Management/Behavior Redirection - The intervention shall be designed to de-escalate situations in which a risk to self, others, or property exists. Services are provided by a BHP and shall assist a client to regain self-control and re-establish effective management of behavioral symptoms associated with a psychological disorder in an age-appropriate manner.

(C) Crisis Psychotherapy, Mobile team - Mobile crisis services are short-term intensive services started during a mental health crisis or emergency to help the client. Mobile crisis services must be available 24 hours per day, 365 days per year and provided onsite by a mobile crisis team in a community setting, and provided promptly. In most cases, a two-person crisis team is on call and available to respond. The team may be comprised of a BHP and a paraprofessional (I.e., QBHT, CPSP), who are trained in crisis intervention skills and in serving as the first responders to children and families needing help on an emergency basis.

(D) Crisis Stabilization, Facility-Based - These services include professional treatment services to provide extended stabilization in a 24-hour, structured residential setting. This service is provided to a client after the crisis assessment as an alternative to inpatient hospitalization, for extended stabilization. This service does not include respite. Professional services are provided by a BHP.

State: Oklahoma
Date Received: June 30, 2013
Date Approved: November 18, 2015
Date Effective: April 1, 2013
Transmittal Number: 13-12

Revised 04-01-13

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

4b. Early and Periodic Screening, Diagnosis and Treatment of Conditions Found (continued)

B. Diagnosis and Treatment (continued)

8. Rehabilitative Services: Outpatient Behavioral Health

(c) Covered Services (continued)

ii. **Children's Psychosocial Rehabilitation (CPSR)** - CPSR is an array of services that are provided in the child's home, or in the location where behavioral challenges are most likely to occur such as school, or in community settings. CPSR (IIH and TBS) services are limited to 6 units each per day for a QBHA I and a QBHA II within the Therapeutic Foster Family Homes (TFFHs) setting. CPSR (IIH)-Group is limited to 16 units per day for a QBHA I and a QBHA II within the Therapeutic Foster Family Homes (TFFHs) setting. CPSR services are available, and limits can be exceeded, for all children, youth and young adults aged 0-21 that meet the medical necessity criteria. The CPSR components are described in (A)-(C) below:

(A) Intensive Family Intervention (IFI) - This is community-based intensive behavioral health intervention delivered to treat emotional disturbances or co-occurring substance use disorders. Services are designed to correct or ameliorate symptoms of mental health and/or substance abuse problems and to reduce the likelihood of the need for more intensive/restrictive services. Services include family therapy with the individual and family directed specifically towards the identified youth and his or her behavioral health needs and goals as identified in the individualized plan of care. Treatment may include trauma-informed and evidence based practices (EBP) related to adverse childhood experiences. IFI services may be provided individually in the office, home or community, or in single or multi-family group sessions. Group sessions may not be provided in the home. IFI services are directed exclusively toward the treatment of the SoonerCare eligible individual. These services are provided by a BHP.

(B) Intensive In-home (IIH) Support, Skills Training - Services are designed to restore, rehabilitate and support the individual's emotional and social development and learning. Services are intended for children, youth and young adults to provide intensive, on-going interventions that are specified in the individual's person-centered, individualized plan of care. This service reinforces the desired behavioral or cognitive changes by assisting the child and family in everyday application of the clinical plan of care's strategies and resultant insights. These services are designed to avoid the need for more restrictive care such as hospitalization and residential care. Components include:

(1) **"Problem identification"** is made in collaboration with the client in terms of obstacles that are barriers to the client's personal goals in his/her current life;

(2) **"Goal setting"** generates short-term approximations to the client's personal goals with specification of the social behavior that is required for successful attainment of the short-term, incremental goals. The goal-setting endeavor requires the provider to elicit from the client detailed descriptions of what communication skills are to be learned, with whom are they to be used, where, and when;

(3) **"Role play" or "behavioral rehearsal"**. Through these, the client demonstrates the verbal, nonverbal, and paralinguistic skills required for successful social interaction in the interpersonal situation set as the goal. Positive and corrective feedback is given to the patient focused on the quality of the behaviors exhibited in the role play;

(4) **"Social modeling"** is provided by demonstrating the desired interpersonal behaviors in a form that can be vicariously learned by the observing patient;

(5) **"Behavioral practice"** by the client is repeated until the communication reaches a level of quality tantamount to success in the real-life situation;

(6) **"Positive social reinforcement"** is given contingent on those behavioral skills that showed improvement;

(7) **"Positive reinforcement" and "Problem solving"** is provided at the next session based on the patient's experience using the skills on their own in a real life setting, since the last session.

This service, along with all of the components are provided by a QBHT or higher, who works with the client's lead BHP to implement the plan of care. Services may be provided individually or in group sessions. Group sessions may not be provided in the home and must use evidence based practices.

State: Oklahoma
Date Received: 30 August, 2019
Date Approved: 18 October, 2019
Effective Date: 1 September, 2019
Transmittal Number: 19-0018

Revised 09-01-2019

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

4b. Early and Periodic Screening, Diagnosis and Treatment of Conditions Found (continued)

B. Diagnosis and Treatment (continued)

8. Rehabilitative Services: Outpatient Behavioral Health

(c) Covered Services (continued)

iv. **Children's Psychosocial Rehabilitation (CPSR)** (continued)

(C) Therapeutic Behavioral Services, (TBS) - Services are goal directed activities for each client to restore, retain and improve the self-help, socialization, communication, and adaptive skills necessary to reside successfully in home and community-based settings. It also includes problem identification and goal setting, medication support, restoring function, and providing support and redirection when needed. TBS activities are behavioral interventions to complement more intensive behavioral health services and may include the following components:

(1) Basic living and self-help skills: Clients are given the skills to manage their daily lives which have been affected by mental health and/or substance use disorder issues; Clients' lives are restored by learning safe and appropriate behaviors to use, which may include stress and anger management, behavior redirection and self-esteem enhancement;

(2) Social skills: Through rehabilitative interventions, clients are able to identify and comprehend the physical, emotional and interpersonal needs of others which enables them to interact with others;

(3) Communication skills: Clients are able to overcome the disabling effects that mental health and/or substance use disorder issues have on their every day lives by learning how to appropriately communicate their physical, emotional and interpersonal needs to others;

(4) Organization and time-management skills: Clients are enabled to manage and prioritize their daily activities which have been diminished by their mental health and/or substance use disorder issues;

(5) Transitional living skills: Clients are enabled through rehabilitative interventions to begin partial-independent and/or fully independent lives;

The activities in paragraphs (B)(1)-(5) above are provided one-on-one, and may be provided by a QBHA or higher under the supervision of, or direction of a BHP. All services may be provided in the home, residential or school settings, or in the community.

v. **Peer Services: Parent and Youth Support Services** – Parent and youth support services include developing and linking with formal and informal supports; instilling confidence; assisting in the development of goals; serving as an advocate, mentor, or facilitator for resolution of issues; and teaching skills necessary to improve coping abilities. The providers of peer support services are family members or youth with "lived experience" who have personally faced the challenges of coping with serious mental health and/or substance use disorder conditions, either as a consumer or a caregiver. These peers provide support, education, skills training, and advocacy in ways that are both accessible and acceptable to families and youth. Child training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the child, provided under the direction of a child and family treatment team and intended to support the family with maintaining the child in the home and community. Parent support ensures the engagement and active participation of the family in the care planning process and guides families toward taking a proactive role in their child's treatment.

State: Oklahoma
Date Received: June 30, 2013
Date Approved: November 18, 2015
Date Effective: April 1, 2013
Transmittal Number: 13-12

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

4b. Early and Periodic Screening, Diagnosis and Treatment of Conditions Found (continued)

B. Diagnosis and Treatment (continued)

8. Rehabilitative Services: Outpatient Behavioral Health

(d) Covered Services (continued)

vi. **Peer Services: Parent and Youth Support Services (continued)**

Following are the minimum requirements for coverage of Peer support:

A. **Supervision –** Services must be provided, under the supervision of a BHP.

B. **Care coordination -** Services are goal directed and coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals.

C. **Training and Credentialing -** This service is provided by a trained/certified CPSP under the supervision of a BHP**.** For provider qualifications, see Attachment 3.1-A, page 1a-6.4(b).

vii. **Intensive Outpatient Substance Abuse (IOP/SA) Rehabilitation-** Structured group services individuals who have emotional or behavioral problems related to substance abuse/chemical dependency, to restore and support recovery from alcoholism, problem drinking, drug abuse, drug dependency addiction or nicotine use and addiction. Individual counseling may be provided as a supportive adjunct to group sessions. This service is provided by a BHP or CADC.

viii. **Therapeutic Day Treatment (TDT) -** Day Treatment is for the stabilization of individuals with severe emotional and/or behavioral disturbances. These interventions are designed to reduce symptoms, improve behavioral functioning, increase the individual's ability to cope with and relate to others, promote recovery, and enhance the client's capacity to function in an educational setting, or to be maintained in community based services. Services shall be provided in a facility away from the client's residence. Treatment activities include: family, group and Individual psychotherapy, medication training & support, and CPSR (for description of CPSR see Attachment 3.1A, Page 1a-6.5a). Staff collaborates with the school and other service providers prior to admission and throughout service duration. Services do not include routine supervision, child care, respite or personal care. Individual, family and group psychotherapy is be provided by a BHP. Medication training & support is provided by a physician assistant or licensed registered nurse under the supervision of a physician, or an advanced practice nurse. Group rehabilitation is provided by a QBHT or higher supervised by a BHP.

ix. **Multi-systemic Therapy (MST) -** Multi-systemic therapy is an intensive family and community-based treatment program that focuses on addressing all environmental systems of youth whose service needs require the involvement of multiple components within the system of care. The MST model is based on empirical data and evidence based interventions that target specific behaviors with individualized behavioral interventions. The MST program seeks to improve the real-world functioning of youth by changing their natural settings in ways to promote prosocial behavior while decreasing antisocial behavior. Therapists work with youth and their families to address the known causes of delinquency on an individualized, yet comprehensive basis. MST is a home-based service delivery model. All MST services must be provided to, or directed exclusively toward the treatment of the SoonerCare eligible youth.

State: Oklahoma
Date Received: June 30, 2013
Date Approved: November 18, 2015
Date Effective: April 1, 2013
Transmittal Number: 13-12

Revised 04-01-13

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

4b. Early and Periodic Screening, Diagnosis and Treatment of Conditions Found (continued)

B. Diagnosis and Treatment (continued)

8. Rehabilitative Services: Outpatient Behavioral Health

(c) Covered Services (continued)

(A) Eligible Providers: MST

Refer to Attachment 3.1-A, pages 1a-6.4 through 1a-6.4b for individual provider qualifications. In addition, the provider agency must be licensed and trained by MST, Inc., of Charleston, South Carolina and receive regular consultation from them.

(B) MST Team

Services are provided through a team approach (BHP and QBHT) to individuals and their families. The intent of the team approach is to:

(1) promote the family's capacity to monitor and manage the youth's behavior;
(2) (involve families and other systems, such as the school, probation officers, extended families and community connections;
(3) provide access to a variety of interventions 24 hours per day, seven days per week by staff that will maintain contact and intervene as one organizational unit; and
(4) include structured face-to-face therapeutic interventions to provide support and guidance in all areas of functional domains (adaptive, communication, psychosocial, problem solving, behavior management, etc.)

(C) MST Service Components:

An initial psychiatric, psychological or psychosocial assessment/evaluation completed by a BHP is used to document medical necessity and to identify the focus of the MST intervention;

(1) Therapeutic interventions with the individual and his or her family such as strategic family therapy, structural family therapy, intensive family intervention (IFI), and cognitive behavioral therapy;
(2) Peer services (see Attachment 3.1A, Page 1a-6.5b for individual service description);
(3) Specialized therapeutic and rehabilitative interventions to address all areas seen as contributing to an individual's delinquency including, but not limited to:
- substance abuse; or
- sexual abuse; or
- domestic violence; and
- crisis stabilization

(D) MST Exclusions:

MST cannot be billed in conjunction with the following:

- Children's Psychosocial Rehabilitation;
- Partial Hospitalization/ Intensive Outpatient Treatment;
- Residential Services (PRTF, RBMS, TFC or Group Services)
- Targeted Case Management
- Individual, family, group therapy
- Mobile crisis intervention
- Peer-to-Peer services
-

The duration of MST is typically three to six months. Weekly interventions may range from 3 to 20 hours per week and may be less as case nears closure.

Revised 04-01-13

State: Oklahoma
Date Received: June 30, 2013
Date Approved: November 18, 2015
Date Effective: April 1, 2013
Transmittal Number: 13-12

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

4b. Early and Periodic Screening, Diagnosis and Treatment of Conditions Found (continued)

B. Diagnosis and Treatment (continued)

8. Rehabilitative Services: Outpatient Behavioral Health

(c) Covered Services (continued)

x. **Partial Hospitalization (PHP) / Intensive Outpatient (IOP)** – PHP / IOP is an intermediary, stabilizing step for children/adolescents that have had inpatient hospitalization prior to returning to school and community supports or as a less restrictive alternative to children and adolescents when inpatient treatment may not be indicated. PHP/IOP services are services that (1) are reasonable and necessary for the diagnosis or active treatment of the individual's condition, (2) are reasonably expected to improve the individual's condition and functional level and to prevent relapse or hospitalization.

(A) Eligible Providers: PHP/IOP

All outpatient behavioral health providers eligible for reimbursement must be an accredited organization, be an incorporated organization governed by a board of directors and have a current contract on file with the Oklahoma Health Care Authority. The staffs providing PHP/IOP services are employees or contractors of the enrolled agency. The agency is responsible for ensuring that all services are provided by properly credentialed clinicians.

(B) PHP/IOP Team

All services in the PHP/IOP program are provided by a clinical team consisting of the following required professionals: a licensed physician, registered nurse, behavioral health practitioners (BHP). BHPs include any credentialed practitioner licensed for independent practice or under supervision. The clinical team may also include any QBHT. The number of professionals and paraprofessionals required on the clinical team is dependent on the size of the program. Team members must meet the individual qualifications, as applicable, listed in the provider qualifications section.

(C) PHP/IOP Service Components

- Assessment, diagnostic and care plan for mental illness and/or substance abuse disorders by BHP (that do not duplicate the services provided by the inpatient setting)
- Plans of care must be strength-based and address the goals listed in the child's IEP**.** The plan of care is directed under the supervision of a physician; however physician direct supervision is not required;
- Individual/family/group psychotherapies provided by BHPs (family therapy is directed toward treatment of the individual's condition);
- Substance abuse specific services provided by individuals qualified to provide these services (Alcohol and Drug Counselors);
- Drugs and biologicals furnished for therapeutic purposes;
- CPSR groups and educational services to the extent the intervention and education services are closely and clearly related to the individual's care and treatment;
- Medication management;
- Monitoring and follow-up activities including activities and contacts that are necessary to ensure that the plan of care is effectively implemented, and adequately addresses the needs, including education needs of the individual, so that the child can make a successful transition back to home and/or school. This service can be performed by a BHP or a qualified Behavioral Health Case Manager;
- Referral and linking activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services by a qualified Behavioral Health Case Manager.

State: Oklahoma
Date Received: 1 May, 2019
Date Approved: 17 June, 2019
Effective Date: 1 April, 2019
Transmittal Number: 19-0013

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

4b. Early and Periodic Screening, Diagnosis and Treatment of Conditions Found *(continued)*

B. Diagnosis and Treatment *(continued)*

8. Rehabilitative Services: Outpatient Behavioral Health

(c) Covered Services *(continued)*

(D) Eligibility Criteria: PHP/IOP

Any child 0-20 who is an eligible client and meets the medical necessity criteria and programmatic criteria for behavioral health services quality for PHP/IOP. This service must be ordered by a physician, physician's assistant, or advanced registered nurse practitioner, within their scope of practice, and be prior authorized by OHCA or its designated agent. Concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

State: Oklahoma
Date Received: 1 May, 2019
Date Approved: 17 June, 2019
Effective Date: 1 April, 2019
Transmittal Number: 19-0013

(E) Billing Limits: PHP/IOP

1. Treatment is time limited and must be offered a minimum of 3 hours per day, 5 days a week.
2. PHP/IOP is all-inclusive of the service components. PHP/IOP cannot be billed in conjunction with the following:
   - Children's Psychosocial Rehabilitation Services;
   - Residential Services (PRTF or RBMS);
   - Targeted Case Management;
   - Individual, family, or group therapy;
   - Mobile crisis intervention provided within the PHP setting;
   - Peer-to-Peer services;
   - Therapeutic Day Treatment (TDT);
   - Multi-Systemic Therapy (MST);
   - Inpatient/residential psychiatric or residential substance use disorder services;
   - Program of Assertive Community Treatment (PACT);
   - Certified Community Behavioral Health services

(d) Exclusions and Limitations

i. All behavioral health services must be subject to the medical necessity criteria. The services listed in 8(c) iv - x are initiated following the completion of a diagnostic screen or assessment and subsequent development of a plan of care.

ii. Only specialized, rehabilitation or psychological treatment services to address unique, unusual or severe symptoms or disorders will be authorized. Concurrent documentation must be provided that these services are not duplicative in nature.

iii. A QBHT who also provides case management services must document case management separately from rehabilitation services and may not refer to their own agency.

(e) Non-Covered Services

i. Room and Board;
ii. Educational costs;
iii. Services to inmates of public institutions;
iv. Services to clients in Institutions for Mental Diseases (IMDs);
v. Routine supervision and non-medical support services in school setting;
vi. Child care;
vii. Respite;
viii. Personal Care

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

4b. Early and Periodic Screening, Diagnosis and Treatment of Conditions Found *(continued)*

B. Diagnosis and Treatment *(continued)*

9. Preventive Services – (42 CFR 440.130(c))
Outpatient Substance Abuse Prevention Counseling – Interactive, preventive counseling that may include training in life skills, such as problem-solving, responsibility, communication and decision-making skills, which enable individuals to successfully resist social and other pressures to engage in activities that are destructive to their health and future. This service must be recommended by a physician or other licensed practitioner and may be provided by a BHP. A QBHT may provide assistance. For individual provider qualifications, see Attachment 3.1-A, page 1a-6.4.

10. Inpatient Psychiatric Services (42 CFR 440.160) – Provided when medically necessary and prior authorized.

11. Personal Care Services (PCS) (42 CFR 440.167) – Services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or institution for mental disease that are: 1) authorized for an individual by a physician in accordance with a plan of treatment or otherwise authorized for the individual in accordance with an IEP service plan; 2) provided by registered paraprofessionals who have completed training provided by State Department of Education or Personal Care Assistants, including Licensed Practical Nurses who have completed on the job training specific to their duties and who is not a member of the individual's family (or legally responsible relative) Provision of these services allows clients with disabilities to function safely in their activities of daily living in the home and to safely attend school. Services include, but are not limited to: dressing, eating, bathing, assistance with transferring and toileting, positioning and instrumental activities of daily living such as preparing meals and managing medications. PCS also includes assistance while riding a school bus to handle medical or physical emergencies. Services must be prior authorized. The determination of whether a client needs PCS is based on a client's individual needs and a consideration of family resources.

12. School-Based Health Services – Medicaid 1905(a) services delivered in the school setting are provided pursuant to a valid Individualized Education Plan (IEP) in accordance with Individuals with Disabilities Education Act (IDEA) and all relevant supporting documentation. Services provided per the IEP and supporting documentation are considered medically necessary and are provided by or through local educational agencies and/or interlocal cooperatives (schools) to eligible individuals. IEPs my only serve as the basis for medical necessity if the IEP team providers are qualified to make that determination, in accordance with their scope of practice.

Medically necessary services are provided in a school setting during the school day when determined that the school is an appropriate place of service performed by qualified providers as set forth in the State Plan for the services they are providing and shall meet applicable qualifications under 42 CFR Part 440. OHCA-contracted practitioners furnish medically necessary services to the Medicaid eligible child while the school is the operator of the setting, ensures that the student's school educational day is not unnecessarily interrupted, and that there is appropriate parental consent for the services. Schools have the right to limit outpatient visits unrelated to the IEP to before and after the school day so that interruptions the educational day are limited. Prior authorization is required for non-IEP services furnished by an independent practitioner under arrangement with the school. All beneficiaries must be allowed the freedom of choice to receive services from any qualified practitioner including in a community setting.

13. Private Duty Nursing (PDN) Services (42 CFR 440.80) – Services are provided under the direction of the member's physician by a registered nurse (RN) or a licensed practical nurse (LPN) who is employed by an OHCA-contracted home health agency and in good standing in the state in which services are provided. Medically necessary PDN services offered through an OHCA-contracted home health agency must meet one of the following requirements:

- Medicare certified; or
- accredited by The Joint Commission (TJC); and
- licensed through the Oklahoma Department of Health as a Home Care Agency.

Home health service providers that did not participate in Medicaid prior to January 1, 1998, must meet the "Capitalization Requirements" set forth in 42 CFR 489.28.

Medically necessary services are furnished in the member's home or when normal life activities take the member outside of the home.

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

4b. Early and Periodic Screening, Diagnosis and Treatment of Conditions Found (continued)

C. **Other Necessary Health Care** – Such other necessary health care, diagnostic services, treatment, and other measures described in Section 1905(a) of the Social Security Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan. Federal regulations require the state to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe or effective or considered experimental.

D. **Transportation and Scheduling Assistance**
Transportation is provided when necessary in connection with examination or treatment when not otherwise available as authorized.

E. **Continuing Care**

1. **Patient Centered Medical Home** - For purposes of this plan, a continuing care provider means a qualified provider that has an agreement with the State to be a patient centered - medical home (PC-MH) for children with special health care needs (CSHCN). CSHCN are those individuals who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

2. The qualifications for a PC-MH will be established by the State, and may incorporate the principles developed by the AAP and American Academy of Family Practitioners. A PC-MH may include individual private practitioners, group practices, public health agencies and federally qualified health centers. The PC-MH agrees to provide at least the following services to eligible EPSDT recipients:

STATE Oklahoma
DATE RECD 10-12-06
DATE APPD 11-6-08
DATE EFF 10-28-06
HCFA 179 06-15

A

Revised 10-28-06

TN# 06-15 Approval Date 11-6-08 Effective Date 10-28-06
Supersedes
TN# 99-11

Superseded 99-11

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

4b. Early and Periodic Screening, Diagnosis and Treatment of Conditions Found (continued)

E. Continuing Care (continued)

(a) A child health screening, diagnosis and referral for follow-up services;
(b) Maintenance of the member's consolidated health history including information from other providers;
(c) Physician services as needed by the member for acute, episodic or chronic illness or condition;
(d) Provision of dental services or direct referral to an appropriate public health agency, community health center, or private practitioner, for the provision of dental services;
(e) Referral for transportation or scheduling assistance; Primary care case management services: (Interim medical care coordination only for the first 45 days upon entering foster care status for Title IV-E eligibles);

3. **Reporting** – The PC-MH will also provide any reports as required by the State.

4. **State Monitoring** – The State has in place quality assurance procedures to ensure compliance with the medical home agreement.

5. **Coordination with Related Programs** -- The State makes appropriate use of State health agencies, State vocational rehabilitation agencies, and Title V grantees (Maternal and Child Health/Crippled Children's Services). Further, the agency should make use of other public health, mental health, and education programs and related programs, such as Head Start, Title XX (Social Services) programs, and the Special Supplemental Food Program for Women, Infants and Children (WIC), to ensure an effective child health program.

STATE Oklahoma
DATE RECD 10-12-06
DATE APPD 11-6-08
DATE EFF 10-28-06
HCFA 179 06-15

A

Revised 10-28-06

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

Reserved

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

Reserved

State/Territory: OKLAHOMA

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

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: ___ No limitations X With limitations*

4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

4.c. Family planning services and supplies for individuals of child-bearing age.

Provided: ___ No limitations X With limitations*

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Provided: ___ No limitations X With limitations*

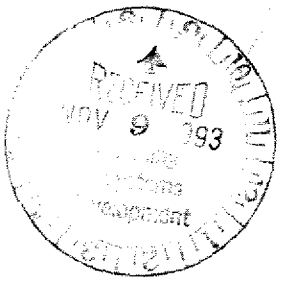
b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: ___ No limitations X With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services.

Provided: ___ No limitations X With limitations*



STATE Oklahoma
DATE REC'D OCT 0 4 1993
DATE APPV'D OCT 2 7 1993
DATE EFF JUL 0 1 1993
HCFA 179 93-15

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* Description provided on attachment.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Family Planning Benefits

1905(a)(4)(C) 4.c(i) Family planning services and supplies for individuals of child-bearing age and for individuals eligible pursuant to Att. 2.2-A(B) if this eligibility option is elected by the State.

Provided: ☐ No limitations ☒ With limitations

Please describe any limitations: Services are limited pursuant to the conditions contained in Att. 3.1-A, 4c.

4.c(ii) Family planning-related services provide under the above State Eligibility Option:

(1) Male annual visit
(2) Gardasil

STATE Oklahoma	A
DATE REC'D 6-29-11	
DATE APP'V'D 7-29-11	
DATE EFF 7-1-11	
HCFA 179 11-05	

SUPERSEDES: NONE - NEW PAGE

New Page 07-01-2011

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

Family Planning Services

4.c. Family Planning Service Limitations

(1) Sterilizations including non-emergency and elective sterilizations are covered only when all the requirements of 42 CFR 441.2, Subpart F are met.

(2) Hysterectomies require an acknowledgement of the sterilization results of the hysterectomy signed by the recipient or her representative prior to the operation.

(3) Family planning services and supplies are covered for individuals of childbearing age as medically appropriate and medically necessary.

State: Oklahoma
Date Received: 31 July, 2017
Date Approved: 15 September, 2017
Effective Date: 1 July, 2017
Transmittal Number: 17-07

State OKLAHOMA

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
CATEGORICALLY NEEDY

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5. **Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.**

Payment is made for compensable medical and surgical outpatient and inpatient services. For adults, physician inpatient services are limited to 24 hospital days paid on hospital claims during a State Fiscal Year for each individual recipient. Physician claims for hospital visits will be paid until the last compensable hospital day is captured. After 24 hospital days have been captured, no inpatient physician services will be paid beyond the last compensable hospital day. Hospital visits are limited to one visit per day per physician. Office visits, home visits or elsewhere are limited to four per month, per patient regardless of the number of physicians and two visits per month in a nursing facility. The following services are excluded from number of visits limitation:

1. Emergency department
2. EPSDT
3. Family planning

Payment is made for medical and surgical services performed by a dentist, to the extent such services may be performed under State law either by a doctor of dental surgery or dental medicine, when those services would be covered if performed by a physician.

SUPERSEDES: TN- 02-01

STATE Oklahoma DATE REC'D 12-23-03 DATE APPV'D 2-2-04 DATE EFF 1-1-04 HCFA 179 03-24	A

Revised 01-01-04

State OKLAHOMA

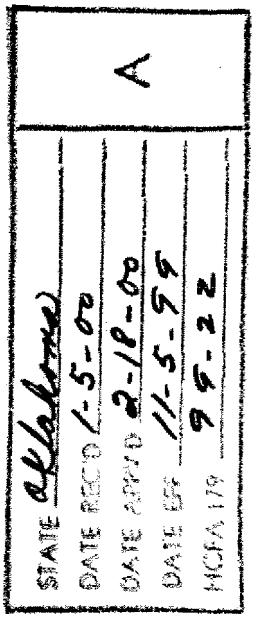
AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED CATEGORICALLY NEEDY

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' Services

Limited to medically necessary surgical procedures; medically necessary outpatient visits; and procedures generally considered as preventive foot care. All preventive care must be medically appropriate and related to the systemic disease. The patient must be under the active care of a doctor of medicine or osteopathy who documents the condition. The nursing home visits must be ordered by the attending physician. The nursing home record must reflect that the visit was not for screening purposes. All outpatient visits are subject to the existing visit limitations.

For children, see Item 4.b., EPSDT.



Revised 11-05-99

State OKLAHOMA

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

6.b. Optometrists' Services

See 4.b. EPSDT

Payment will be made to optometrists for medical services within the scope of the optometric practice as defined by State law for those services. Optometrists' services will be subject to the same amount, duration and scope as physicians.

STATE OK
DATE REC'D AUG 3 1 1987
DATE APP'D SEP 1 1 1987
DATE EFF AUG 1 1987
HCFA I?? 87-12

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Revised 08-01-87

TN# 87-12
Supercedes
TN# 85-6

Approval Date SEP 1 1 1987 Effective Date AUG 1 1987

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

b. Optometrists' services.

[X] Provided: [ ] No limitations [X] with limitations*

[ ] Not provided.

c. Chiropractors' services.

[ ] Provided: [ ] No limitations [ ] with limitations*

[X] Not provided.

d. Other practitioners' services.

[X] Provided: identified on attached sheet with description of limitations, if any.

[ ] Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: [X] No limitations [ ] with limitations*

b. Home health aide services provided by a home health agency.

Provided: [X] No limitations [ ] with limitations*

c. Medical supplies, equipment, and appliances suitable for use in any setting in which normal life activities take place, other than a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

Provided: [X] No limitations [ ] with limitations*

Physical therapy, occupational therapy, or speech pathology and audiology services are not covered when provided by a home health agency.

State/Territory: OKLAHOMA

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

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

/ / Provided: / / No limitations / /With limitations*

/X/ Not provided.

8. Private duty nursing services.

/ / Provided: / / No limitations / /With limitations*

/X/ Not provided.

*Description provided on attachment.

STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APPV'D FEB 27 1992
DATE EFF OCT - 1 1991
HCFA 179 92-03
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AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED CATEGORICALLY NEEDY

6.d. Other Practitioners' Services

A. Psychological Services – See 4b. EPSDT

B. Certified Registered Nurse Anesthetists - Payment is made for inpatient and outpatient anesthesia services which are in the scope of the Medicaid Program and under the appropriate scope of practice allowed under State law for Certified Registered Nurse Anesthetists.

C. Anesthesiologist Assistants - Payment is made for inpatient and outpatient anesthesia services which are in the scope of the Medicaid Program and under the appropriate scope of practice allowed under State law for Anesthesiologist Assistants.

D. Physician Assistants – Payment is made for services provided by licensed Physician Assistants within the current practice guidelines for the State of Oklahoma.

E. Nutritional Services – Payment is made for up to six hours of nutritional counseling per year. All services must be prescribed by a physician, physician assistant, advanced practice nurse or nurse midwife and be face to face encounters between the State licensed dietitian and the client. Limitations on nutritional services are not applicable for EPSDT individuals. Services must be expressly for diagnosing, treating or preventing or minimizing the effects of illnesses. Nutritional services for the treatment of obesity are not covered unless there is documentation that the obesity is a contributing factor in another illness.

F. Health Education and counseling services for pregnant women – Payment is made for pregnancy related and postpartum health education and counseling services provided by practitioners licensed by the state in accordance with 42 CFR 440.060(a). Services are designed to provide educational information to the pregnant woman in caring for herself during pregnancy within existing standards of care. Services include genetic counseling by licensed genetic counselors, lactation consulting and counseling by state licensed nurses and state licensed dieticians who are also certified International Board Lactation Consultants, psychosocial support services by licensed clinical social workers, and prenatal care coordination and patient education by licensed practitioners.

STATE Oklahoma
DATE RECD 2-4-10
DATE APPVD 5-5-10
DATE EFF 2-1-10
HCFA 179 10-03
A

Revised 02-01-10

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

6.d. Other Licensed Practitioners *(continued)*

G. Licensed Behavioral Health Practitioner Services

Services provided by independently licensed clinical psychologists practicing within state scope of practice are covered when medically necessary.

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

6d. Other Practitioners' Services *(continued)*

H. **Genetic Counseling Services** – In accordance with 42 CFR 440.60, genetic counseling services are provided by licensed genetic counselors to members for whom it is medically necessary

I. **Diabetes Self-Management Education and Support (DSMES) Services** – In accordance with 42 CFR 440.60, diabetes self-management education and support services are provided by a Registered Dietician (RD), Registered Nurse (RN), or Pharmacist who is licensed, in good standing in the state in which s/he practices, and has training and experience pertinent to diabetes self-management, or provided by a health care professional holding the certification of a Certified Diabetes Care and Education Specialist (CDCES) or Board-Certified Advanced Diabetes Management (BC-ADM). The CDCES and BC-ADM are licensed practitioners operating within scope of practice under state law or are under the supervision of a licensed practitioner who assumes professional responsibility and such supervision is within the licensed practitioner's scope of practice, consistent with 42 CFR 440.60.

J. **Pharmacy Services** – Per 42 CFR 440.60, licensed Pharmacists may provide any and all services within their scope of practice pursuant to state law, including but not limited to administration of any vaccinations or immunizations recommended by the Advisory Committee on Immunization Practices (ACIP).

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

7. Home Health Services

After January 1, 1998, all Home Health Agencies requesting an initial Medicaid provider agreement with this agency must meet the capitalization requirements as set forth in 42 CFR 489.28 and 42 CFR 440.70(d).

The home health agency providing home health services must be certified to participate as a home health agency under Title XVIII (Medicare) of the Social Security Act, and comply with all applicable state and federal laws and requirements.

Home health services are provided in accordance with 42 CFR 440.70 and include nursing services, home health aide services provided by a home health agency, and medical supplies, equipment and appliances.

Home health services must be provided to a beneficiary on orders written by a physician, nurse practitioner, clinical nurse specialist, or physician assistant as part of a written plan of care, which must be reviewed every sixty (60) days, as specified in 42 CFR 440.70(a)(2). The beneficiary's physician, nurse practitioner, clinical nurse specialist, or physician assistant must document that a face-to-face encounter, in accordance with 42 CFR 440.70(f), occurred no more than ninety (90) days before or thirty (30) days after the start of home health services.

Recipients do not have to be homebound in order to receive home health services. In accordance with 42 CFR 440.70(c)(1), home health services can be provided in any non-institutional setting in which normal life activities take place, other than a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF/IID), or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

Medical supplies, equipment, and appliances are covered when prescribed by a physician and are prior authorized; prior authorizations are reviewed by the Oklahoma Health Care Authority or its contractor or designee. Medical supplies, equipment, and appliances may be provided regardless of whether a beneficiary is receiving services from a home health agency. Services must meet medical necessity criteria.

For the initial ordering of certain medical equipment, the prescribing physician or allowed non-physician practitioner must document that a face-to-face encounter occurred no more than six (6) months prior to the start of services. The face-to-face encounter must be related to the primary reason the beneficiary requires the medical equipment. An allowed non-physician practitioner that performs the face-to-face encounter must communicate the clinical findings of the face-to-face encounter to the ordering physician. Those clinical findings must be incorporated into a written/electronic document included in the beneficiary's medical record.

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

7. Home Health Services *(continued)*

Medical supplies, equipment, and appliances are covered if they:

1. Are relevant to the beneficiary's plan of care;
2. Are medically necessary;
3. Primarily serve a medical purpose; and,
4. Are appropriate for use in the non-institutional setting where the beneficiary's normal life activities take place, other than a hospital, nursing facility, ICF/IID, or any setting in which payment is or could be made under Medicaid for inpatient service that include room and board.

The beneficiary's need for medical supplies, equipment, and appliances must be reviewed by the beneficiary's physician annually.

Medical equipment and appliances must be provided through qualified DME providers. Medical supplies may be provided through a qualified home health agency or DME provider.

NEW 08-01-2020

**AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEFORICALLY NEEDY**

9. Clinic services.
_X__ Provided ____ No limitations _X__ With limitations*

____ Not provided.

10. Dental services.

_X__ Provided ____ No limitations _X__ With limitations*

____ Not provided.

11. Physical therapy and related services.
a. Physical therapy.

_X___ Provided ____ No limitations _X___ With limitations**

____ Not provided.

b. Occupational therapy.
_X___ Provided ____ No limitations _X___ With limitations**

____ Not provided.

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).
_X__ Provided ____ No limitations _X__ With limitations**

____ Not provided.

*Description provided on attachment.
** Limitation applicable to adults only: OT/PT/ST services are provided in the outpatient setting.

State OKLAHOMA

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

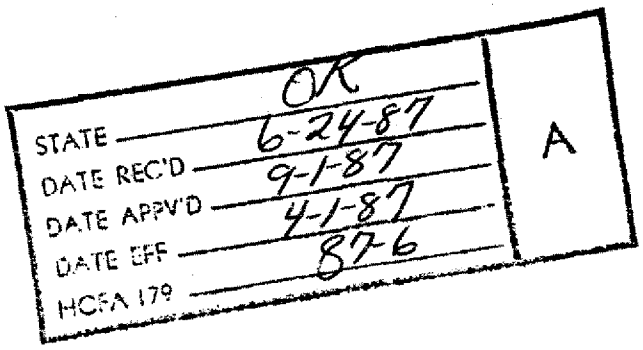
9. (7.) Free-Standing Ambulatory Surgery Center - Payment is made for a facility fee for certain surgical procedures performed in Medicare certified free-standing ambulatory surgical centers which have contracts on file with the Department.

APPROVED BY DHHS/HCFA/DPO
DATE: AUG 15 1986
TRANSMITTAL NO: 85-6

State OKLAHOMA

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

9. Renal Dialysis Facilities-Payment is made for dialysis services provided by Medicare certified renal dialysis facilities which have contracts with the Department.



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

Clinic Services

(a) All medical services performed must be medically necessary and may not be experimental in nature.

(b) Only services furnished by or under the direction of a physician or dentist are covered. Clinic services may be provided in Public Health Clinics, qualified Urgent Care Clinics, qualified Urgent Recovery Clinics and other types of governmental and non-governmental clinics.

(c) Clinic services for which physicians or dentists file directly are not covered.

(d) Clinic services are limited to the same scope of services that are otherwise furnished in the plan, as appropriate.

State: Oklahoma
Date Received: 5-15-15
Date Approved 8-7-15
Date Effective: 4-1-15
Transmittal Number: OK 15-002

Revised 04-01-2015

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

Public Health Clinic Services

(a) Public Health Clinics are governmental providers of medical services. All medical services performed must be medically necessary and or preventive and may not be experimental in nature. Preventive services are health services that are medical or remedial in nature provided to a member to avoid or minimize the occurrence of illness, infection, disability, or to provide care for pregnancy.

- Services must be provided on a face to face basis;
- the service must affect the member's care rather than the member's environment;
- the service must not be a part of another covered service;
- the service must be for the express purpose of treating or preventing (or minimizing the adverse effects of) illness, injury or other impairments to an individual's physical or mental health; and
- the service must be generally accepted by the provider's professional peer group as a safe and effective means to avoid or minimize the illness, infection or disability.

(b) Eligible providers of Public Health Nursing Services include Licensed Public Health Nurses working in a Public Health Clinic. Services must be provided under the direction of a physician and within their scope of practice in accordance with state law.

STATE Oklahoma
DATE REC'D 11-8-11
DATE APPV'D 2-3-12
DATE EFF 10-1-11
HCFA 179 11-09
A

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

10. Dental Services

Dental services for adults age 21 and over are described below and may require prior authorization:

a. Diagnostic:
   1. Examinations
   2. X-Rays

b. Preventive:
   1. Dental Cleanings
   2. Fluoride

c. Restorative: Dental Fillings

d. Non-surgical Periodontal Therapy: Scaling and Root Planing

e. Removable Prosthetics:
   1. Dentures
   2. Partial Dentures

f. Medically Necessary Extractions

For the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) population, dental services are furnished based on medical necessity; refer to Attachment 3.1-A, EPSDT section 5 on Page 1a-6.2.

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

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

b. Dentures.

/ / Provided: / / No limitations / / With limitations*

/X/ Not provided.

c. Prosthetic devices.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

d. Eyeglasses.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

/ / Provided: / / No limitations / / With limitations*

/X/ Not provided.

*Description provided on attachment.

APPROVED BY DHHS/HCFA/DPO
DATE: AUG. 15 1986
TRANSMITTAL NO: 85-6
Revised 4-1-85

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

12a. **Prescribed drugs, dentures, and prosthetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.**

Prescription Drugs

Payment:
Payment is made from Title XIX funds to pharmacies with whom the Agency has a contract on behalf of categorically needy recipients up to a maximum of six (6) prescriptions (new or refill) with a limit of two (2) brand name per month per eligible recipient. A brand limit override is available for one additional brand prescription based on medical necessity and established criteria. The policy regarding the monthly two (2) brand name limitation and the one (1) brand limit override is effective January 1, 2012.

Exceptions:

(1) For persons served by a 1915(c) home and community based services waiver, payment is made from Title XIX funds for up to a maximum of six (6) prescriptions (new or refill) with a limit of three (3) brand name per month per eligible recipient.

(2) Prescription drugs under EPSDT, antineoplastics, antiretroviral agents for persons diagnosed with acquired immune deficiency syndrome (AIDS)/human immunodeficiency virus (HIV), certain prescriptions which require frequent monitoring, contraceptives, drugs used for medication assisted treatment, naloxone, prenatal vitamins, drugs used for tobacco cessation products, and hemophilia drugs are not limited to either the six (6) prescriptions per month or the two (2) brand name drugs per month limit.

Limitations:

(1) Prescription quantities are limited to a 34 day supply unless (1) the medication is included in the Maintenance Drug List, in which case, a 90 day supply may be dispensed or (2) the drug has a recommended dispensing quantity less than either of those limits. Drug classes listed on the Maintenance Drug List include anticoagulation, asthma, diabetic, hormone, cardiovascular, thyroid, and seizure. A complete list of the selected drugs included on the Maintenance Drug List can be viewed on the agency's website at www.okhca.org.

(2) Some prescription drugs may require prior authorization as determined by the Drug Utilization Review Board (DUR).

(3) Only prescription drugs whose manufacturers have a rebate agreement with CMS are covered.

(4) Investigational drugs are not covered, including FDA approved drugs being used in post-marketing studies.

Prior Authorization

The prior authorization process provides for a response by telephone or other telecommunications device within 24 hours of receipt of a completed prior authorization request. In emergency situations, providers may be reimbursed for a 72 hour supply of medication.

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

12a. **Prescribed drugs, dentures, prosthetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist** *(continued)*

Tiered Drug List

The DUR Board will determine medical necessity for drugs covered under the Oklahoma tiered drug list and establish criteria for any prior authorization process. A preferred product, tiered drug list is utilized for certain categories of drugs. Drugs included in Tier One are generally available without additional documentation. A prior authorization process is available for drugs not included in Tier One.

Supplemental Drug Rebate

Pursuant to Section 1927 of the Act, the State has the following policies for Medicaid supplemental rebates:

A model agreement between the State and a drug manufacturer for drugs provided to the Medicaid population, submitted to CMS on January 2, 2004, and entitled "State of Oklahoma, Oklahoma Health Care Authority Supplemental Rebate Agreement" and subsequent revisions have been authorized by CMS.

Supplemental rebates received by the State in excess of those required under the national rebate agreement will be shared with CMS on the same percentage basis as applied under the national rebate agreement.

Drugs of manufacturers who do not participate in the supplemental rebate program will still be available to Medicaid recipients.

Beginning January 1, 2017, Oklahoma became part of the Sovereign States Drug Consortium (SSDC). SSDC negotiates supplemental rebates for Oklahoma. The State retains all options to accept or reject offers. Drugs of manufacturers who do not participate in the supplemental rebate program will still be available to Medicaid recipients. The updated SSDC rebate agreement between the State and participating manufacturers for drugs provided to the Medicaid program, submitted to CMS on April 4, 2022 supersedes the SSDC rebate agreement approved in OK SPA 18-08. CMS has authorized the updated agreement. The updated agreement applies to drugs dispensed effective January 1, 2023.

Products for which a signed Medicaid State Supplemental Rebate Agreement is on file will have preferred status. This status may be reflected in the product's placement in lower tiers of the Tiered Drug List, inclusion on a Preferred Drug List, or by removing a prior authorization requirement from the product.

The State may enter into value-based contracts with manufacturers on a voluntary basis. These contracts will be executed on the model agreement entitled "Value-Based Supplemental Rebate Agreement" submitted to CMS on November 4, 2019 and authorized for use beginning January 1, 2020.

State: Oklahoma
Date Received: 7 November, 2019
Date Approved: 2 January, 2020
Effective Date: 1 January, 2020
Transmittal Number: 20-0002

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

12.a. Prescription drugs (continued)

An Open Formulary is administered, maintained, and subject to the provisions of Title 42, United State Code (U.S.C.), Section 1396r-8. All covered drugs may be excluded or coverage limited if the prescribed use is not for a medically accepted indication as provided under 42 U.S.C. §1396r-8 or the drug is subject to such restriction pursuant to the rebate agreement between the manufacturer and CMS.

The following legend drugs are excluded from coverage:

Anorexia or Weight Gain Medications: Medications used for anorexia or weight gain will not be a covered drug benefit. Exceptions: Methylphenidate and Dextroamphetamine shall be covered drug benefits for Medicaid covered children when prescribed for hyperactivity and narcolepsy. A prior authorization is required for adults. Methamphetamine and Methamphetamine/Dextroamphetamine require prior authorization for both children and adults.

Fertility Medications: Medications used to promote fertility will not be a covered drug benefit.

Cough and Cold Medications: Medications used for the symptomatic relief of coughs and colds will not be a covered drug benefit.

Prescription Vitamins and Minerals Products: Legend vitamin medications will not be a covered drug benefit. Exception: Vitamin medications containing fluoride for children, prenatal vitamins, prescription iron supplements for pregnant women, prescription vitamins to treat end stage renal disease, prescription vitamins covered for specific diagnosis when the FDA has approved use for a specific indication, and medically necessary prescription vitamin preparations for children under 21 when pursuant to EPSDT protocol, shall be a covered drug benefit.

Obesity Medications: Medications with primary usage for the treatment of obesity, such as appetite suppressants, will not be a covered drug benefit.

Less-than-effective Medications: Medications determined by the FDA to be less-than-effective are not covered.

Experimental Medications: Medications that are experimental or investigational are not covered.

Legend Medications Requiring Associated Tests: Legend medications requiring associated tests and/or monitoring will be a covered drug benefit only after obtaining prior authorization. A prior authorization process will also be used to authorize coverage of selected non-covered medications for individuals with specific diseases.

Non-Legend Medications: Non-legend medications are limited to the following categories for children only: non-sedating antihistamines, pediculicides, and topical anti-fungals. The State maintains a complete listing of covered non-prescription (over-the-cover or OTC) drug categories on its public website.

State: Oklahoma
Date Received: 26 June, 2018
Date Approved: 31 July, 2018
Effective Date: 1 April, 2018
Transmittal Number: 18-25

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

12.c. Prosthetics and Orthotics

Prosthetics means a replacement, corrective, or supportive device (including repair and replacement parts) worn on or in the body, to artificially replace a missing portion of the body, prevent or correct physical deformity or malfunction, or support a weak or deformed portion of the body.

Orthotics means an item used for the correction or prevention of skeletal deformities.

For children, see item 4.b., EPSDT.

State OKLAHOMA

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

12.d. Eyeglasses

See 4.b. EPSDT

APPROVED BY DHHS/HCFA/DPO
DATE: AUG. 15 1986
TRANSMITTAL NO: 85-7

b. Screening services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not Provided.

c. Preventive services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not Provided.

d. Rehabilitative services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not Provided.

14. Services for individuals age 65 and older in institutions for mental diseases.

a. Inpatient hospital services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Nursing facility services.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

*Description provided on attachment.

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

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

b. Screening Services

Refer to Attachment 3.1-A, Page 1a-4.

c. Preventive Services

Refer to Attachment 3.1-A, Page 6aa-1

d. Rehabilitative Services

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

13.c Preventive Services

A doula, or birth worker, is a trained professional who provides emotional, physical, and informational support during the prenatal, labor, delivery, and postpartum periods. Doulas are non-clinical and do not provide medical care. Doulas should not replace the services of licensed and trained medical professionals including, but not limited to, physicians, physician assistants, advanced practice registered nurses, and certified nurse midwives.

Services:
Doula services may include, but are not limited to:

- Providing emotional and physical support, including but not limited to prenatal coaching, physical comfort measures, and person-centered care honoring cultural and family traditions;
- Advocating and working as part of the beneficiary's multidisciplinary team;
- Prenatal counseling and assisting the beneficiary in preparing for and carrying out plans for birth;
- Teaching and advocating on behalf of the birthing parent during appointment visits;
- Facilitating and assuring access and linkage to resources that can improve birth-related outcomes, such as transportation, housing, alcohol & drug cessation, WIC, SNAP, and intimate partner violence resources;
- Providing ongoing education, with emphasis on postpartum care and resources;
- Providing information on infant feeding, breastfeeding guidance and resources, including referrals to lactation consultants as needed; and
- Supporting the whole birth team, including the birthing parent's partner, family members and other support persons.

Limitations:

- Doula services must be recommended by a physician or other licensed practitioner of the healing arts, including physician assistants, certified nurse practitioners, obstetricians, or certified nurse midwives.
- Beneficiaries are allowed eight prenatal/postpartum visits and one Labor & Delivery Care visit. Visits have a minimum duration of 60 minutes and may be conducted in person or via telehealth, but the Labor & Delivery Care visit may not be conducted via telehealth. The doula will work with the beneficiary to determine how to utilize these visits to best meet the needs of the beneficiary, including how many visits will occur during the prenatal period or postpartum period.
    - A prior authorization is required for additional visits, for beneficiaries with extenuating medical circumstances.
- Doulas will coordinate directly with the beneficiary to determine the most appropriate service location for prenatal and postpartum visits, which may include the beneficiary's residence, the physician's office, the doula's office, a hospital, or in the community. The Labor & Delivery Care visit may not occur in the beneficiary's residence.
- For the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) population, services are furnished based on medical necessity.

Eligible Providers:

- All providers of doula services must be at least 18 years of age and have an NPI number.
- Providers must be certified by an organization recognized by the Oklahoma Health Care Authority for the certification of doulas. This list may be found at www.oklahoma.gov/ohca/doula.
    - The types of certifications accepted are:
        - Birth Doula
        - Postpartum Doula
        - Full-Spectrum Doula
        - Community-Based Doula

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

13.d. Rehabilitative Services 42 CFR 440.130(d)
13.d.1. Outpatient Behavioral Health Services

Outpatient behavioral health services are covered for adults and children when provided in accordance with a documented individualized service plan developed to treat the identified mental health and/or substance abuse disorder(s).

A. Eligible Providers

Eligible providers are community-based outpatient behavioral health organizations that have a current accreditation or certification status as a provider of behavioral health services from:

(1) The Commission on the Accreditation of Rehabilitative Facilities (CARF); or
(2) The Joint Commission on the Accreditation of Healthcare Organizations (TJC); or
(3) The Council on Accreditation (COA); or
(4) Accreditation Commission for Health Care (ACHC); and/or
(5) The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) in accordance with State Statute.

Accredited providers must be able to demonstrate that the scope of the current accreditation or certification includes all programs, services, and sites where Medicaid compensated services are rendered.

B. Provider Specialties

Eligible organizations may provide services in accordance with their accreditation and/or certification specialty:

(1) **Public Programs** – Public programs are State-operated, freestanding Community Mental Health Centers (CMHCs) and regionally based private behavioral health organizations that contract with ODMHSAS as CMHCs for outpatient behavioral health and/or substance abuse services. CMHCs must also be under the direction of a licensed physician.
(2) **Private Programs** – Private programs are freestanding outpatient behavioral health organizations certified for the provision of outpatient behavioral health and/or substance abuse services. Private programs may be non-profit or for-profit and may have no contractual relationship with the ODMHSAS for the provision of outpatient behavioral health services.

State: Oklahoma
Date Received: 8 March, 2019
Date Approved: 4 June, 2019
Effective Date: 1 July, 2019
Transmittal Number: 19-0010

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

13.d Rehabilitative Services *(continued)*

13.d.1. Outpatient Behavioral Health Services *(continued)*

C. Covered Services *(continued)*

The following services are included in the Outpatient Behavioral Health Services and are included in the fee schedule which is kept current on the Agency data base, the Agency library, and are available to the public.

Mental Health Assessment by a Non-Physician – Mental Health Assessment by a Non-Physician includes a history of psychiatric symptoms, concerns and problems, mental health status, psychosocial history, a DSM multi-axial diagnosis for all five Axis, an evaluation of alcohol and other drug use, as well as the client's strengths. A moderate complexity modifier is allowed for clients seeking services. This service is performed by a licensed behavioral health professional (LBHP). Refer to Attachment 3.1-A, Page 6a-1.3a for provider qualifications.

Behavioral Health Services Plan Development by a Non-Physician – This is a process by which the information obtained in the assessment is evaluated and used to develop a service plan that has individualized goals, objectives, activities and services that will enable a client to improve. It is to focus on recovery and must include a discharge plan. This service is conducted by the treatment team, which includes the client and all involved practitioners. Refer to Attachment 3.1-A, Pages 6a-1.3a and b for provider qualifications.

Individual/Interactive Psychotherapy – Individual Psychotherapy is a treatment for mental illnesses and behavioral disturbances in which the clinician, through definitive therapeutic communication attempts to alleviate, reverse or change maladaptive behaviors or emotional disturbances. Interactive Psychotherapy is generally furnished to children or other individuals who lack the expressive language or communication skills necessary to understand the clinician and usually involves the use of equipment or an interpreter. This service is performed by a licensed behavioral health professional (LBHP) or a Certified Alcohol and Drug Counselor (CADC) for substance abuse only. CADC's are permitted to provide Individual/Interactive Psychotherapy for substance abuse only through June 30, 2013. Effective July 1, 2013 all Individual/Interactive Psychotherapy must be provided by LBHPs. Refer to Attachment 3.1-A, Pages 6a-1.3a and 1.3e for provider qualifications.

Family Psychotherapy – Family Psychotherapy is a psychotherapeutic interaction between an LBHP or a CADC for substance abuse only and the client's family, guardian and/or support system. CADC's are permitted to provide family psychotherapy through June 30, 2013; effective July 1, 2013 all family psychotherapy must be provided by LBHP's. It must be performed for the direct benefit of the Medicaid recipient. Refer to Attachment 3.1-A, Pages 6a-1.3a and 1.3e for provider qualifications.

Group Psychotherapy – Group Psychotherapy is a method of treating behavioral disorders using the interaction between two or more individuals and the practitioner or therapist. It is provided by a LBHP or a CADC for substance abuse only. CADCs are permitted to provide group psychotherapy when treating alcohol and other drug disorders only through June 30, 2013; effective July 1, 2013 all group psychotherapy must be provided by LBHPs. Refer to Attachment 3.1-A, Pages 6a-1.3a and 1.3e for provider qualifications.

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

13.d Rehabilitative Services (continued)

13.d.1. Outpatient Behavioral Health Services (continued)

C. Covered Services (continued)

Community Recovery Support – Community Recovery Support is a service delivery role in the ODMHSAS public and contracted provider system throughout the mental health care system where the provider understands what creates recovery and how to support environments conducive of recovery. The provider works from the perspective of their experiential expertise and specialized credential training. Each provider must successfully complete over 40 hours of specialized training, demonstrate integration of newly acquired skills and pass a written exam in order to become credentialed. Services include but are not limited to: teach and mentor the value of every individual's recovery experience; assist members in determining objectives and how to articulate to reach recovery goals; assist in creating a crisis plan; facilitate peer support groups; and utilize and teach problem solving techniques with patients. Refer to Attachment 3.1-A, Page 6a-1.3e for provider qualifications.

STATE Oklahoma	A
DATE REC'D 9-28-10	
DATE APPV'D 12-16-10	
DATE EFF 7-1-10	
HCFA 179 10-32	

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

13.d Rehabilitative Services *(continued)*

13.d.1. Outpatient Behavioral Health Services *(continued)*

C. Covered Services *(continued)*

Psychosocial Rehabilitation Services – Psychosocial Rehabilitation services are behavioral health remedial services that are necessary to improve the client's ability to function in the community. They are performed to improve the client's social skills and ability of the client to live independently in the community. They may be performed in a group or one to one. This service is performed by a Behavioral Health Rehabilitation Specialist (BHRS) or licensed behavioral health professional. Refer to Attachment 3.1-A, Page 6a-1.3b through 1.3d for provider qualifications.

Crisis Intervention Services – Crisis intervention is performed to respond to acute behavioral or emotional dysfunction as evidenced by severe psychiatric distress. It is performed by a behavioral health professional. Refer to Attachment 3.1-A, Page 6a-1.3a and Page 6a-1.3b for provider qualifications.

Psychological Testing – Psychological testing is provided using generally accepted testing instruments in order to better diagnose and treat a client. Refer to Attachment 3.1-A, Page 6a-1.3d for provider qualifications.

Medication Training and Support – Medication Training and Support is a review and educational session performed by a registered nurse or a physician assistant focusing on a client's response to medication and compliance with the medication regimen.

Crisis Intervention Services (facility-based stabilization) – This service is to provide emergency stabilization to resolve psychiatric and/or substance abuse crisis. It includes detoxification, assessment, physician care and therapy. It may only be performed by providers designated and qualified by the ODMHSAS to provide care for the community. Facility-based stabilization crisis intervention facilities must have 16 beds or less.

Alcohol and Drug Assessment – Assessment for alcohol and drug disorders includes an assessment of past and present use, the administration of the Addictions Severity Index, current and past functioning in all major life areas as well as client strengths, weaknesses and treatment preferences. It is performed by a licensed behavioral health professional.

Alcohol and/or Substance Abuse Services Treatment Plan Development – This service is performed by the licensed behavioral health professional and other professionals who comprise the treatment team as well as the client and other resource persons identified by the client. The current edition of the American Society of Addiction Medicine criteria must be followed. It must contain individualized goals, objectives, activities and services that support recovery. It must include a discharge plan.

Alcohol and/or Substance Abuse Services, Skill Development – Skills development for alcohol and other substance abuse disorders are behavioral health remedial services that are necessary to improve the client's ability to function in the community. They promote and teach recovery skills necessary to and prevent relapse. They may be performed in a group or one to a licensed behavioral health professional, a behavioral health d alcohol and drug counselor.

State: Oklahoma
Date Received: 30 August, 2019
Date Approved: 18 October, 2019
Effective Date: 1 September, 2019
Transmittal Number: 19-0018

liminary screening and risk assessment to determine the likelihood ncing mental health, addiction, or trauma related disorders. The ence or specific type of such disorder but to establish the need for referral for more in-depth clinical evaluation and assessment and/or referral to relevant service resources. Refer to Attachment 3.1-A, Page 6a-1.3c for provider qualifications.

Revised 05-12-23

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

13.d Rehabilitative Services (continued)

13.d.1. Outpatient Behavioral Health Services (continued)

C. Covered Services (continued)

Individual Provider Qualifications
Rehabilitative Services

Type of Service	Individual Provider Type	Qualifications
Behavioral health assessment, behavioral health service plan development, individual, family, group treatment	**Behavioral Health Practitioners**	**Level 1** **(A) Psychiatrists** - Allopathic or Osteopathic physicians with a current license and board certification in psychiatry or board eligible in the state in which services are provided, **or** **(B) Advanced Practice Registered Nurse (APRN) -** Registered nurse with current licensure and certification of recognition from the board of nursing in the state in which services are provided and certified in a psychiatric mental health specialty; **or** **(C) Clinical Psychologists -** A clinical psychologist who is duly licensed to practice by the State Board of Examiners of Psychologists; **or** **(D) Current resident in psychiatry; or** **(E) Physician Assistants (PA) -** An Individual licensed in good standing in Oklahoma and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions **Level 2:** **(A) Licensed, Master's Prepared** - Practitioners with a Master's degree and fully licensed to practice in the state in which services are provided, as determined by one of the licensing boards listed below: (1) Clinical Social Workers; (2) Professional Counselors; (3) Marriage & Family Therapists; (4) Behavioral Practitioners; or (5) Alcohol or Drug Counselor;

State: Oklahoma
Date Received: September 19, 2013
Date Approved: December 01, 2015
Date Effective: July 1, 2013
Transmittal Number: 13-13

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

13.d Rehabilitative Services (continued)
13.d.1. Outpatient Behavioral Health Services (continued)
C. Covered Services (continued)

Individual Provider Qualifications
Rehabilitative Services (continued)

Type of Service	Individual Provider Type	Qualifications
Behavioral health assessment, behavioral health service plan development, individual, family, group treatment (cont.)	Behavioral Health Practitioners (cont.)	**(B) Licensure Candidates** - An individual with a Master's degree or higher, actively and regularly receiving board approved clinical supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met by one of the licensing boards listed in Level 1 (C) or Level 2 (A) above, **or** **(C) Psychological Clinicians** – Professionals with a Master's degree or higher with certification to provide behavioral health services.
Psychosocial Rehabilitation Services, individual and group	• BHP • Certified Alcohol and Drug Counselor (CADC) • Behavioral Health Rehabilitation Specialist (BHRS) • Certified Behavioral Case Manager II (CM II)	See description above for BHP See description in Supplement 1 to Attachment 3.1-A, Page 1e for CM II BHRS must have: (1) Current certification as a Behavioral Health Case Manager II (CM II) from ODMHSAS (2) BHRS designations made between July 1, 2010 through June 30, 2013 will be recognized until June 30, 2014.
Crisis Intervention Services	BHP	See description above for BHP
Psychological Testing / Assessment	• BHP • Psychometrists, • Psychological technician of a psychologist	Certified psychometrist, psychological technician of a psychologist, or LBHP. Psychological technicians must have a bachelor degree and be actively involved in a Master level program that has already trained the applicant specifically to provide the service under the direct supervision of the psychologist under which the tech is working.
Medication Training and Support	• Registered Nurse • Physician Assistant • Advanced Registered Nurse Practitioner	Licensed RN Licensed PA Licensed APRN
Alcohol and drug assessment, Alcohol and drug treatment plan development	• BHP	See description above for BHP

Revised 07-01-13

State: Oklahoma
Date Received: September 19, 2013
Date Approved: December 01, 2015
Date Effective: July 1, 2013
Transmittal Number: 13-13

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

13.d Rehabilitative Services *(continued)*

13.d.1. Outpatient Behavioral Health Services *(continued)*

C. Covered Services *(continued)*

Individual Provider Qualifications
Rehabilitative Services *(continued)*

Psychosocial Rehabilitation Services, individual and group *(continued)*	Behavioral Health Rehabilitation Specialist (BHRS) *(continued)*	(2) Bachelor or master degree that demonstrates the individual degree requirements of (1) of this subsection, as reviewed and approved by OHCA or its designated agent; or (3) A current license as a registered nurse in the state where services are provided; or (4) Certification as an Alcohol and Drug Counselor. Allowed to provide substance abuse rehabilitative treatment to those with alcohol and/or other drug dependencies or addictions as a primary or secondary DSM-IV Axis I diagnosis; or (5) Current certification as a Behavioral Health Case Manager II or III from ODMHSAS. On or after 07/01/10: (1) Bachelor degree earned from a regionally accredited college or university recognized by the United States Department of Education and completion of the ODMHSAS training as a Behavioral Health Rehabilitation Specialist; or (2) CPRP (Certified Psychiatric Rehabilitation Practitioner) credential; or (3) Certification as an Alcohol and Drug Counselor; or
Behavioral Health Screening	• BHP • CADC • CM II • CM I • C-PRSS	See description for BHP on page 6a-1.3a and 6a-1.3b See description for CM I and CM II in Supplement 1 to Attachment 3.1- A, Page 1e See description for CADC and C-PRSS on page 6a-1.3e

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

13.d Rehabilitative Services (continued)

13.d.1. Outpatient Behavioral Health Services (continued)

C. Covered Services (continued)

Individual Provider Qualifications
Rehabilitative Services
(continued)

Psychosocial Rehabilitation Services, individual and group (cont'd)	Behavioral Health Rehabilitation Specialist (BHRS) cont'd	(4) A current license as a registered nurse in the state where services are provided and completion of the ODMHSAS training as a Behavioral Health Specialist; or (5) If qualified as a BHRS prior to 07/01/10 and have an ODMHSAS credential on file.
Crisis Intervention Services	LBHP	See description above for LBHP
Psychological Testing / Assessment	Psychologists, psychometrists, psychological technician of a psychologist or LBHP	Licensed Psychologists, certified psychometrist, psychological technician of a psychologist, or LBHP. For assessment conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. Psychological technicians must have a bachelor degree and be actively involved in a Master level program that has already trained the applicant specifically to provide the service under the direct supervision of the psychologist under which the tech is working.
Medication Training and Support	Registered Nurse or Physician Assistant	Licensed RN Licensed PA
Alcohol and drug assessment, Alcohol and drug treatment plan development	LBHP	See description above for LBHP

STATE Oklahoma
DATE REC'D 9-28-10
DATE APPV'D 12-16-10
DATE EFF 7-1-10
HCFA 179 10-32

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

13.d Rehabilitative Services (continued)

13.d.1. Outpatient Behavioral Health Services (continued)

C. Covered Services (continued)

STATE Oklahoma
DATE REC'D 2-28-12
DATE APPV'D 5/24/2012
DATE EFF 7-1-12
SUPERSEDES 12-02
A

Individual Provider Qualifications
Rehabilitative Services
(continued)

Individual, family, group treatment for substance abuse	LBHP or Certified Alcohol and Drug Counselor (CADC) CADCs are permitted to provide individual, family and group psychotherapy when treating alcohol and other drug disorders only through June 30, 2013. Effective July 1, 2013 all individual, family and group psychotherapy must be provided by LBHPs.	See descriptions above for LBHP and BHRS. CADC must have: (1) At a minimum, a bachelor degree in a behavioral health field that is recognized by the Oklahoma Board of Licensed Alcohol and Drug Counselors as appropriate to practice as a CADC in this state. (2) Successfully completed at least two years of full-time supervised work experience Refer to the Licensed Alcohol and Drug Counselors Act found in Title 59 Chapter 43B of the Oklahoma Statutes for a complete list of education and training requirements.
Alcohol and/or Substance Abuse Skills Development – Individual and Group	LBHP, BHRS, or Certified Alcohol and Drug Counselor (CADC)	See descriptions above for LBHP, CADC and BHRS. (3)
Community Recovery Support	Recovery Support Specialist (RSS)	(1) High School diploma or GED; (2) Minimum one year participation in local or national member advocacy or knowledge in the area of behavioral health recovery; (3) Current or former member of behavioral health services; (4) Successful completion of the ODMHSAS Recovery Support Provider Training and Test; and (5) Must be trained/credentialed by ODMHSAS.

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

13.d. Rehabilitation Services

13.d.1. Outpatient Behavioral Health Services *(continued)*

D. Limitation on Services: All services will be subject to medical necessity criteria, and most require prior authorization by OHCA or its designated agent. Members residing in a nursing facility are not eligible for outpatient behavioral health services.

Partial Hospitalization Program (PHP) 42 CFR 410.43

Treatment is intensive nonresidential, structured, and therapeutic for individuals with substance use disorder (SUD), mental health diagnoses, and/or co-occurring disorders. It can be used as an alternative to and/or a step-down from inpatient or residential treatment or to stabilize a deteriorating condition that may result in a need for inpatient or residential care. PHP services are (1) reasonable and necessary for the diagnosis or active treatment of the individual's condition and (2) reasonably expected to improve the individual's condition and functional level and to prevent relapse or hospitalization/residential care.

For the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) population, services are furnished based on medical necessity and as per Attachment 3.1-A, page 1a-6.5e.

A. Service Components

PHP includes the service components listed within Attachment 3.1-A, Page 6a-1.3g through 6a-1.3h and must be directed by a physician, physician's assistant, or advanced registered nurse practitioner that meets the requirements of a Level 1 Behavioral Health Practitioner (BHP) in accordance with Attachment 3.1-A, Page 6a-1.3a.

B. Limitations

Treatment is time limited, based on medical necessity, and must be offered a minimum of 3 hours per day, 5 days a week. Individuals must meet ongoing medical necessity criteria and services must be prior authorized by OHCA or its designated agent. Length of program participation or the need to move up or down the continuum of services to another level of care is based on the individual's needs.

PHP cannot be billed in conjunction with the following services:

- Inpatient/residential psychiatric or residential substance use disorder services;
- Individual/family/group therapy for behavioral health and/or substance abuse;
- Psychosocial rehabilitation services/substance abuse skills development (individual and group);
- Targeted Case Management;
- Mobile crisis intervention provided within the PHP setting;
- Peer Recovery Support;
- Program of Assertive Community Treatment;
- Therapeutic Day Treatment;
- Multi-Systemic Treatment; and/or
- Certified Community Behavioral Health services.

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

13.d. Rehabilitation Services *(continued)*

13.d.1. Outpatient Behavioral Health Services *(continued)*

Partial Hospitalization Program (PHP) (continued)

C. Eligible Providers

PHP providers eligible for reimbursement must meet the accreditation requirements as per Attachment 3.1-A, page 6a-1.1 (A) and be an incorporated organization governed by a board of directors.

PHP service components are provided by qualified professionals as specified within the table below. The staff providing PHP services are employees or contractors of the enrolled agency. The agency is responsible for ensuring that all services are provided by properly credentialed clinicians.

All PHP services are provided by a clinical team consisting of a licensed physician, a registered nurse, and one or more Behavioral Health Practitioners; see Attachment 3.1-A, Page 6a-1.3a for provider qualifications. The clinical team may also include one or more Qualified Behavioral Health Technicians (QBHTs) and/or Recovery Support Specialists; see Attachment 3.1-A, Page 6a-1.5 and Page 6a-1.3e for provider qualifications.

The number of professionals and paraprofessionals required on the clinical team is dependent on the size of the program. Team members must meet the individual qualifications, as applicable, listed in the provider qualifications section.

D. Service Descriptions

The amount and frequency of services is provided in alignment with the member's individualized service plan.

Care Management

Care management services includes assessment of a member; development of a specific treatment plan; and referral and linkage to community supports and community-based or lower level of care services to promote continued recovery. Care management services are performed by a Behavioral Health Practitioner, or Certified Behavioral Health Case Manager, refer to the chart below for provider qualifications.

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

13.d. Rehabilitation Services *(continued)*
13.d.1. Outpatient Behavioral Health Services *(continued)*
Partial Hospitalization Program (PHP) (continued)
D. Service Descriptions (continued)

Partial Hospitalization Program
Individual Provider Qualifications

Service	Service State Plan Page	Provider	Provider Qualifications State Plan Page
Behavioral health/alcohol and drug assessment	Attachment 3.1-A, Page 6a-1.3	Behavioral Health Practitioner (BHP)	Attachment 3.1-A, Page 6a-1.3a-b
Behavioral health/alcohol and drug service plan development	Attachment 3.1-A, Page 6a-1.3	Behavioral Health Practitioner (BHP)	Attachment 3.1-A, Page 6a-1.3a-b
Individual, group, and/or family therapy	Attachment 3.1-A, Page 6a-1.2	Licensed Behavioral Health Practitioner (LBHP)	Attachment 3.1-A, Page 6a-1.3a
Psychosocial rehabilitation services/substance abuse skills development (individual and group)	Attachment 3.1-A, Page 6a-1.3	Licensed Behavioral Health Practitioner (LBHP); Certified Behavioral Health Case Manager II (CM II)	Attachment 3.1-A, Page 6a-1.3b Attachment 3.1-A, Page 6a-1.3b
Medication training and support	Attachment 3.1-A, Page 6a-1.3	Registered Nurse; Physician Assistant; Advanced Registered Nurse Practitioner	Attachment 3.1-A, page 6a-1.3b
Crisis intervention services	Attachment 3.1-A, Page 6a-1.3	Licensed Behavioral Health Practitioner (LBHP)	Attachment 3.1-A, Page 6a- 1.3a and 1.3d
Care management	Attachment 3.1-, Page 6a-1.3g	Behavioral Health Practitioner (BHP); Certified Alcohol & Drug Counselor (CADC); Certified Behavioral Health Case Manager I or II (CM I or II)	Attachment 3.1-A, Page 6a-1.3a-b Attachment 3.1-A, Page 6a-1.3e Supplement 1 to Attachment 3.1-A, Page 1e

(E) Non-Covered Services

- Room and Board
- Educational costs
- Services to inmates of public institutions
- Routine supervision and non-medical support services in school setting
- Child care
- Respite
- Personal Care

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

13.d. Rehabilitation Services *(continued)*

13.d.2 Program of Assertive Community Treatment (PACT)

PACT is an evidence-based service delivery model for providing comprehensive community-based behavioral health treatment and rehabilitation services to address mental health and co-occurring substance use disorders for individuals with more intensive psychiatric needs. Services are furnished by a multidisciplinary and mobile mental health team who functions interchangeably to provide the rehabilitation and treatment designed to enable the consumer to live successfully in the community in an independent or semi-independent arrangement.

A. Eligible Organizations

In addition to the accreditation requirements for provider organizations listed in Attachment 3.1-A, Page 6a-1.1, providers of PACT services are provided by specific teams within a SoonerCare contracted outpatient behavioral health organization and must be certified by the Oklahoma Department of Mental Health and Substance Abuse Services. In order to have a sufficient range of expertise represented on the team and enough staff to cover evenings and weekends, on-call duty, and vacations, the team in most cases should be made up of 10-12 FTE. PACT team members shall provide "first responder" crisis response 24 hours a day, 7 days a week, 365 days a year to consumers experiencing a crisis.

B. Multidisciplinary Team

Team members must collectively possess a wide range of aptitudes and professional skills, individual competence and experience working with individuals with severe and persistent mental illness. Qualified team members include:

- Behavioral Health Professionals (BHPs);
- Nurses (RN or LPN);
- Qualified Behavioral Health Technicians (QBHTs); and
- Certified Peer Recovery Support Specialists (PRSS).

The team leader or a clinical staff designee shall assume responsibility for supervising and directing all PACT team activities. The team lead must be a BHP (Level 1 or Level 2). PRSS services must be provided under the supervision of a BHP. Refer to Attachment 3.1-A, Pages 6a-1.5-1.6f for a complete description of provider qualifications.

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

13.d Rehabilitative Services
13.d.2 Program of Assertive Community Treatment (PACT)
B. **Multidisciplinary Team** *(continued)*

Provider Type	Individual Provider Qualifications
Behavioral Health Professionals (BHPs)	***Level 1:*** **(A) Psychiatrists** - Allopathic or Osteopathic physicians with a current license and board certification in psychiatry or board eligible in the state in which services are provided, **or** **(B) Advanced Practice Registered Nurses (APRNs) -** Registered nurse with current licensure and certification of recognition from the board of nursing in the state in which services are provided and certified in a psychiatric mental health specialty; **or** **(C) Clinical Psychologists -** A clinical psychologist who is duly licensed to practice by the State Board of Examiners of Psychologists; **or** **(D) Current resident in psychiatry; or** **(E) Physician Assistants (PA) -** An Individual licensed in good standing in Oklahoma and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions
	Level 2: **(A) Licensed, Master's Prepared**- Practitioners with a Master's degree and fully licensed to practice in the state in which services are provided, as determined by one of the licensing boards listed below: (1) Licensed Clinical Social Workers (LCSWs); (2) Licensed Professional Counselors (LPC) (3) Licensed Marriage & Family Therapists (LMFTs); (4) Licensed Behavioral Practitioners (LBPs); (5) Licensed Alcohol and Drug Counselor (LADCs) **(B) Licensure Candidates–** An individual with a Master's degree or higher, actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met by one of the licensing boards listed in (A) above. **(C) Psychological Clinicians** – Professionals with a Master's degree or higher with certification to provide behavioral health services
Nurses	**(A)** Registered Nurse; **(B)** License Practical Nurse • Individual must be currently licensed and in good standing in the state in which services are provided; • Each nurse shall have at least one (1) year of mental health experience or work a total of forty (40) hours at a psychiatric medication clinic within the first three (3) months of employment.
Qualified Behavioral Health Technician (QBHT)	Bachelor's Degree and**:** • Certification as Behavioral Health Case Manager 1 or II; or • Certification as Alcohol and Drug Counselor **For substance abuse services:** Must meet the minimum requirements for a QBHT, **AND** • Certification as an Alcohol and Drug Counselor, and successful completion of at least two years full time work experience; or; • LBHP with certification, training; and competency in alcohol and or substance abuse, OR • Be a registered nurse with current licensure.
Certified Peer Recovery Support Specialist (PRSS)	**Peer Recovery Support Specialist (PRSS)** • Be at least 18 years of age; • Have demonstrated recovery from a mental illness, substance abuse disorder or both • Be willing to self-disclose about their own recovery.

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

13.d Rehabilitative Services

13.d.2 Program of Assertive Community Treatment

C. Covered Service Components and Descriptions (Service Contacts)

i. Person-Centered and Family- Centered Treatment Planning and Review
A process in which the information obtained in the comprehensive assessment is evaluated and used to develop a treatment plan that has individualized goals, objectives, activities, and services that will enable the consumer to improve. The initial assessment is used as a guide until the comprehensive assessment is completed. It is to focus on recovery and must include a discharge plan. This service is conducted by the treatment team, which includes the consumer and involved practitioners. The entire team signs the plan.

ii. Care Coordination
Activities provided directly by PACT teams that have the purpose of coordinating and managing the care and services furnished to each consumer, assuring a fixed point of responsibility for providing treatment, rehabilitation and support services.

iii. Medication Training and Administration
Services include the following: A review and educational session focused on consumer's response to medication and compliance with the medication regimen, and/or medication administration. Prescription administration, and ordering of medication by appropriate medical staff; assisting the consumer in accessing medications; carefully monitoring medication response and side effects; Helping consumers develop ability to take medications with greater independence. Medication training and administration is performed by a nurse (within scope of practice) or physician assistant under the supervision of a physician.

iv. Health Promotion and Wellness Self-Management
Individual and group psychoeducation and counseling to improve the individual's social skills that include psychoeducational individual and group therapy to:

- provide health and nutrition counseling to prevent health problems;
- promote patient education and self-management about chronic illness and mental illness, treatment, and recovery;
- teach skills for coping with specific symptoms and stress management;
- facilitate the development of a personal crisis management plan, including suicide prevention or psychiatric advance directive;
- provide delivery of manualized wellness management interventions via group and individual work such as Wellness Recovery Action Plans (WRAP) or Illness/Wellness Management and Recovery (IMR/WMR).

Any qualified team member may perform this service.

State: Oklahoma
Date Received: June 30, 2015
Date Approved: January 27, 2016
Date Effective: April 1, 2015
Transmittal Number: 15-06

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

13.d Rehabilitative Services

13.d.2 Program of Assertive Community Treatment (continued)

v. Peer and Family Support

These activities include individual and group skill-building activities to restore and strengthen the consumer's unique social and family relationships that include:

- psycho-educational services (e.g., provide accurate information on mental illness & treatment to families and facilitate communication skills and problem solving);
- teaching coping skills to families in order to support the consumer's recovery;
- enlisting family support in recovery of the consumer;
- facilitating the consumer's natural supports through access to local support networks; and trainings, such as NAMI's Family-to-Family; and
- helping consumer's expand network of natural supports.

Family services are for the direct benefit of the consumer. Any qualified team member may perform this service.

vi. Psychotherapy

Individual psychotherapy is a face-to-face treatment for mental illness or behavioral disturbances, in which the clinician, through definitive therapeutic communication, attempts to alleviate, reverse or change maladaptive behaviors or emotional disturbances. Family psychotherapy is a face- to- face psychotherapeutic interaction between a BHP and the consumer's family, guardian and/or support system. Family therapy must be provided for the direct benefit of the consumer**.** This service must be provided by a BHP.

vii. Crisis Assessment and Intervention Services

An immediately available service to meet the psychological, physiological and environmental needs of individuals who are experiencing a mental health or substance abuse crisis. This service is performed by a BHP.

viii. Psychosocial Rehabilitation

Behavioral health remedial services that are necessary to improve the consumer's ability to function in the community. They are performed to improve the consumer's social skills and ability of the consumer to live independently in the community. Services include individual or group skill building activities that focus on:

- the development of skills to be used by individuals in their living, learning, social and working environments,
- Social, problem solving and coping skill development;
- Illness and medication self-management.

This service is performed by a QBHT under supervision of BHP.

ix. Co-Occurring Treatment for Substance Abuse

These services shall include but not be limited to individual and group interventions to assist consumer's to: (A) identify substance use, effects and patterns; (B) Recognize the relationship between substance use and mental illness and psychotropic medications; (C) develop motivation for decreasing substance use; and (D) develop coping skills and alternatives to minimize substance use and achieve periods of abstinence and stability. Individual counseling may be provided as a supportive adjunct to group sessions. All staff providing substance abuse treatment must be appropriately registered, certified, or licensed.

Revised 01-01-15

State: Oklahoma
Date Received: June 30, 2015
Date Approved: January 27, 2016
Date Effective: April 1, 2015
Transmittal Number: 15-06

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

13.d Rehabilitative Services

13.d.2 Program of Assertive Community Treatment (continued)

D. Limitation on Services

(a) PACT services must be medically necessary and recommended by a BHP prior to receiving these services. An initial screening/assessment must be completed to receive the service(s). Covered services are available only to Medicaid eligible consumers with a written treatment plan containing the recommended necessary psychiatric, rehabilitation and support services. The treatment plan is completed by an authorized BHP.

(b) Employment services, personal care services, childcare and respite services are not billable activities. Consumers living in an IMD, nursing facility or inmates of public correctional institutions are not eligible for PACT services.

(c) **Health Home Services –** PACT teams may also be designated Health Homes. The service components listed in C. i-iv may also be considered Health Home services and duplicate payment cannot be made.

State: Oklahoma
Date Received: June 30, 2015
Date Approved: January 27, 2016
Date Effective: April 1, 2015
Transmittal Number: 15-06

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

13.d Rehabilitative Services

13.d.3 Certified Community Behavioral Health (CCBH) Services

CCBH service delivery is designed to provide a comprehensive range of mental health and/or substance abuse rehabilitative services. Services are furnished by an interdisciplinary and mobile mental health team who functions interchangeably.

A. Eligible Organizations

(1) Eligible providers of CCBH services must be one of the following:

- A Community Mental Health Center;
- An entity operated under authority of the Indian Health Services (IHS), an Indian tribe, or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the IHS pursuant to the Indian Self-Determination Act;
- An entity that is an urban Indian organization pursuant to a grant or contract with the IHS under Title V of the Indian Health Care Improvement Act (PL 94-437).

(2) In addition to meeting one of the requirements above, a CCBH must meet all of the terms and conditions listed below, and be certified by ODMHSAS:

- Accreditation or certification by one of the provider organizations listed in Attachment 3.1-A, Page 6a-1.1, 13.D.1, A;
- Must be under the direction of a licensed physician;
- Meet state administrative rule requirements for CCBHs, to include procedures and agreements in place to facilitate referral for services needed beyond the scope of the facility;
- Have a 24/7 walk-in crisis clinic or psychiatric urgent care or have an agreement in place with a state-sanctioned alternative. A state-sanctioned alternative is a Community-based Structured Crisis Center (CBSCC) with a psychiatric urgent care unit as certified by ODMHSAS.
- Actively use an Office of National Coordinator (ONC) certified Electronic Health Record (EHR) as demonstrated on the ONC Certified Health IT Product List;
- Have a contract with a Health Information Exchange (HIE) and demonstrate staff use of obtaining and sending data through the HIE, as well as policy stating frequency of use and security protocols; and
- Report on encounter, clinical outcomes, and quality improvement. This includes meeting all federal and state specifications of the required CMS quality measure reporting, as well as performance improvement reports outlining activities taken to improve outcomes.

State: Oklahoma
Date Received: 8 March, 2019
Date Approved: 4 June, 2019
Effective Date: 1 July, 2019
Transmittal Number: 19-0010

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

13.d Rehabilitative Services
13.d. Certified Community Behavioral Health (CCBH) Services

B. Interdisciplinary Treatment Team

The interdisciplinary treatment team is composed of practitioners qualified to furnish covered services. The clinical treatment team members must include:

- Level 1 Behavioral Health Professional (Licensed psychiatrist);
- Consulting primary care physician, advanced practice registered nurse, or physician assistant;
- Level 2 Behavioral Health Professionals (BHPs);
- Nurses (RN or LPN);
- Qualified Behavioral Health Technicians (QBHTs);
- Certified Peer Recovery Support Specialists (PRSS and FSPs); and
- Qualified Behavioral Health Aides (QBHAs).

Optional team members may include the following:

- Certified behavioral health case manager I;
- Licensed Occupational Therapists;
- Occupational therapist assistant; and
- Licensed nutritionists.

State: Oklahoma
Date Received: 8 March, 2019
Date Approved: 4 June, 2019
Effective Date: 1 July, 2019
Transmittal Number: 19-0010

NEW 07-01-19

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

13.d Rehabilitative Services
13.d. Certified Community Behavioral Health (CCBH) Services *(continued)*

A. Interdisciplinary Treatment Team Qualifications

Provider Type	Individual Provider Qualifications
Behavioral Health Professionals (BHPs)	***Level 1:*** **A. Psychiatrists** – Allopathic or Osteopathic physicians with a current license and board certification in psychiatry or board eligible in the state in which services are provided, **or** **B. Advanced Practice Registered Nurses (APRNs)** – Registered nurse with current licensure and certification of recognition from the board of nursing in the state in which services are provided and certified in a psychiatric mental health specialty; **or** **C. Clinical Psychologists** – A clinical psychologist who is duly licensed to practice by the State Board of Examiners of Psychologists; **or** **D. Current resident in psychiatry; or** **E. Physician Assistants (PA)** – An Individual licensed in good standing in Oklahoma and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions
	Level 2: **A. Licensed, Master's Prepared**- Practitioners with a master's degree and fully licensed to practice in the state in which services are provided, as determined by one of the licensing boards listed below: (1) Licensed Clinical Social Workers (LCSWs); (2) Licensed Professional Counselors (LPC) (3) Licensed Marriage & Family Therapists (LMFTs); (4) Licensed Behavioral Practitioners (LBPs); (5) Licensed Alcohol and Drug Counselor (LADCs) **B. Licensure Candidates**– An individual with a master's degree or higher eligible to pursue licensure in one of the specialties listed in (A) above, actively and regularly receiving board approved supervision, and extended supervision by a fully licensed practitioner listed in Level 2 A. (1) through (5) if board's supervision requirement is met by one of the licensing boards listed in (A) above. **C. Psychological Clinicians** – Professionals with a master's degree or higher with certification to provide behavioral health services
Nurses	**A.** Registered Nurse; **B.** License Practical Nurse • Individual must be currently licensed and in good standing in the state in which services are provided; • Each nurse shall have at least one (1) year of mental health experience or work a total of forty (40) hours at a psychiatric medication clinic within the first three (3) months of employment.

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

State: Oklahoma
Date Received: 8 March, 2019
Date Approved: 4 June, 2019
Effective Date: 1 July, 2019
Transmittal Number: 19-0010

13.d Rehabilitative Services

13.d.3 Certified Community Behavioral Health (CCBH) Services *(continued)*
C. Interdisciplinary Treatment Team Qualifications *(continued)*

Provider Type	Individual Provider Qualifications
Qualified Behavioral Health Technician (QBHT)	**Minimum Qualifications:** • Bachelor's Degree and: • Certification as Behavioral Health Case Manager II; or • Certification as an Alcohol and Drug Counselor All of the services provided to the client pursuant to the individualized service plan are supervised by a Level I or Level II BHP.
Certified Peer Recovery Support Specialist (PRSS)	**Minimum Qualifications:** • Self-identified clients who are in recovery from mental illness and/or substance use; or • A parent of a child with a similar mental illness and/or substance use disorder; or • An adult with an on-going and/or personal experience with a family member; or • An adult with an on-going and/or personal experience with a family member with a similar mental illness and/or substance use disorder; and • Have a high school diploma or equivalent; • Successful completion of required training according to a curriculum approved by the ODMHSAS prior to providing the service; and • Pass certification examination. **Peer Recovery Support Specialist (PRSS)** • Be at least eighteen (18) years of age; • Have demonstrated recovery from a mental illness and/or substance abuse disorder; and • Be willing to self-disclose about their own recovery. **Supervision:** Must be supervised by a competent mental health professional meeting the requirements of a Level 1 or Level 2 BHP or Nurse. **Training and Certification:** Must complete twelve (12) hours of continuing education per year and submit documentation of attendance for the continuing education to ODMHSAS annually.

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

State: Oklahoma
Date Received: 8 March, 2019
Date Approved: 4 June, 2019
Effective Date: 1 July, 2019
Transmittal Number: 19-0010

13.d Rehabilitative Services
13.d.3 Certified Community Behavioral Health (CCBH) Services *(continued)*
C. Interdisciplinary Treatment Team Qualifications *(continued)*

Provider Type	Individual Provider Qualifications
Certified Peer Recovery Support Specialist (PRSS) *(continued)*	**Family Support Provider (FSP)** • Be twenty-one (21) years of age, and: • Have successful experience (child is stable at home in the community) as a family member of a child or youth with serious emotional disturbance; or • Have lived experience as the primary caregiver of a child or youth who has received services for substance use disorder and/or co-occurring substance use and mental health; or • Have lived experience being the caregiver for a child with Child Welfare/Child Protective Services involvement; and • Pass an OSBI background check. **Supervision** • Must be supervised by a competent mental health professional meeting the requirements of a Level 1 or Level 2 BHP. • Treatment plans must be overseen and approved by a Level 1 or Level 2 BHP. **Training** Must successfully complete Family Support Training according to a curriculum approved by the ODMHSAS; and pass the examination with a score of 80% or better.
Qualified Behavioral Health Aide (QBHA)	**Minimum Qualifications:** • Must have a high school diploma or equivalent; and • Must complete required training and continuing education; and • Be supervised by Level 1 or Level 2 BHP; • Has a case manager I certification by ODMHSAS.
Licensed Occupational Therapists	**Minimum Qualifications:** **Occupational Therapist and Occupational Therapist Assistant** • Licensed by the State in which the provider practices. • Meets the federal requirements at 42 CFR 440.110. • An Occupational Therapist Assistant is licensed to provide occupational therapy treatment under the general supervision of a licensed occupational therapist.

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

13.d Rehabilitative Services

13.d.3 Certified Community Behavioral Health (CCBH) Services *(continued)*

D. Covered Service Components and Descriptions

State: Oklahoma
Date Received: 8 March, 2019
Date Approved: 4 June, 2019
Effective Date: 1 July, 2019
Transmittal Number: 19-0010

(1) Crisis Assessment and Intervention Services

An immediately available service to meet the psychological, physiological, and environmental needs of individuals who are experiencing a mental health or substance abuse crisis. Services include the following:

a. **Mobile Crisis Response Services** – Immediate crisis assessment, intervention, stabilization, follow-up, and linkage to community resources and mental health care provided face-to-face, 24/7/365 by a mobile crisis team in a community setting. The mobile crisis response team consists of Level 1 or Level 2 BHPs and a QBHT, or just a Level 1 or Level 2 BHP;

- **Emergency crisis intervention service** – Evaluation and assessment service provided by a Level 1 or Level 2 BHP in an office or clinic setting;
- **Facility based crisis stabilization** – Services consisting of 24/7/365 evaluation, observation, crisis stabilization intervention for clients experiencing mental health or substance use disorder related crises; or those who present with co-occurring disorders. Facility-based crisis stabilization is provided directly by a CMHC with sixteen (16) beds or less, or by a state-sanctioned alternative. This service is provided by a team directed by a physician. Qualified staff include Level 1 or Level 2 BHPs, nurses, QBHTs, and Certified Peer Recovery Support Specialists.

(2) Behavioral Health Integrated (BHI) Services

Activities provided that have the purpose of coordinating and managing mental health and rehabilitative services furnished to each client, assuring a fixed point of responsibility for providing treatment, rehabilitation and support services. Care coordination includes establishing accountability and communicating/sharing knowledge. This service is provided by a BHP, Nurse, QBHT, or Peer Support Provider.

(3) Person-Centered and Family-Centered Treatment Planning

An individualized plan integrating medical and behavioral health needs and service delivery in collaboration with and endorsed by the client, the adult client's family to the extent the client so wishes, or family/caregivers of youth and children, is developed by a BHP, and is coordinated with staff or programs necessary to carry out the plan. The plan includes individualized goals, objectives, and activities, including crisis planning and wellness action plans that will enable the client to improve. For children and youth assessed with Serious Emotional Disturbance with significant behavioral health needs, treatment planning is a Wraparound process consistent with System of Care values, in accordance with Attachment 3.1-A, Page 1a-6.5. A Wraparound planning process supports children and youth in returning to or remaining in the community. This process is conducted by the treatment team listed in 13d.3 (B). The initial plan must be reviewed and signed off by a Level 1 or Level 2 BHP. If the plan is signed by a licensure candidate, it must also be counter-signed by a fully licensed Level 1 or Level 2 BHP.

(4) Psychotherapy

Individual psychotherapy is a face-to-face treatment for mental illness or behavioral disturbances, in which the clinician, through definitive therapeutic communication, attempts to alleviate, reverse or change maladaptive behaviors or emotional disturbances. Family psychotherapy is a face- to- face psychotherapeutic interaction between a clinician and the client's family. Families can include biological parents and their partners, adoptive parents and their partners, foster parents and their partners, grandparents and their partners, siblings and their partners, care givers, friends, and others as defined by the family. Psychotherapy to the client's family is for the direct benefit of the client, in accordance with the client's needs and treatment goals identified in the client's treatment plan. This service must be provided by a Level 1 or Level 2 BHP.

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

13.d Rehabilitative Services
13.d.3 Certified Community Behavioral Health (CCBH) Services *(continued)*

D. Covered Service Components and Descriptions *(continued)*

(5) Medication Training and Support

Services include the following: A review and medication educational session focused on client's response to medication and compliance with the medication regimen; helping clients develop the ability to take medications with greater independence; and/or assisting the client in accessing medications and medication administration. These services may be performed by a licensed RN, APRN and Physician Assistant under the supervision of a physician.

(6) Psychosocial Rehabilitation Services

Psychiatric rehabilitation services that are necessary to improve the client's ability to function in the community. They are performed to improve the client's social skills and ability of the client to live independently in the community. Services include individual or group skill building activities that focus on:

a. The restoration of skills to be used by individuals in their living, learning, social and working environments;
b. Social, problem solving and coping skill development; and/or
c. Illness and medication self-management;

This service is solely restorative in nature and only includes direct medical services to clients**.** This service is performed by a BHP or QBHT under supervision of a licensed BHP.

(7) Psychoeducation and Counseling

Services are designed to restore, rehabilitate, and support the individual's overall health and wellness. Services are intended for clients to provide purposeful and ongoing psychoeducation and counseling that are specified in the individual's person-centered, individualized plan of care. Components include delivery of manualized wellness management interventions such as:

a. **Wellness Recovery Action Plans (or WRAP®)** is a self-management and recovery system designed to decrease intrusive or troubling feelings and behaviors; increase personal empowerment; improve quality of life; and assist people in achieving their own life goals and dreams.
b. **Illness Management and Recovery/Wellness Management and Recovery (IMR/WMR**) are evidence-based practice models designed to help people who have experienced psychiatric symptoms. Elements include: developing personalized strategies for managing their mental illness and moving forward with their lives; setting and pursuing personal goals; learning information and skills to develop a sense of mastery over their psychiatric illness; and helping clients put strategies into action in their everyday lives. WMR is an essential part of recovery in that it improves the individual's ability to manage one's illness, avoids relapses and hospitalizations by giving people greater control over their lives, allows individuals more time to pursue goals by lessening the time spent dealing with their mental illness, and leads to better quality of life by lessening the individual's distress from symptoms.
c. Components for either model include practitioner use of motivational, educational, and cognitive behavioral techniques such as**:**
   - Psychoeducation about mental illness;
   - Cognitive behavioral approaches to medication;
   - Planning for relapse prevention;
   - Social skills training to strengthen social support; and
   - Coping skills to manage symptoms of mental illness.

State: Oklahoma
Date Received: 8 March, 2019
Date Approved: 4 June, 2019
Effective Date: 1 July, 2019
Transmittal Number: 19-0010

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

State: Oklahoma
Date Received: 8 March, 2019
Date Approved: 4 June, 2019
Effective Date: 1 July, 2019
Transmittal Number: 19-0010

13.d Rehabilitative Services
13.d.3 Certified Community Behavioral Health (CCBH) Services *(continued)*
D. Covered Service Components and Descriptions *(continued)*

(7) Psychoeducation and Counseling *(continued)*

d. Psychoeducation and Counseling can be weekly sessions, individual or group format, and generally last between three (3) to six (6) months. WRAP and IMR/WMR components are psychoeducation and counseling services, which are based on a client's specific medical needs in accordance with the client's individual treatment plan. Education does not take place in a classroom setting. This service is provided by a Nurse, Nutritionist, or QBHT.

(8) Peer Supports, Peer Counseling and Family/Caregiver Supports

These activities include individual and group skill-building activities to restore and strengthen the client's unique social and family relationships. Services for adults include:

- Psycho-educational services (e.g., provide accurate information on mental illness & treatment to families and facilitate communication skills and problem solving);
- Teaching coping skills to families in order to support the client's recovery;
- Enlisting family support in recovery of the client;
- Facilitating the client's natural supports through access to local support networks; and trainings, such as NAMI's Family-to-Family; and
- Helping client's expand network of natural supports.

The parents/legal guardians of Medicaid-eligible children can receive Peer Support services when the service is directed exclusively toward the benefit of a Medicaid-eligible child. Activities could include:

- Developing formal and informal supports;
- Instilling confidence and assisting in the development of goals; and
- Serving as an advocate, mentor, or facilitator for resolution of issues and skills necessary to enhance and improve the health of a child with emotional, behavioral, or co-occurring disorders.

Eligible team members include individuals that meet the qualifications for a Certified Peer Recovery Support Specialist. Refer to Attachment 3.1-A, Page 6a-1.12 through Page 6a-1.13 for provider qualifications.

(9) Occupational Therapy

The therapeutic use of everyday life activities (occupations) with an individual or groups for the purpose of participation in roles and situations in home, school, workplace, community, and other settings for the purpose of promoting health and wellness. Occupational therapy services are provided to those who have developed an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restrictions. Occupational therapy addresses the physical, cognitive, psychosocial, sensory, and other aspects of performance in a variety of contexts to support engagement in everyday life activities that affect health, well-being, and quality of life. This service is solely restorative in nature and provided by a qualified occupational therapist or occupational therapist assistant. Refer to Attachment 3.1-A, Page 6a-1.13 for provider qualifications.

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

13.d Rehabilitative Services

13.d.3 Certified Community Behavioral Health (CCBH) Services *(continued)*
D. Covered Service Components and Descriptions *(continued)*

Limitation on Services

(1) Initial screening, assessment, and diagnosis must be completed to receive the service(s). CCBH services must be medically necessary and recommended by a Level 1 or Level 2 BHP, as permitted within their scope of his/her practice under state law or other licensed practitioner of the healing arts within the scope of his/her practice under state law. Occupational therapy services must be prescribed by a physician or other licensed practitioner of the healing arts, in accordance with State and federal law Services are covered when provided in accordance with a person-centered and family-centered treatment plan. Employment services, personal care services, childcare, and respite services are not billable activities.

(2) For the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) population of all Medicaid eligible children under the age of 21, services are furnished based on medical necessity. Comparable services are available to children who do not meet the medial necessity criteria for CCBH services in accordance with EPSDT requirements at 1905(r) of the Social Security Act and state plan comparability of services requirements at 42 CFR 440.240.

(3) Clients living in an IMD, ICF/IID, nursing facility, or inmates of public correctional institutions are not eligible for CCBH services. Individuals receiving services through a Program of All Inclusive Care for the Elderly (PACE) are also not eligible for CCBH Services.

State: Oklahoma
Date Received: 8 March, 2019
Date Approved: 4 June, 2019
Effective Date: 1 July, 2019
Transmittal Number: 19-0010

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

13.d. Rehabilitative Services

13.d.5 Residential Substance Use Disorder Services

Residential Substance Use Disorder (SUD) Services (42 CFR 440.130(d))
Residential SUD services are provided as part of a comprehensive continuum of SUD services and are available to all Medicaid eligible individuals with significant functional impairments resulting from an identified SUD diagnosis. Services must be medically necessary and must promote the maximum reduction of symptoms and/or restoration of an individual to his/her best age-appropriate functional level according to an individualized treatment plan.

Services must also be provided in accordance with the American Society of Addiction Medicine (ASAM) Level 3 guidelines. Settings must include 24-hour professionally directed evaluation, observation and medical monitoring, as well as a planned regimen of individualized treatment services. They feature permanent facilities, including residential beds, and function under a defined set of policies, procedures and clinical protocols. The rehabilitation and recovery focus is designed to promote skills for coping with and managing substance use symptoms and behaviors.

A. Eligible Providers

Eligible providers are residential level of care facilities with 16 beds or less:

- Accredited by the Joint Commission, or the Commission on Accreditation of Rehabilitative Facilities (CARF), or the Council on Accreditation (COA); and,
- Certified by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) as a residential provider of substance use disorder services, unless exempt from state jurisdiction or an exempted entity as defined in State statute; and,
- Contracted with the State Medicaid Agency; and,
- Provided a Certificate of Need (CON), if required by ODMHSAS, in accordance with applicable State policy.

B. Service Descriptions: Levels of Care

The amount and frequency of services is provided in alignment with the member's individualized service plan and in accordance with ASAM criteria.

Level 3.1 – Clinically Managed Low-Intensity Residential Services for Adolescents and Adults
Low-intensity treatment is directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility and reintegrating the individual into work, community and family life. Services provided at this level of care include assessment and treatment plan development as well as at least six (6) hours per week of a combination of services that may include individual, group, and/or family therapy, skill development, community recovery support, care management, and crisis intervention services as per Section C in Attachment 3.1-A, Page 6a-1.23.

Level 3.3 – Clinically Managed Population-Specific High-Intensity Residential Services for Adults
High-intensity treatment is designed to accommodate individuals with cognitive or other impairments, including co-occurring psychiatric disorders. Services provided at this level of care include at least twenty-four (24) hours per week of a combination of services that may address both substance use and co-occurring mental health needs. Services provided at this level of care include assessment and treatment plan development as well as individual, group, and family therapy, skill development, community recovery support, care management, and crisis intervention services as per Section C in Attachment 3.1-A, Page 6a-1.23.

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

13.d. Rehabilitative Services (*continued)*
13.d.5. Residential Substance Use Disorder Services (*continued)*
B. Service Description: Levels of Care (*continued)*

Level 3.5 – Clinically Managed Medium Intensity for Adolescents/High-Intensity for Adults Residential Services
The goal of this level of service is to prepare individuals for continued treatment at lower levels of care and reintegration back into the community. Services provided at this level of care include assessment and treatment plan development as well as at least twenty-four (24) hours per week of a combination of services that may include individual, group, and family therapy, skill development, community recovery support, care management, and crisis intervention services as per Section C in Attachment 3.1-A, Page 6a-1.23. Adolescents attending academic training are required to be provided a minimum of fifteen (15) hours per week of services. Level 3.5 *intensive* provides the types of aforementioned services for this level of care; however, the required number of treatment hours at level 3.5 *intensive* is at least thirty-seven (37) hours per week of a combination of services.

Level 3.7 – Medically Monitored High Intensity Inpatient Services for Adolescents and Withdrawal Management for Adults
This service provides withdrawal management outside of an acute setting under the direction of a licensed physician. Facilities must provide 24 hour, 7 days a week physician supervision, as well as 24 hour, 7 days a week monitoring from licensed nurses to members who are withdrawing or are intoxicated from alcohol or other drugs but are not experiencing medical or neurological symptoms that would require hospitalization. Medications are prescribed and administered if needed during withdrawal management. The goal of this level of service is to stabilize and prepare individuals for continued treatment at lower levels of care. Please refer to Section C. in Attachment 3.1-A, Page 6a-1.23 for a list of services that may be provided in this setting.

Residential Family-Based Treatment: Programs for Individuals with Dependent Children and Pregnant Women
Services are provided to individuals with dependent children and to pregnant women through specialty programs that provide services in accordance with 13.d.5. (C) and are included in the description of ASAM level of care 3.1 or level of care 3.5/3.5 *intensive*. Treatment hour requirements and types of services provided are the same as those indicated for the respective level of care, with the exception that the treatment hours required for level 3.5 *intensive* in specialty programs is thirty-five (35) hours per week of treatment services. Assessment and treatment plan development are components of care that are required in addition to the required weekly treatment hours.

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

13.d. Rehabilitative Services (*continued)*
13.d.5. Residential Substance Use Disorder Services (*continued)*

C. Covered Services & Provider Qualifications

Care Management
Care management services in residential substance use disorder treatment settings includes assessment of a member; development of a specific treatment plan; and referral and linkage to SUD community supports and community-based or lower level of care services to promote continued recovery after the member discharges from the treatment facility. Care management services are performed by a Behavioral Health Practitioner, Certified Alcohol and Drug Counselor, or Certified Behavioral Health Case Manager, refer to the chart below for provider qualifications.

Service	Service State Plan Page	Provider	Provider Qualifications
Alcohol & drug assessment	Attachment 3.1-A, Page 6a-1.3	Behavioral Health Practitioner (BHP)	Attachment 3.1-A, Page 6a-1.3a-b
Alcohol and/or substance abuse services treatment plan development	Attachment 3.1-A, Page 6a-1.3	Behavioral Health Practitioner (BHP)	Attachment 3.1-A, Page 6a-1.3a-b
Individual, group, and/or family therapy	Attachment 3.1-A, Page 6a-1.2	Licensed Behavioral Health Practitioner (LBHP); Drug Counselor (CADC)	Attachment 3.1-A, Page 6a-1.3a Attachment 3.1-A, Page 6a-1.3e
Alcohol and/or substance abuse services, skill development – individual and group	Attachment 3.1-A, Page 6a-1.3	Licensed Behavioral Health Practitioner (LBHP); Behavioral Health Rehabilitation Specialist (BHRS)/Case Manager II; Certified Alcohol & Drug Counselor (CADC)	Attachment 3.1-A, Page 6a-1.3a-b Attachment 3.1-A, Page 6a-1.3b-c Supplement 1 to Attachment 3.1-A, Page 1.3e Attachment 3.1-A, Page 6a-1.3e
Community recovery support	Attachment 3.1-A, Page 6a-1.2a	Recovery Support Specialist (RSS)	Attachment 3.1-A, Page 6a-1.3e
Crisis intervention services	Attachment 3.1-A, Page 6a-1.3	Licensed Behavioral Health Practitioner (LBHP)	Attachment 3.1-A, Page 6a-1.3a and 1.3d
Care management	Attachment 3.1-, page 6a-1.23	Behavioral Health Practitioner (BHP) Certified Alcohol & Drug Counselor (CADC) Certified Behavioral Health Case Manager (CM II)	Attachment 3.1-A, Page 6a-1.3a-b Attachment 3.1-A, Page 6a-1.3e Supplement 1 to Attachment 3.1-A, Page 1e

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

13.d. Rehabilitative Services (*continued)*
13.d.5. Residential Substance Use Disorder Services (*continued)*

D. Excluded Services

The following services are excluded from coverage:

- Room and board is not a covered and/or reimbursable service;
- Components that are not provided to or exclusively for the treatment of the eligible individual;
- Services or components of services of which the basic nature is to supplant housekeeping or basic services for the convenience of a person receiving covered services;
- Physician directed services and medications (these services are reimbursed outside of the residential SUD per diem);
- Telephone calls or other electronic contacts (not inclusive of telehealth); and
- Field trips, social, or physical exercise activity groups.

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

13.d. Rehabilitative Services (*continued*)

13.d.6. Alternative Treatments for Pain Management (42 CFR 440.130(d))

Alternative treatments for pain management are non-pharmacological treatments recommended by a physician or other licensed practitioner of the healing arts for adults age twenty-one (21) or older with acute, subacute, and chronic spinal/back pain or injury. Treatments are intended to reduce pain, increase mobility, optimize function, and decrease use and misuse of opioid medications and may include the services below.

A. Services

Evaluation/re-evaluation: physical examination or assessment to develop a treatment plan to address spinal pain and improve a person's ability to move, restore function, and prevent disability. This service is provided by a physical therapist, physical therapist assistant, and/or a chiropractor; refer to Attachment 3.1-A, Page 6a-1.26 for individual provider qualifications.

Therapeutic exercises: processes or activities designed to develop strength, endurance, range of motion and flexibility to alleviate spinal pain and restore a beneficiary to their best possible functional level. This service is provided by a physical therapist and/or physical therapist assistant; refer to Attachment 3.1-A, Page 6a-1.26 for individual provider qualifications.

Therapeutic activities: dynamic rehabilitative techniques involving movement to improve functional performance in a progressive manner with the intended outcome of a reduction in back pain. This service is provided by a physical therapist and/or physical therapist assistant; refer to Attachment 3.1-A, Page 6a-1.26 for individual provider qualifications.

Manual spinal manipulation: physical adjustments to the spine to correct subluxation and/or address acute or chronic spinal pain. Manual spinal manipulations are performed by a licensed chiropractor. This service is provided by a chiropractor; refer to Attachment 3.1-A, Page 6a-1.26 for individual provider qualifications.

B. Limitations

Annual service limits for therapeutic exercises and therapeutic activities are not to exceed 12 hours or 48 units (one unit of service is 15 minutes) and require prior authorization. A visit may consist of multiple units of service on the same date; the time for units of service is added together and rounded up only once per visit. An initial evaluation and one re-evaluation per calendar year do not require prior authorization

Annual service limits for manual spinal manipulation are not to exceed 12 visits with prior authorization. An initial evaluation and one re-evaluation per calendar year do not require prior authorization

Additional units/visits for alternative treatments for pain management may be exceeded based upon medical necessity.

For the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) population, services are furnished based on medical necessity.

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

13.d. Rehabilitative Services (*continued*)

13.d.6. Alternative Treatments for Pain Management (*continued*)

C. Eligible Providers
Providers of alternative treatments for pain management will provide services in non-hospital-based settings only.

Alternative Treatments for Pain Management
Individual Provider Qualifications

Type of Service	Individual Provider Type	Qualifications
Evaluation/Re-evaluation	Physical therapist Physical therapist assistant Chiropractor	**Physical therapist** A licensed physical therapist is a state-licensed individual that is in good standing providing services within their scope of practice in accordance with state law at 42 CFR 440.110. **Physical therapist assistant** A licensed physical therapist assistant is a state-licensed individual that is in good standing providing services within their scope of practice in accordance with state law while working under the direction of a licensed physical therapist and meets the requirements at 42 CFR 440.110. **Chiropractor** A licensed chiropractor is a state-licensed individual that is in good standing providing services within their scope of practice in accordance with state law.
Therapeutic exercises Therapeutic activities	Physical therapist Physical therapist assistant	**Physical therapist** A licensed physical therapist is a state-licensed individual that is in good standing providing services within their scope of practice in accordance with state law at 42 CFR 440.110. **Physical therapist assistant** A licensed physical therapist assistant is a state-licensed individual that is in good standing providing services within their scope of practice in accordance with state law while working under the direction of a licensed physical therapist and meets the requirements at 42 CFR 440.110.
Manual spinal manipulation	Chiropractor	**Chiropractor** A licensed chiropractor is a state-licensed individual that is in good standing providing services within their scope of practice in accordance with state law.

NEW 01-01-22

State OKLAHOMA

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

14. Services for individuals age 65 or older in institutions for mental diseases

(a) Inpatient hospital services

Limited to those persons whose Title XVIII, Part A benefits are exhausted for this particular service and/or those persons who are not eligible for Title XVIII benefits.

APPROVED BY DHHS/HCFA/DPO
DATE: AUG. 15 1986
TRANSMITTAL NO: 85-6

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

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

[X] Provided [ ] No limitations [X] With limitations* [ ] Not Provided:

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

[X] Provided [ ] No limitations [X] With limitations* [ ] Not Provided:

16. Inpatient psychiatric facility services for individuals under 21 years of age.

[X] Provided [X] No limitations [ ] With limitations* [ ] Not Provided:

17. Nurse-midwife services

[X] Provided [X] No limitations [ ] With limitations* [ ] Not Provided:

18. Hospice care for individuals under 21 years of age (in accordance with section 1905(o) of the Act).

[ ] Provided [ ] No limitations [X] Provided in accordance with section 2302 of the Affordable Care Act

[X] With limitations* [ ] Not Provided:

*Description provided on attachment

State: Oklahoma
Date Received: March 29, 2018
Date Approved: DEC 04 2018
Date Effective: January 1, 2018
Transmittal Number: 18-02

State OKLAHOMA

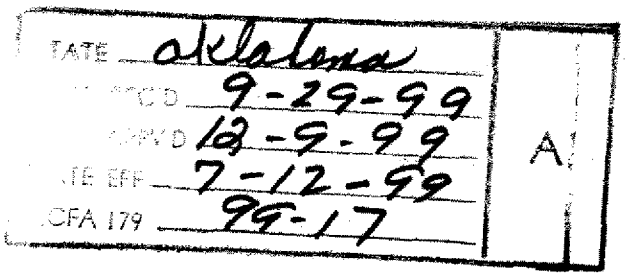
AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED CATEGORICALLY NEEDY

15. Services in an intermediate care facility for the mentally retarded (other than such services in an institution for mental diseases) for individuals who are determined, in accordance with Section 1902(a)(31)(A), to be in need of such care.

Payment is made for ICF/MR services after approval by the Agency for such care. ICF/MR services include coverage of all medically necessary prescriptions not otherwise covered under the Plan.

ICF/MR services include coverage of basic dental care. Restorative dental care also is covered when pre-authorized.

ICF/MR services include coverage of specially adapted prosthetic devices when pre-authorized.



Revised 07-12-99

TN# 99-17 Approval Date 12-9-99 Effective Date 7-12-99
Supersedes
TN# 97-07

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

16. Inpatient Psychiatric Services for individuals under Age 21 (42 CFR 440.160)

(A) Eligible Providers (42 CFR 441.151; 42 CFR 440.160)

Inpatient psychiatric services for individuals under age 21 (or age 22 if the individual was receiving services prior to reaching age 22) are provided under the direction of a physician pursuant to an individual's plan of care and are limited to those who are receiving such services in an institution which is:

- A psychiatric hospital that undergoes a State survey to determine whether the hospital meets the requirements for participation in Medicare as a psychiatric hospital as specified in 42 CFR 482.60, or is accredited by a national organization whose psychiatric hospital accrediting program has been approved by CMS; or

- A hospital with an inpatient psychiatric program that undergoes a State survey to determine whether the hospital meets the requirements for participation in Medicare as a hospital, as specified in 42 CFR part 482, or is accredited by a national accrediting organization whose hospital accrediting program has been approved by CMS; or

- A psychiatric facility that is not a hospital (defined as a Psychiatric Residential Treatment Facility (PRTF) in 42 CFR 483.352) that is accredited by the Joint Commission on Accreditation of Healthcare Organizations (TJC), the Council on Accreditation for Families and Children, the Commission on Accreditation of Rehabilitation Facilities (CARF), or by any other accrediting organization, with comparable standards, that is recognized by the State.

Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) services that are determined medically necessary in order to correct or ameliorate health conditions are provided to individuals under age 21 in inpatient psychiatric hospitals and facilities regardless of whether such services are identified in the individual's plan of care.

The State assures that it meets all requirements in 42 CFR 440.160, 42 CFR 441 Subpart D, and 42 CFR 483 Subpart G.

(B) Services Provided under Arrangement

The State assures that psychiatric facilities:

- arrange for and oversee the provision of all services;
- maintain all medical records of care furnished to the individual; and
- ensure that all services are furnished under the direction of a physician.

State: Oklahoma
Date Received: 22 March, 2019
Date Approved: 7 May, 2019
Effective Date: 1 January, 2019
Transmittal Number: 19-0001

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OKLAHOMA

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

19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

X Provided: X With limitations

___ Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

X Provided: X With limitations*

___ Not provided.

20. Extended services for pregnant women

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

X Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

X Additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

Oklahoma
STATE
DATE RECD 12-26-94
DATE APPVD 12-27-94 A
DATE EFF 10-01-94
HCFA 179 94-23

State/Territory: OKLAHOMA

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

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider (in accordance with section 1920 of the Act).

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

[ ] Provided: [ ] No limitations [ ] With limitations*

[X] Not provided.

23. Pediatric or family nurse practitioners' services.

[X] Provided: [ ] No limitations [X] With limitations*

*Description provided on attachment.

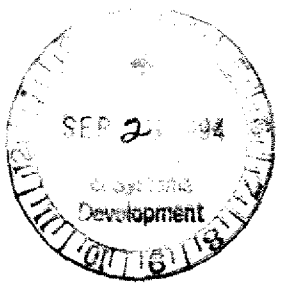
STATE Oklahoma
DATE REC'D JAN 29 1992
DATE APPV'D FEB 27 1992
DATE EFF OCT - 1 1991
HCFA 179 92-03
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State: OKLAHOMA

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

19.b. Special tuberculosis (TB) related services under Section 1902(z)(2) of the Act

Ambulatory services to persons infected with TB are those services defined in Section 1902(z)(2) of the Act and are not limited by the limits of the State Plan but require prior authorization when those limits are exceeded.



STATE Oklahoma
DATE REC'D SEP 0 1 1994
DATE APPV'D SEP 2 0 1994
DATE EFF AUG 0 1 1994
HCFA 179 94-13

A

State: OKLAHOMA

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES
CATEGORICALLY NEEDY

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20. Extended services for pregnant women

a. Pregnancy-related and postpartum services for 60 days after the pregnancy. Services are limited to pregnancy-related and postpartum services within the scope of the State Plan.

b. High risk pregnant women, as identified in the risk assessment tool (POPRAS III), are eligible for the following package of enhanced high risk services in qualified maternity clinics:

- Nutritional Assessment/Counseling

  Counseling is appropriate for women whose complications require the services of a dietician/nutritionist for treatment of a pregnancy related complication, e.g., diabetes, over/under weight. The services are provided by a registered dietician or licensed nutritionist. The nutritional assessment is done by the registered dietician or licensed nutritionist, and is considered as one unit of nutritional assessment/counseling. If the high risk pregnant woman is eligible for WIC, the nutritional assessment for this program will coordinate with the WIC assessment in order to prevent two programs from doing duplicate assessments.

- Health Education

  Health education is covered only for high risk pregnant women, as identified in the high risk assessment tool (POPRAS III). It is designed to prevent the development of further complications during pregnancy and to provide educational information to the pregnant woman in caring for herself during pregnancy. This service may be provided by a registered nurse, nurse practitioner, certified nurse midwife, nutritionist/dietician, or social worker. Education may include, but is not limited to, prenatal care, danger signs in pregnancy; labor and delivery; nutrition, pregnancy risk reduction, postpartum care, reproductive health.

RECEIVED
JUL 7 1994
Planning & Systems Development

STATE Oklahoma
DATE REC'D MAR 30 1992
DATE APPV'D JUN 28 1994
DATE EFF FEB - 1 1992
HCFA 179 92-07

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Revised 02-01-92

TN# 92-07 Approval Date JUN 28 1994 Effective Date FEB - 1 1992
Supersedes
TN# 87-09

State: OKLAHOMA

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES
CATEGORICALLY NEEDY

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20. Extended services for pregnant women (cont'd)

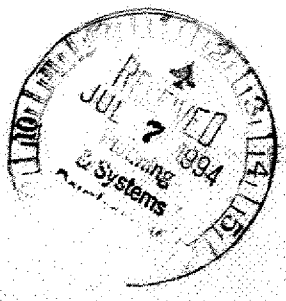
- Psychosocial Assessment/Counseling

  Psychosocial assessment/counseling is covered only for high risk pregnant women, as identified in the high risk assessment tool (POPRAS III). Psychosocial assessment/counseling is appropriate in order to develop a social work care plan based upon the health risks due to psychosocial factors. Counseling is appropriate for women whose complications require psychosocial intervention as an essential element of treatment in dealing with the complication e.g., use/abuse of drugs/alcohol, significant psychological condition, etc. This service will be used to reduce the likelihood of a poor birth outcome. This service must be provided by a Masters of Social Work (MSW) or a bachelor level social worker under the direct supervision of a MSW.

- Genetics Assessment Counseling

  Genetics assessment/counseling is covered only for high risk pregnant women, as identified in the high risk assessment tool (POPRAS III). It is designed to deliver information to a pregnant woman about inherited disorders or environmental exposures to toxic substances that may cause congenital defects in the fetus. This service is performed by a genetic counselor or a registered nurse in consultation with a genetic counselor.

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STATE Oklahoma
DATE REC'D MAR 30 1992
DATE APPV'D JUN 28 1994
DATE EFF FEB 1 1992
HCFA 179 92-07

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New 02-01-92

State OKLAHOMA

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

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21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).

Limited to ambulatory services otherwise available under the State Plan.

STATE Oklahoma
DATE REC'D APR - 1 1991
APR 24 1991
JAN - 1 1991
91-04

A

New 01-01-91

TN# 91-04 Approval Date APR 24 1991 Effective Date JAN - 1 1991
Supersedes
TN#

STATE OKLAHOMA

23. Payment will be made for primary care health services to pediatric or family nurse practitioners' (known as Advanced Practice Nurses under the Nurse Practice Act of Oklahoma) within the scope of their practice under State Law. Advanced Practice Nurses' services will be subject to the same amount, duration and scope as physicians.

STATE oklahoma DATE REC'D 12-16-98 DATE APPV'D 3-5-99 DATE EFF 10-14-98 HCFA 179 98-22	A

New 10-14-98

TN# 98-22 Approval Date 3-5-99 Effective Date 10-14-98
Supersedes
TN#

SUPERSEDES: NONE - NEW PAGE

State/Territory: OKLAHOMA

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

24. Any other medical care and any other type of remedial care recognized under State law, specified by the secretary.

a. Transportation.
☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Services of Christian Science nurses.
☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

c. Care and services provided in Christian Science sanitoria.
☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided

d. Nursing facility services for patients under 21 years of age.
☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

e. Emergency hospital services.
☐ Provided ☐ No limitations ☐ With limitations*
☒ Not provided.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.
☒ Provided ☐ No limitations ☒ With limitations*
☐ Not provided.

g. Birthing Center Services.
☒ Provided ☐ No limitations ☒ With limitations*
☐ Not provided.

h. Critical Access Hospital.
☒ Provided ☐ No limitations ☒ With limitations*
☐ Not Provided.

*Description on attachment

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

24.a Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.

a 1. Transportation

☐ No limitations
☒ With Limitations

Effective July 1, 2023, the State will provide secure behavioral health transportation for members presumed to be experiencing a behavioral health crisis who require transportation to a treatment facility for the purpose of examination, inpatient services, emergency psychiatric detention, or other emergency psychiatric actions requiring treatment within a behavioral health facility as authorized by state law. All transports must be made to the nearest appropriate treatment facility. Transports completed by law enforcement or transports to correctional facilities are not authorized under this Plan. Service providers must be Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) designated Qualified Transportation Service Providers (QTSPs) and meet the following criteria:

QSTP Drivers Must:

A. Be at least 21 years of age and hold a valid driver's license issued by the State of Oklahoma;
B. Undergo a criminal background check and not have been convicted of or received a deferred or probated sentence related to any felony crime, a crime involving moral turpitude or a crime of domestic violence; and not have any criminal charges pending within any jurisdiction;
C. Be able to ensure persons transported are protected from harm and injuries due to abuse, self-abuse, neglect, sexual incidents, serious injuries and other sources of immediate danger;
D. Be able to provide emergency care or have an established plan to access emergency care;
E. Be trained in effective communication skills with persons with mental illness, consumer rights, CPR/first aid, and confidentiality as prescribed by ODMHSAS and be able to recognize and plan for problematic behaviors in a therapeutic and safe manner;
F. Be knowledgeable of statutes and standards related to transporting consumers and complete a 16-hour Therapeutic Options Course approved by ODMHSAS

QTSP Vehicles Must:

A. Be well maintained and in good mechanical condition with the following equipment in operational condition:
i. Air conditioner;
ii. Heater; and
iii. Chemical-type fire extinguisher, of at least a one-quart capacity, located in the same compartment of the vehicle as the driver.
iv. two-way radio or cellular telephone
B. Have a safety partition between the driver’s area and the passenger area and safety locks to prevent a consumer from exiting a car that is in motion;
C. If transporting individuals in wheelchairs, be equipped with:
i. An electrical or hydraulically operated lift mechanism or a ramp with a non-skid surface;
ii. Means of securing a wheelchair to the inside of the vehicle to prevent any lateral, forward, backward, or vertical motion of the wheelchair within the vehicle;
iii. A rear-view mirror that enables the driver to view any passenger in a wheelchair; and
iv. A door at the rear of the vehicle for an emergency exit.

New 07-01-23

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

24.a Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary. *(continued)*

a 2. Brokered Transportation

☒ Provided under section 1902(a)(70)

The State assures it has established a non-emergency medical transportation program in order to more cost-effectively provide transportation, and can document, upon request from CMS, that the transportation broker was procured in compliance with the requirements of 45 CFR 92.36 (b)-(f). The broker is not a governmental entity and does not itself provide transportation or refer or subcontract with a transportation broker with whom it has a financial relationship.

(1) The State will operate the broker program without the requirements of the following paragraphs of section 1902(a);
- ☐ (1) statewideness (indicate areas of State that are covered)
- ☐ (10)(B) comparability (indicate participating beneficiary groups)
- ☒ (23) freedom of choice (indicate mandatory population group)

(2) Transportation services provided will include:
- ☒ wheelchair van
- ☒ taxi
- ☒ stretcher car
- ☒ bus passes
- ☒ tickets
- ☐ secured transportation
- ☒ such other transportation as the Secretary determines appropriate (please describe) – Private automobile drivers

(3) The State assures that transportation services will be provided under a contract with a broker who:
   i. Is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs;

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

24.a Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary. (continued)

(ii) has oversight procedures to monitor beneficiary access and complaints and ensures that transport personnel are licensed, qualified, competent, and courteous;

(iii) is subject to regular auditing and oversight by the State in order to ensure the quality of the transportation services provided and the adequacy of beneficiary access to medical care and services;

(iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate);

(v) is not a provider of transportation itself as prescribed at 42 CFR 440.170(a)(4)(i) (D)(ii)(A)

(4) The broker contract will provide transportation to the following categorically needy mandatory populations:

☒Low-income families with children (section 1931)

☒Low-income pregnant women

☒Low-income infants

☒Low-income children 1 through 5

☒Low-income children 6 - 19

☒Qualified pregnant women

☒Qualified children

☒IV-E Federal foster care and adoption assistance children

☒TMA recipients (due to employment)

☒TMA recipients (due to child support)

☒SSI recipients

STATE Oklahoma
DATE REC'D. 6-10-10
DATE APP'D 9-2-10
DATE EFF 9-1-10
HCFA 179 10-19
A

(5) The broker contract will provide transportation to the following categorically needy optional populations:

☒Optional low-income pregnant women

☒Optional low-income infants

☒Optional targeted low-income children

☒Individuals under 21 who are under Sate adoption assistance agreements

☒Individuals under age 21 who were in foster care on their 18th birthday

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

24.a Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary. (continued)

☐Individuals who meet income and resource requirements of AFDC or SSI

☐Individuals who would meet the income & resource requirements of AFDC if child care costs were paid from earnings rather than by a State agency

☐Individuals who would be eligible for AFDC if State plan had been as broad as allowed under Federal law

☐Individuals who would be eligible for AFDC or SSI if they were not in a medical institution

☐Individuals infected with TB

☒Individuals screened for breast or cervical cancer by CDC program

☐Individuals receiving COBRA continuation benefits

☐Individuals in special income level group, in a medical institution for at least 30 consecutive days, with gross income not exceeding 300% of SSI income standard

☒Individuals receiving home and community based waiver services who would only be eligible under State plan if in a medical institution.

☐Individuals terminally ill if in a medical institution and will receive hospice care

☒Individuals aged or disabled with income not above 100% FPL

☒Individuals receiving only an optional State supplement in a 209(b) State

☐Individuals working disabled who buy into Medicaid (BBA working disabled group)

☐Employed medically improved individuals who buy into Medicaid under TWWIIA Medical Improvement Group

☒Individuals disabled age 18 or younger who would require an institutional level of care (TEFRA 134 kids)

STATE Oklahoma A
DATE REC'D 3-21-2013
DATE APPV'D 5-31-2013
DATE EFF July 1, 2013
TEFRA 134 13-03

(6) The State will pay the contracted broker by the following method:

☒(i) risk capitation

☐ (ii) non-risk capitation

☒ (iii) other (e.g., brokerage fee and direct payment to providers)

FFS mileage rate for those individuals eligible for Non-Emergency Transportation (NET) but not included in NET capitation roster.

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

24.a Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary. (continued)

(7) The State assures that necessary transportation to and from providers of medical services will be provided. All transportation by public carrier or private vehicle is coordinated statewide through a designated SoonerRide transportation broker.

(8) Effective for dates of services on or after January 1, 2006, the State will provide non-emergency transportation to full-benefit dual eligible members, who are eligible for prescription drugs under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), to obtain their Part D prescription drugs from pharmacy providers .

STATE Oklahoma
DATE REC'D 5-24-06
DATE APPVD 6-26-06
DATE EFF 6-1-06
HCFA 179 06-06

A

New Page

State OKLAHOMA

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

24.d. Nursing facility services provided for patients under 21 years of age

Payment is made for nursing facility services after approval by the Agency for such care. Nursing facility services include coverage of all medically necessary prescribed drugs.

STATE Oklahoma
DATE REC'D 9-29-99
DATE APPV'D 12-9-99
DATE EFF 7-12-99
HCFA 179 99-17
A

Revised 07-12-99

TN# 99-17 Approval Date 12-9-99 Effective Date 7-12-99
Supersedes
TN# 92-07

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

24.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and rendered by qualified person under supervision of a R.N.

Personal care services (PCS) are Activities for Daily Living and Instrumental Activities for Daily Living (ADL/IADL) assistance provided to individuals determined to be medically and financially eligible to receive services. Personal care services are provided as per 42 CFR 440.167, in the individual's home, an educational or employment setting, and with prior approval. The personal care provider is an individual who is not legally responsible for the client and has demonstrated competency to provide the services documented in the person centered plan. Providers of personal care services include home health and personal care agencies contracted with the State Medicaid Agency who meet required state licensing requirements and their qualified staff. A registered nurse (RN) is responsible for making the determination of competency, the implementation and monitoring of the service plan, and for supervision of the personal care provider.

Electronic Visit Verification (EVV) for Personal Care Services (PCS)

The State will comply with the Electronic Visit Verification System (EVV) requirements for personal care services by January 1, 2021 in accordance with the requirements of Section 12006 of the 21st Century Cures Act (the Cures Act).

State OKLAHOMA

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

24.g. Birthing Center Services

Payment is made for compensable birthing center services to those facilities, places, or institutions which are maintained or established primarily for the purpose of providing services of a certified midwife or licensed doctor to attend a woman in delivery and birth. Services for adults and children include admission to the birthing center of low risk uncomplicated pregnancies, with an anticipated spontaneous delivery for the period of labor and delivery. Services are limited to one each nine months.

Eligible providers are birthing centers which have been licensed by the Oklahoma State Health Department and meet the following requirements:

(1) Have a written agreement with a board certified OB/GYN to provide coverage for consultation, collaboration or referral services as defined by the American College of Nurse Midwives.

(2) Have a medical director who is a board certified OB/GYN and is responsible for establishing patient protocols and other functions as defined in requirements for state licensure. This individual may, or may not, be the physician providing individual patient coverage for consultation, collaborative or referral service.

(3) Have a written agreement with a referral hospital which is a Class II hospital. Class II hospital is defined as a facility with 24-hour availability of OB/GYN and capability of performing a c-section within thirty minutes.

(4) Must be accredited by the Commission for the Accreditation of Freestanding Birth Centers.

STATE Oklahoma
DATE REC'D 12-30-93
DATE APP'D 2-3-94
DATE EFF 10-11-93
HCFA 179 93-20
A

New 10-11-93

TN# 93-20 Approval Date 2/3/94 Effective Date 10/11/93
Supersedes
TN# None-New Page

State: OKLAHOMA

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

24.h. **Critical Access Hospital**

Acute care hospitals that qualify as Critical Access Hospitals (CAHs) will receive a payment adjustment to the prospective per diem rates. CAHs are rural public or non-profit hospitals which provide 24 hour emergency care services, are limited to 15 inpatient beds (can have 10 additional swing beds) and inpatient stays are limited to 96 hours. In order to qualify for the payment adjustment, a hospital must be designated as a CAH by the Oklahoma State Department of Health.

STATE Oklahoma
DATE REC'D 09-29-2000
DATE APPV'D 06-06-2001
DATE EFF 08-01-2000
HCFA 179 OK-00-14
A

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

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A

X provided not provided

29. Medication Assisted Treatment

As per Section 1905(a)(29) of the Act, for the period of October 1, 2020, through September 30, 2025, Medication assisted treatment (MAT) services are covered as a mandatory benefit for adults and children who meet the medical necessity criteria for receipt of services. Services may require prior authorization by OHCA or its designated agent.

Medication-Assisted Treatment Services

MAT is an evidence-based practice using methadone, naltrexone, buprenorphine, and all other forms of MAT approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) for the treatment of OUD. With respect to the provision of such drugs and biological products, MAT also includes the provision of counseling and behavioral therapy.

Eligible Providers:

(1) **Office-Based Opioid Treatment (OBOT) provider**:

(a) physician contracted with the State to provide MAT services in OBOT settings, who are licensed and in good standing in the State, maintain a federal waiver to dispense and administer narcotics, and maintain state registration to dispense dangerous drugs; or

(b) a physician's assistant (PA) or advanced practice registered nurse (APRN) contracted with the State to provide MAT services, licensed and in good standing, and supervised as required by law.

OBOT providers must have capacity to provide directly or by referral all drugs approved by the Food and Drug Administration for the treatment of opioid use disorder, including for maintenance, detoxification, overdose reversal, and relapse prevention. OBOT providers must have capacity to provide directly or by referral appropriate counseling and behavioral therapy. OBOT providers are limited to the drugs allowed by law to be prescribed and/or administered in a setting that is not an Opioid Treatment Program.

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

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29. Medication-Assisted Treatment *(continued)*
Eligible Providers *(continued)*

(2) **Opioid Treatment Program (OTP) -** a program or provider registered under federal law, certified as an OTP by the Substance Abuse and Mental Health Services Administration (SAMHSA), certified as an OTP by the Oklahoma Department of Mental Health and Substance Abuse Services unless deemed an exempt entity as defined by federal law, registered by the Drug Enforcement Agency (DEA) and the Oklahoma Bureau of Narcotics and Dangerous Drugs (OBNDD), engaged in opioid treatment of individuals by use of an opioid agonist treatment medication, including methadone, and contracted with the State. An OTP must have the capacity to provide the full range of services included in the definition of MAT and must document both medication dosing and supporting behavioral health services. OTP programs may include:

(a) **OTP MAT Provider** - a licensed physician in good standing, maintaining a current federal waiver to prescribe drugs and biological products for the treatment of opioid-use disorder, and maintaining a current State registration to dispense dangerous medications; or

(b) **OTP Exempt MAT Provider** - a licensed PA or APRN in good standing, supervised, when required, by a physician described in (2)(a) above, and exempt from federal regulatory requirements for OTPs.

(c) **OTP Behavioral Health Services Providers** - professionals that meet the qualifications at Attachment 3.1-A, Page 11c and who provide the services noted within the same referenced page.

(d) **Medication Unit Affiliated with an OTP Established under 42 CFR. 8.11(i)** - a dosing location or medication station that obtains its methadone drug supply from a primary OTP site, which retains all records for the medication unit, except dosing and drug screens, which dispenses MAT drugs for observed intake, and which has on staff an OTP MAT Provider as defined above.

The following services are excluded from coverage:

1. Components that are not provided to or exclusively for the treatment of the eligible individual;
2. Services or components of services of which the basic nature is to supplant housekeeping or basic services for the convenience of a person receiving covered services;
3. Room and board;
4. Telephone calls or other electronic contacts, not inclusive of telehealth; and
5. Field trips or social or physical exercise activity groups.

Utilization Controls

___x___ The state has drug utilization controls in place.
- ___x___ Generic first policy
- ___x___ Preferred drug lists
- ___x___ Clinical criteria
- ___x___ Quantity limits

_____ The state does not have drug utilization controls in place.

Limitations
N/A

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

29. Medication-Assisted Treatment *(continued)*
Eligible Providers *(continued)*

Individual Provider Qualifications
Medication Assisted Treatment Services, Medical and Drug Components

Type of Service	Individual Provider Type	Qualifications
Medication-Assisted Treatment (MAT), office-based opioid treatment (OBOT), drug dispensing and administration (excluding methadone)	1. Physician 2. Physician's Assistant 3. Advanced Practice Registered Nurse	1. Licensed physician in good standing with a current federal waiver to dispense narcotic drugs for narcotic treatment (as per 21 USC 823(g)(2)) and current registration or exemption to dispense dangerous drugs 2. Licensed PA in good standing supervised, when required, by a physician described in (1) above. 3. Licensed APRN in good standing supervised, when required, by a physician described in (1) above.
Medication-Assisted Treatment (MAT), Opioid Treatment Program (OTP), drug dispensing and administration	1. Physician 2. Physician's Assistant (PA) 3. Advanced Practice Registered Nurse (APRN)	1. Licensed physician in good standing with a current federal waiver to dispense narcotic drugs for narcotic treatment (as per 21 USC. 823(g)(2)), current registration or exemption to dispense dangerous drugs as per state law, and who is employed by or contracted with certified OTP contracted with the State. 2. Licensed PA in good standing, supervised, when required, by a physician described in (1) above, exempt from regulatory requirements for OTPs (42 CFR 8.11(h)), and employed by or contracted with a certified OTP contracted with the State. 3. Licensed APRN in good standing, supervised, when required, by a physician described in (1) above, exempt from regulatory requirements for OTPs (42 CFR 8.11(h)), and employed by or contracted with a certified OTP contracted with the State.

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

29. Medication-Assisted Treatment *(continued)*
Eligible Providers *(continued)*

Individual Provider Qualifications
Medication Assisted Treatment Services, Behavioral Health Components

Service	Service State Plan Page	Provider	Provider Qualifications
Medication Training and Support	Attachment 3.1-A, Page 6a-1.3	Registered Nurse Physician Assistant Advanced Practice Registered Nurse	Attachment 3.1-A, Page 6a-1.3b
Alcohol & drug assessment	Attachment 3.1-A, Page 6a-1.3	Behavioral Health Practitioner (BHP)	Attachment 3.1-A, Page 6a-1.3a-b
Alcohol and/or substance abuse services treatment plan development	Attachment 3.1-A, Page 6a-1.3	Behavioral Health Practitioner (BHP)	Attachment 3.1-A, Page 6a-1.3a-b
Individual, group, and/or family therapy	Attachment 3.1-A, Page 6a-1.2	Licensed Behavioral Health Practitioner (LBHP); Drug Counselor (CADC)	Attachment 3.1-A, Page 6a-1.3a Attachment 3.1-A, Page 6a-1.3e
Alcohol and/or substance abuse services, skill development – individual and group	Attachment 3.1-A, Page 6a-1.3	Licensed Behavioral Health Practitioner (LBHP); Behavioral Health Rehabilitation Specialist (BHRS)/Case Manager II; Certified Alcohol & Drug Counselor (CADC)	Attachment 3.1-A, Page 6a-1.3a-b Attachment 3.1-A, Page 6a-1.3b-c Supplement 1 to Attachment 3.1-A, Page 1.3e Attachment 3.1-A, Page 6a-1.3e
Community recovery support	Attachment 3.1-A, Page 6a-1.2a	Recovery Support Specialist (RSS)	Attachment 3.1-A, Page 6a-1.3e
Crisis intervention services	Attachment 3.1-A, Page 6a-1.3	Licensed Behavioral Health Practitioner (LBHP)	Attachment 3.1-A, Page 6a-1.3a and 1.3d

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

30. Coverage of Routine Patient Cost in Qualifying Clinical Trials

Provided: X

I. **General Assurances:**

Routine Patient Cost – Section 1905(gg)(1)

X Coverage of routine patient cost for items and services as defined in section 1905(gg)(1) that are furnished in connection with participation in a qualified clinical trial.

Qualifying Clinical Trial – Section 1905(gg)(2)

X A qualified clinical trial is a clinical trial that meets the definition at section 1905(gg)(2).

Coverage Determination – Section 1905(gg)(3)

X A determination with respect to coverage for an individual participating in a qualified clinical trial will be made in accordance with section 1905(gg)(3).

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 210 of the Consolidated Appropriations Act of 2021 amending section 1905(a) of the Social Security Act (the Act), by adding a new mandatory benefit at section 1905(a)(30). Section 210 mandates coverage of routine patient services and costs furnished in connection with participation by Medicaid beneficiaries in qualifying clinical trials effective January 1, 2022. Section 210 also amended sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory under the state plan and any benchmark or benchmark equivalent coverage (also referred to as alternative benefit plans, or ABPs). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #74). Public burden for all of the collection of information requirements under this control number is estimated to take about 56 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Oklahoma

CASE MANAGEMENT SERVICES

In file T.B.

A. Target Group:

B. Areas of State in which services will be provided:

/ / Entire State.

/ / Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

/ / Services are provided in accordance with section 1902(a)(10)(B) of the Act.

/ / Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

E. Qualification of Providers:

NOT APPLICABLE

STATE	OK
DATE REC'D	JUN 29 1987
DATE APP'V'D	JAN 11 1988
DATE EFF	APR 1 1987
HCFA 179	87-9

A

New 04-01-87

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES

Target Group:

Chronically and/or severely mentally ill age 18 years and older or children who are at imminent risk of out-of home placement due to psychiatric or substance abuse reasons.

For case management services provided to individuals in medical institutions: [Olmstead letter #3]

X Target group is comprised of individuals transitioning to a community setting and case-management services will be made available for up to 180 consecutive days of the covered stay in the medical institution.

The target group does not include any of the excluded groups as stated in the 2000 Olmstead letter #3 and paragraphs (A) and (B) following paragraph section 1905(a)(28) of the Act. Oklahoma assures compliance through edits in the MMIS.

Areas of state in which services will be provided:

X Entire State

_ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of services:

_ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

X Services are not comparable in amount duration and scope.

Definition of services: [DRA & 2001 SMD]
Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Case Management includes the following assistance:

SUPERSEDES: TN 08-11

STATE Oklahoma
DATE REC'D 2-28-12
DATE APPV'D 10.24.12
DATE EFF 1-1-12
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES (continued)
Target Group: chronically and/or severely mentally ill age 18 years and older or children who are at imminent risk of out-of home placement due to psychiatric or substance abuse reasons. (continued)

- Assessment of an individual to determine the need for any medical, educational, social or other services. These assessment activities include:
  - Taking client history;
  - Identifying the individual's needs and completing related documentation;
  - Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

- Development of a specific care plan that:
  - Is based on the information collected through the assessment;
  - Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - Identifies a course of action to respond to the assessed needs of the eligible individual.

- Referral and related activities:
  - To help an eligible individual obtain needed services including activities that help link an individual with:
    - Medical, social, educational providers; or
    - Other programs and services capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

- Monitoring and follow-up activities:
  - Activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the individual's needs. These activities, and contact, may be with the individual, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary; including at least one annual monitoring to assure following conditions are met:

SUPERSEDES: TN 08-11

STATE Oklahoma
DATE REC'D 2-28-12
DATE APPV'D 10-24-12
DATE EFF 1-1-12
HCFA 179 12-03

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CASE MANAGEMENT SERVICES (continued)
Target Group: chronically and/or severely mentally ill age 18 years and older or children who are at imminent risk of out-of home placement due to psychiatric or substance abuse reasons. (continued)

- Services are being furnished in accordance with the individual's care plan;
- Services in the care plan are adequate; and
- If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and to service arrangements with providers.

Case management may include:

- Contact with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services.

Types of Case management:

- Standard case management with caseloads of 30-35 consumers.

- Intensive case management that focuses on the treatment of adults who are chronically or severely mental ill and who are also identified as high utilizers of mental health services and need extra assistance in accessing services and developing the skills necessary to remain in the community. The primary functions of intensive case management services are to assure an adequate and appropriate range of services are being provided to individuals to include: linkage with the mental health system, linkage with needed support system, and coordination of the various system components in order to achieve a successful outcome; aggressive outreach; and client education and resource skills development. Intensive case management caseloads are smaller, between 10 and 15 and the consumer typically has access 24 hours per day, 7 days per week.

- Wraparound facilitation service process that has been demonstrated as an effective way to support children and youth with severe emotional disturbance to live successfully in the community with their families. The wraparound service process identifies and builds on the strengths and culture of the child, family, and support system to create integrated and individualized plans to address the needs of the child and family that put the child at risk of long term residential placement. Typically, to produce a high fidelity wraparound process, a facilitator can facilitate between 8 and 10 families and is available 24 hours per day, 7 days per week.

SUPERSEDES TN- 09-11

STATE Oklahoma
DATE REC'D 2-28-12
DATE APPV'D 10-24-12
DATE EFF 1-1-12
12-03

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CASE MANAGEMENT SERVICES *(continued)*
Target Group: Chronically and/or severely mentally ill age 18 years and older or children who are at imminent risk of out-of home placement due to psychiatric or substance abuse reasons.

Qualifications of providers:
Case managers performing the service must be:

1. Licensed Behavioral Health Professional (LBHP) as described on Attachment 3.1-A Page 1a-6.11;
2. Currently Certified Alcohol and Drug Counselor (CADC); or
3. Currently certified as a Behavioral Health Case Manager through the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS). In order to obtain certification as a case manager, individuals must meet the following requirements:
    a. Case Manager II – meets the following:
        i. Qualifications.
            I. A bachelor's or master's degree in a behavioral health related field, earned from a regionally accredited college or university recognized by the United States Department of Education or a bachelor's or master's degree in education with at least nine (9) hours of college credit in a behavioral health related field; or
            II. Current licensure as a registered nurse and in good standing in the state in which services are provided with experience in behavioral health care; or
            III. A Bachelor's or master's degree in a non-behavioral health related field and current certification as a Psychiatric Rehabilitation Practitioner (CPRP).
        ii. Training Requirements.
            I. Behavioral health case management web-based training as specified by ODMHSAS,
            II. Individuals who have not received a certificate in children's psychiatric rehabilitation from the US Psychiatric Rehabilitation Association (USPRA) must complete the behavioral health rehabilitation web-based training as specified by ODMHAS,
            III. Complete one day of face-to-face behavioral health case management training, and
            IV. Individuals not certified as Psychiatric Rehabilitation Practitioners (CPRP) must complete two days of face-to-face behavioral health rehabilitation training.
        iii. Exam
            I. Successful completion of web-based competency exams for behavioral health rehabilitation and behavioral health case management is required in order to be certified.
            II. CPRP applicants for certification need only successfully complete the web-based competency exam for behavioral health case management.
        iv. Case Manager II certifications issued on or before June 30, 2013 will continue to be recognized until June 30, 2014.
    b. Case Manager I – meets the following:
        i. Has a high school diploma and:
            I. 60 college credit hours; or
            II. 36 total months of experience working with persons who have a mental illness and/or substance abuse issues (documentation of experience must be on file with ODMHSAS).
        ii. Complete two days of case management training as specified by ODMHSAS.
        iii. Successful completion of web-based competency exam for behavioral health case management.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES (continued)
Target Group: Chronically and/or severely mentally ill age 18 years and older or children who are at imminent risk of out-of home placement due to psychiatric or substance abuse reasons.

c. Wraparound Facilitator Case Manager – LBHP, CADC or CM II and has the following:
   i. Successful completion of the ODMHSS training for wraparound facilitation within six months of employment; and
   ii. Participate in ongoing coaching provided by ODMHSAS and employing agency; and
   iii. Successfully complete wraparound credentialing process within nine months of beginning process; and
   iv. Direct supervision or immediate access and a minimum of one hour weekly clinical consultation with a Qualified Mental Health Professional, as required by ODMHSAS.
d. Intensive Case Manager – LBHP, CADC or CM II and has the following:
   i. A minimum of two years behavioral health case management experience, crisis intervention experience, and
   ii. Must have attended the ODMHSAS intensive case management training.

Freedom of Choice:
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.

- Eligible recipients will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
- Eligible recipients will have free choice of the providers of other medical care under the plan.

Freedom of Choice Exception:

X Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Revised 07-01-13

State: Oklahoma
Date Received: September 19, 2013
Date Approved: December 01, 2015
Date Effective: July 1, 2013
Transmittal Number: 13-13

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES *(continued)*
Target Group: Chronically and/or severely mentally ill age 18 years and older or children who are at imminent risk of out-of home placement due to psychiatric or substance abuse reasons.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.

- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and

- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):

- Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Limitations:

- Case management does not include the following:
  - Activities not consistent with the definition of case management services under Section 6052 of the Deficit Reduction Act (DRA); the direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred. (2001 SMD)
  - Activities integral to the administration of foster care programs. (2001 SMD); and
  - Activities for which third parties are liable to pay. (2001 SMD)
- The State assures that individuals meeting provider qualifications under the plan to provide case management as well as other direct medical, educational, social or other services for which an eligible individual has been referred will not provide both case management and direct services to the same individual.

- Effective for services provided on or after 11-01-19, standard case management will be limited to 12 units per member per month. Additional units may be authorized for members that meet established medical necessity criteria.

State: Oklahoma
Date Received: 09 October, 2019
Date Approved: 04 November, 2019
Effective Date: 1 November, 2019
Transmittal Number: 19-0038

Revised 11-01-19

State/Territory: Oklahoma

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES

Target Group:

High Risk Pregnant Women
First Time Pregnant Women and Their Infants
Developmentally Disabled Children 0-3 Years of Age

For case management services provided to individuals in medical institutions: [Olmstead letter # 3]

Target group is comprised of individuals transitioning to a community setting and case management services will be made available for up to 180 consecutive days of the covered stay in the medical institution.

The target group does not include any of the excluded groups as stated in the 2000 Olmstead letter #3 and paragraphs (A) and (B) following paragraph section 1905(a)(28) of the Act. Oklahoma assures compliance through edits in the MMIS.

Areas of State in which services will be provided:

X Entire State

_ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than statewide:

Comparability of Services:

_ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

X Services are not comparable in amount, duration, and scope

Definition of Services: [DRA & 2001 SMD]
Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services. Case management includes the following assistance:

Revised 07-01-08

SUPERSEDES 92-07

STATE Oklahoma
DATE REC'D 3-31-08
DATE APP'VD 9-11-09
DATE EFF 7-1-08
HCFA 179 08-05

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES (continued)

High Risk Pregnant Women, First Time Pregnant Women and Their Infants and Developmentally Disabled Children 0-3 Years of Age (continued)

- Comprehensive assessment and periodic reassessment of an individual to determine the need for any medical, educational, social or other services. These assessment activities include:
  - Taking client history;
  - Identifying the individual's needs and completing related documentation;
  - Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

- Development (and periodic revision) of a specific care plan that:
  - Is based on the information collected through the assessment;
  - Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - Identifies a course of action to respond to the assessed needs of the eligible individual.

- Referral and related activities:
  - To help an eligible individual obtain needed services including activities that help link an individual with:
    - Medical, social, educational providers; or
    - Other programs and services capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

- Monitoring and follow-up activities:
  - Activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the individual's needs. These activities, and contact, may be with the individual, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary, including at least one annual monitoring to assure following conditions are met:
    - Services are being furnished in accordance with the individual's care plan;
    - Services in the care plan are adequate; and
    - If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and to service arrangements with providers.

Revised 07-01-08

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES (continued)

High Risk Pregnant Women, First Time Pregnant Women and Their Infants and Developmentally Disabled Children 0-3 Years of Age (continued)

Case management may include:

- Contact with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services.

Qualifications of providers:

- Case Manager qualifications for high risk pregnant women:
  (A) Must have a degree in a related field and at least one year of experience in community health case management or perinatal care.
  (B) In the case of Registered Nurses with an associate degree, the case managers must have two years of experience in community health case management or perinatal care.

- Case Manager qualifications for 1st time mothers:
  (A) Licensed registered nurses; and
  (B) Training and required certification in home visitation program.

- Case manager qualifications for developmentally disabled children 0-3 Years of Age:
  (A) Graduation from an accredited college or university with a bachelor's degree in education, social work, health-related field and one year of experience in one or more of these fields;
  (B) Knowledge of community-based, facility and institutional resources available to the target group and the experience to link to said resources;
  (C) Experience in working in education, health or human service field;
  (D) Administrative experience to meet state and federal requirements as well as requirements set out by the certifying agency;
  (E) Ability to maintain programmatic and financial records required by the certifying agency including the capacity to document case records consistent with program standards and state and federal requirements;
  (F) Receipt of approved State Department of Education Training.

New Page 07-01-08

SUPERSEDES: NONE - NEW PAGE

STATE Oklahoma
DATE RECD 3-31-08
DATE APPVD 9-11-09
DATE EFF 7-1-08
HCFA 179 08-05

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES (continued)

High Risk Pregnant Women, First Time Pregnant Women and Their Infants and Developmentally Disabled Children 0-3 Years of Age (continued)

Freedom of choice:
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

- Eligible recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.
- Eligible recipients will have free choice of the providers of other medical care under the plan.

Freedom of Choice Exception:
Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services:
The State assures that:

- Case management services will be provided in a manner consistent with the best interest of recipients and will not be used to restrict an individual's access to other services under the plan; [section 1902(a)(19)]
- Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services; [section 1902 (a)(19)]
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan. [42 CFR 431.10(e)]

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

New Page 07-01-08

SUPERSEDES: NONE - NEW PAGE

STATE Oklahoma
DATE RECD 3-31-08
DATE APPVD 9-11-09
DATE EFF 7-1-08
HCFA 179 08-05
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES (continued)

High Risk Pregnant Women, First Time Pregnant Women and Their Infants and Developmentally Disabled Children 0-3 Years of Age (continued)

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:
Case Management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

New Page 07-01-08

SUPERSEDES: NONE - NEW PAGE

STATE Oklahoma
DATE REC'D 3-31-08
DATE APP'D 9-11-09
DATE EFF 7-1-08
HCFA 179 08-05
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: OKLAHOMA

CASE MANAGEMENT SERVICES

A. Target Group: Persons under age 21 who are in imminent risk of out-of-home placement for psychiatric or substance abuse reasons or are in out-of-home placement due to psychiatric or substance abuse reasons.

B. Areas of State in which services will be provided:

☒ Entire State.

☐ Only in the following geographic areas (authority of Section 1915 (g)(1) of the Act is invoked to provide services less than statewide:

C. Comparability of Services:

☐ Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount, duration and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services: Case management services are those provided to assist a client in gaining access to needed medical, social, educational and other services essential to meeting basic human needs. This includes assisting the client in gaining access to basic community resources, referral and linkage to services, and is not restrictive in nature.

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STATE Oklahoma
DATE REC'D 06-26-01
DATE APP'D 08-03-01
DATE EFF 06-25-01
HCFA 179 OK-01-14

Provider Specialities

Private Facilities – Private facilities are those facilities who contract directly with the Oklahoma Health Care Authority to provide case management services.

DMHSAS Contracted Facilities – DMHSAS contracted facilities are those facilities who contract with the DMHSAS to provide services. These facilities receive an appropriation from the DMHSAS and report to DMHSAS via the OMHIS system.

Public Facilities – Public facilities are the regionally based Community Mental Health Centers.

Service	Unit	Limitations
Case Management	15 minutes	All units require prior authorization

All services will be subject to the medical necessity criteria. The client has the right to refuse case management and cannot be restricted from other services because of a refusal of case management services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

TARGETED CASE MANAGEMENT SERVICES

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):
The target group includes children under age 18 who are assessed as at risk of abuse or neglect as defined in Title 10A §1-1-105 of the Oklahoma Statutes and who are in emergency, temporary or permanent custody of the Department of Human Services (DHS) or in voluntary status who are placed in out-of-home care or trial adoption.

_X_ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 180 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):
_X_ Entire State
___ Only in the following geographic areas:

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
_X_ Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services [42 CFR 440.169(b)]: Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual;

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Targeted Case Management (continued)
Definition of services (continued)

- Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
  - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

- Monitoring and follow-up activities:
  - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
    1. services are being furnished in accordance with the individual's care plan;
    2. services in the care plan are adequate; and
    3. changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

X At-Risk Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
[42 CFR 440.169(e)]

Qualifications of providers [42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)]:
Case Management Agency Qualifications:
The provider agency must:
1. Meet applicable State and Federal laws governing the participation of providers in the Medicaid program.
2. Be certified by the OHCA as a qualified At-Risk Case Management Provider.

SUPERSEDES: TN- 97-10

STATE Oklahoma
DATE REC'D 3-31-08
DATE APP'D 10-25-10
DATE EFF 12-1-09
HCFA 179 08-07
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Targeted Case Management (continued)
Qualifications of providers (continued)

Certification Process
The At-Risk Case management provider must:

1. Demonstrate that their staff has experience working with the target population.
2. Have a minimum of five years experience in providing all core elements of case management including:
    a. Individual strengths and needs assessment
    b. Needs-based service planning
    c. Service coordination and monitoring
    d. Ongoing assessment and treatment plan revision.
3. Have adequate administrative capacity to fulfill State and Federal requirements.
4. Have financial management capacity and system that provides documentation of services and costs.
5. Have capacity to document and maintain individual case records in accordance with State and Federal requirements.
6. Have ability to meet all State and Federal laws governing the participation of providers in the State Medicaid program including, but not limited to, the ability to meet Federal and State requirements for documentation billing and audits.
7. Have a minimum of five years experience in providing the case management services that coordinate and link the community resources required by the target population.
8. Have a minimum of five years experience in meeting the case management and service needs of the target population, including statewide contract management/oversight and administration of services funded through the Oklahoma Children's initiative.

At-Risk Case Manager Qualifications:

1. Must be employed by an approved provider agency;
2. Possess a minimum of a bachelor of social work degree; or a bachelor degree and one year of experience in professional social work; or a master's degree in behavioral science.
3. Possess knowledge of laws, rules, regulations, legislation, policies and procedures as they pertain to:
    a. Social work;
    b. Laws, rules, regulations and policies and procedures governing agency programs;
    c. Community resources;
    d. Human development stages and related dysfunctions;
    e. Sensitivity of cultural diversity; and
    f. Emotional, physical and mental needs of client

STATE Oklahoma
DATE REC'D 3-31-08
DATE APPV'D 10-25-10
DATE EFF 12-1-09
HCFA 179 08-07
A

SUPERSEDES: TN 97-10

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Targeted Case Management (continued)
At-Risk Case Manager Qualifications (continued)

4. Possess skill in:
    a. Interviewing;
    b. Getting clients to explore opportunities and extracting information;
    c. Casework management;
    d. Setting goals in cooperation with clients;
    e. Time management;
    f. Prioritizing and organizing needs of clients;
    g. Courtroom testimony, terminology and procedures;
    h. Crisis intervention;
    i. Working with a multidisciplinary approach; and
    j. Developing, evaluation and modifying an intervention plan on an ongoing basis.

Freedom of choice [42 CFR 441.18(a)(1)]:
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception [§1915(g)(1) and 42 CFR 441.18(b)]:
____ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

Access to Services [42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)]:
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

STATE Oklahoma
DATE REC'D 3-31-08
DATE APP'VD 10-25-10
DATE EFF 12-1-09
HCFA 179 08-07
A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Targeted Case Management (continued)

Payment [42 CFR 441.18(a)(4)]:
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records [42 CFR 441.18(a)(7)]:
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. [42 CFR 441.18(c)]

FFP is only available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. [§1902(a)(25) and 1905(c)]

STATE Oklahoma
DATE REC'D 3-31-08
DATE APPV'D 10-25-10
DATE EFF 12-1-09
HCFA 179 08-07
A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

TARGETED CASE MANAGEMENT SERVICES

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):
The target group includes eligible individuals under age 21 who are assessed as at risk of abuse or neglect as define in Title 10A §1-1-105 of the Oklahoma Statutes and who are involved in, or at serious risk of involvement with the juvenile justice system. The target group does not include those who are involuntarily in secure custody of law enforcement or judicial systems, except individuals who meet Medicaid criteria for inpatient care as defined in 42 CFR § 435.1009; 42 CFR § 435.1010.

X Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 180 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):
X Entire State
___ Only in the following geographic areas:

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
X Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services [42 CFR 440.169(b)]: Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

Each eligible individual is assessed by utilizing an evidence-based, comprehensive assessment tool at the beginning of case assignment. The tool is designed to assess levels of risk, needs, or strengths within multiple areas, and to facilitate targeted and effective interventions. Any area showing a moderate to high-risk/need/strength score could result in additional goals and action steps documented within the individualized treatment plan. Each eligible individual is reassessed and scored again, at least once every six (6) months. If behavior shifts or life-changing events occur prior to six (6) months, the eligible individual is reassessed and the Individualized Treatment Service Plan is adjusted to reflect identified needs. Any needed changes in services, service providers, treatment type, frequency, or duration may also be effected at this time.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Targeted Case Management *(continued)*
Definition of services *(continued)*

- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual.

- Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
  - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

- Monitoring and follow-up activities:
  - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
    1. services are being furnished in accordance with the individual's care plan;
    2. services in the care plan are adequate; and
    3. changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

The targeted case manager performs at least one documented, face-to-face encounter per month with each eligible individual to review progress towards achieving Individualized Treatment Service Plan goals and objectives. The targeted case manager also engages in at least one contact per month with the parent(s) or legal guardian(s) of the eligible individual. Weekly or monthly contacts (often by telephone) are performed by the targeted case manager with family, school personnel, medical, and other service providers to stay aware of treatment and progress, support the coordination of services, and ensure that eligible individuals are provided with necessary services in a coordinated, timely, effective, and efficient manner.

Targeted Case Management *(continued)*
Definition of services *(continued)*

_X_ Targeted case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
[42 CFR 440.169(e)]

Qualifications of providers [42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)]:
Case Management Agency Qualifications:
The provider agency must:

1. Meet applicable State and Federal laws governing the participation of providers in the Medicaid program.
2. Demonstrate that their staff has experience working with the target population.
3. Have a minimum of five years' experience in providing all core elements of case management including:
    a. Individual strengths and needs assessment;
    b. Needs-based service planning;
    c. Service coordination and monitoring; and
    d. Ongoing assessment and treatment plan revision.
4. Have adequate administrative capacity to fulfill State and Federal requirements.
5. Have financial management capacity and system that provides documentation of services and costs in accordance with Generally Accepted Government Auditing Standards (GAGAS).
6. Have capacity to document and maintain individual case records in accordance with State and Federal requirements.
7. Have ability to meet all State and Federal laws governing the participation of providers in the State Medicaid program including, but not limited to, the ability to meet Federal and State requirements for documentation billing and audits.
8. Have a minimum of five years' experience in providing case management services that coordinate and link to community resources required by the target population.
9. Have a minimum of five years' experience in meeting the case management and service needs of the target population, including statewide contract management/oversight and administration of services.
10. Have responsibility for planning and coordinating statewide juvenile justice and delinquency prevention services in accordance with Oklahoma Statutes.
11. Have ability to evaluate the effectiveness, accessibility, and quality of TCM services on a community-wide basis.

Targeted Case Management *(continued)*

Targeted Case Manager Qualifications:

1. Must be employed by an approved provider agency;
2. Possess a minimum of a Bachelor's degree in a behavioral science, or a Bachelor's degree and one year of professional experience in juvenile justice or a related field;
3. Possess knowledge of:
    a. Laws, rules, regulations, legislation, policies, and procedures as they pertain to the State administration of juvenile justice and the investigation of juvenile delinquency;
    b. Community resources;
    c. Human developmental stages and related dysfunctions, social work theory and practices;
    d. Adverse childhood experiences (ACE) and the impact of trauma on the developing brain;
    e. The risk and protective factors of child delinquency;
    f. Solution-focused practices and the critical role protective factors play in intervention planning;
    g. Sensitivity of cultural diversity; and,
    h. Clinical and counseling techniques and treatment of juvenile delinquency.
4. Possess skill in:
    a. Crisis intervention;
    b. Gathering necessary information to determine the needs of the child;
    c. Casework management;
    d. Courtroom testimony, terminology, and procedures;
    e. Effective communication;
    f. Developing, evaluating and modifying intervention plans on an ongoing basis;
    g. Establishing and maintaining constructive relationships with children and their families;
    h. Helping families become and maintain as functional family units; and
    i. Working with courts and law enforcement entities.
5. Have the ability to access multi-disciplinary staff, when needed. This includes, at a minimum, medical professionals as needed and a child protective services social worker.

Freedom of choice [42 CFR 441.18(a)(1)]:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Targeted Case Management (continued)

Freedom of Choice Exception [§1915(g)(1) and 42 CFR 441.18(b)]:
____ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

Access to Services [42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)]:
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment [42 CFR 441.18(a)(4)]:
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records [42 CFR 441.18(a)(7)]:
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

STATE Oklahoma
DATE RECD 3-31-08
DATE APPVD 8-19-10
DATE EFF 12-1-09
HCFA 179 08-08
A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Targeted Case Management (continued)
Limitations (continued)

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. [42 CFR 441.18(c)]

FFP is only available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. [§1902(a)(25) and 1905(c)]

STATE Oklahoma
DATE REC'D 3-31-08
DATE APPV'D 8-19-10
DATE EFF 12-1-09
HCFA 179 08-08

A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

TARGETED CASE MANAGEMENT SERVICES

Target Group [42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)]:
The target group is persons with mental retardation and/or related conditions who are served by the Home and Community Based Services (HCBS) Waiver; or individuals who reside in institutions and have requested HCBS and receive TCM prior to entering the waiver; or who are being assessed for admission to the HCBS Waivers.

__X__ Target group includes individuals transitioning to a community setting. Case management services will be made available for up to 180 days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915 of the Act):
X Entire State
_ Only in the following geographic areas:

Comparability of services [§1902(a)(10)(B) and 1915(g)(1)]
___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
__X__ Services are not comparable in amount, duration, and scope [§1915(g)(1)]

Definition of services [42 CFR 440.169(b)]: Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services. Targeted Case Management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. These assessment activities include:
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

  Assessments are completed prior to enrollment in the home and community based waivers and at least annually thereafter in order to identify needs and develop and update the plan of care.

Revised 03-03-08

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Targeted Case Management (continued)
Definition of services (continued)

- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual;

- Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:
  - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

- Monitoring and follow-up activities:
  - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
    1. services are being furnished in accordance with the individuals' care plan;
    2. services in the care plan are adequate; and
    3. changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

    Case managers conduct monitoring and follow up activities based on the needs of the participant. At a minimum, case managers conduct face-to-face visits twice a year to monitor the participant's health and welfare and the effectiveness of the plan of care in meeting the participant's needs. Case managers may also observe service delivery and review related documentation, talk with participants, family members, guardians, advocates and service providers regarding the health and welfare of the participant and implementation of the plan of care and its effectiveness in meeting the person's needs in order to identify any follow up or changes needed.

Revised 03-03-08

SUPERSEDES: TN- 97-14

STATE Oklahoma
DATE RECD. 3-31-08
DATE APPVD 8-25-10
DATE EFF 3-3-08
HCFA 179 08-09

A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Targeted Case Management *(continued)*
Definition of services *(continued)*
Monitoring and follow-up activities *(continued)*

The case manager must provide documentation to supplement the plan of care which includes:

1. information supporting the selection of outcomes;
2. information supporting the approaches selected;
3. information supporting case management decisions and actions;
4. documentation of communication with the client and, as appropriate, his/her representative;
5. documentation of linkages with resources;
6. documentation of follow-up and monitoring of the plan;
7. other factual information relevant to the case.

X Case management may include contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback; and alerting case managers to changes in the eligible individual's needs. [42 CFR 440.169(e)]

Qualifications of providers [42 CFR 441.18(a)(8)(v) and 42 CFR 441.1B(b)]: Case Management Agency Qualifications:
The provider agency must:

1. meet applicable State and Federal laws governing the participation of providers in the Medicaid program.
2. be certified by the OHCA as a qualified DDSD Provider.

Case Manager Qualifications:

1. Possess a bachelor's degree in human services field and one year of professional experience working directly with persons with intellectual or other developmental disabilities or in social work, case management, special education, psychology, counseling, vocational rehabilitation, physical therapy, occupational therapy, speech therapy, nursing or a closely related field; or
2. Possess a valid permanent license as approved by a member-state participating in the Enhanced Nurse Licensure Compact (eNLC) to practice professional nursing (an interim work permit or a temporary license issued by a member-state of the Enhanced Nurse Licensure Compact (eNLC) will be accepted as long as it remains valid; however, a valid permanent license must be obtained prior to the completion of the probationary period), and one year of professional nursing experience working directly with persons with intellectual or other developmental disabilities; or one year of professional nursing experience, and one year working directly with persons with intellectual or other developmental disabilities.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Targeted Case Management (continued)
Case Manager Qualifications (continued)

3. Case managers will be required to possess necessary qualifications to be a qualified Mental Retardation Professional as defined in the Conditions of Participation for Intermediate Care Facilities for the Mentally Retarded.
4. Possess knowledge of:
   a. Case management methods, principles and techniques;
   b. Types of developmental disabilities represented within the caseload;
   c. Types of providers and services available for consumers;
   d. The behavioral sciences and allied disciplines involved in the evaluation, care and training of persons with developmental disabilities;
   e. Interviewing principles and techniques;
   f. Adaptive communication techniques and non-verbal communication.
5. Possess skill in:
   a. Managing a caseload;
   b. Effectively intervening in crisis situations;
   c. Working cooperatively and effectively with other professionals in a team situation;
   d. Collecting and analyzing information;
   e. Making decisions relating to services provided to consumers;
   f. Developing a logical and practical plan of treatment for consumers with developmental disabilities;
   g. Evaluating the progress of consumers and the qualify of their habilitation programs;
   h. communicating effectively;
   i. Mediating with providers and agencies to resolve problems.

Freedom of choice [42 CFR 441.18(a)(1)]:
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Revised 03-03-08

SUPERSEDES: TN- 97-14

STATE Oklahoma
DATE REC'D 3-31-08
DATE APP'D 8-25-10
DATE EFF 3-3-08
HCFA 179 08-09

A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Targeted Case Management (continued)

Freedom of Choice Exception [§1915(g)(1) and 42 CFR 441.18(b)]:
_X_ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services [42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment [42 CFR 441.18(a)(4)]:
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records [42 CFR 441.18(a)(7)]:
Providers maintain case records that document for all individuals receiving case management as follows: (1) The name of the individual; (ii) The dates of the case management services; (iii) The name of the provider agency (if relevant) and the person providing the case management services; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Revised 03-03-08

SUPERSEDES: TN- 97-14

STATE Oklahoma
DATE REC'D 3-31-08
DATE APP'D 8-25-10
DATE EFF 3-3-08
HCFA 179 08-09
A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Targeted Case Management (continued)
Limitations (continued):

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. [42 CFR 441.18(c)]

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. [§1902(a)(25) and 1905(c)]

STATE Oklahoma
DATE RECD 3-31-08
DATE APP'D 8-25-10
DATE EFF 3-3-08
HCFA 179 08-09
A

New Page 03-03-08

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

_____ The State of Oklahoma has not entered into any valid program agreements with a PACE provider and the Secretary of the Department of Health and Human Services

____X___ The State of Oklahoma has entered into a valid program agreement(s) with a PACE provider(s) and the Secretary.

State: Oklahoma
Date Received: 28 May, 2014
Date Approved: 9 July, 2014
Date Effective: 1 July, 2014
Transmittal Number: 14-08

Enclosure 3

State of Oklahoma
PACE State Plan Amendment Pre-Print

Citation 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1905(a)(26) and 1934

__X__ 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-A identifies the medical and remedial services provided to the categorically needy. (Note: Other programs to be offered to Categorically 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 Categorically 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.)

SUPERSEDES: NONE - NEW PAGE

STATE Oklahoma
DATE REC'D 3-8-07
DATE APP'VD 10-9-07
DATE EFF 2-1-07
HCFA 179 07-06

A

Enclosure 4

State of Oklahoma
PACE State Plan Amendment Pre-Print

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

SUPERSEDES: NONE - NEW PAGE

STATE Oklahoma
DATE REC'D 3-8-07
DATE APPV'D 10-9-07
DATE EFF 2-1-07
HCFA 179 07-06

A

Enclosure 5

Attachment 3.1-A

State of Oklahoma
PACE State Plan Amendment Pre-Print

Amount, Duration and Scope of Medical and Remedial Care Services Provided To the Categorically Needy

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 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.

STATE Oklahoma
DATE RECD 3-8-07
DATE APPVD 10-9-07
DATE EFF 2-1-07
HCFA 179 07-06

A

SUPERSEDES: NONE - NEW PAGE

Enclosure 6

Attachment 3.1-B

State of Oklahoma
PACE State Plan Amendment Pre-Print

Amount, Duration and Scope of Medical and Remedial Care Services Provided To the Medically Needy

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

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

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

SUPERSEDES: NONE - NEW PAGE

STATE Oklahoma
DATE REC'D 3-8-07
DATE APP'VD 10-9-07
DATE EFF 2-1-07
HCFA 179 07-06

A

STATE Oklahoma
DATE REC'D 3-8-07
DATE APPV'D 10-9-07
DATE EFF 2-1-07
HCFA 179 07-06

A

Enclosure 7

Supplement 3 to Attachment 3.1-A

State of Oklahoma
PACE State Plan Amendment Pre-Print

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._____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.)

B. __X__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._____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).

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):_____

2._____The following dollar amount: $_____

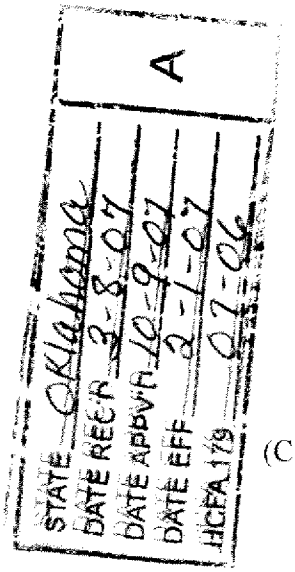
Note: If this amount changes, this item will be revised.

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.

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

6.____ The amount is determined using the following formula:

_____

_____

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.

A

STATE Oklahoma
DATE REC'D 3-8-07
DATE APP'D 10-9-07
DATE EFF 2-1-07
HCFA 179 07-06

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):_____
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.**

STATE Oklahoma
DATE REC'D 3-8-07
DATE APPV'D 10-9-07
DATE EFF 2-1-07
HCFA 179 07-06

A

(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.

Spousal Post Eligibility

3.____ State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a

community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a.) Allowances for the needs of the:

1. Individual (check one)

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

1. ____ SSI
2. ____ Medically Needy
3. ____ The special income level for the institutionalized
4. ____ Percent of the Federal Poverty Level: ____%
5. ____ Other (specify): _____

(B)____ The following dollar amount: $_____

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

(C)____ The following formula is used to determine the needs allowance:

_____

_____

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

_____

_____

II. Rates and Payments

A. The State assures CMS that the capitated rates will be less than the cost to the agency of providing State plan approved services to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the amount the state would have otherwise paid for a comparable population.

1. _X_ Rates are set at a percent of the amount that would otherwise been paid for a comparable population.
2. ____ Experience-based (contractors/State's cost experience or encounter date) (please describe)
3. ____ Adjusted Community Rate (please describe)
4. ____ Other (please describe)

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner.

C. The State will submit all capitated rates to the CMS Regional Office for prior approval and will include the name, organizational affiliate of any actuary used, and attestation/description of the capitation rates.

The capitation rate development for PACE involves setting a baseline per member per month (PMPM) expenditure rate. A base year is established, and a data extract of claims processed for the PACE target population during this period. The target population is limited to persons ages 55 and older certified as nursing facility level of care. This data was used to establish the amount that would otherwise have been paid (AWOP). The data from the base year will be reviewed annually and updated as needed, and consistent with CMS regulation and guidance. The rate developed through this process will be below the AWOP.

III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency OKLAHOMA

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation (s)		Provision (s)
1935(d)(1)	1.	Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible benefits under Part A or Part B.
1927(d)(2) and 1935(d)(2)	2.	The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid-only recipients, and where noted, to full benefit dual eligible beneficiaries who have coverage under the Medicare Prescription Drug Benefit –Part D.
		The following excluded drugs are covered:
	☐	(a) agents when used for anorexia, weight loss, weight gain
	☐	(b) agents when used to promote fertility
	☐	(c) agents when used for cosmetic purposes or hair growth
	☐	(d) agents when used for the symptomatic relief cough and colds
	X	(e) prescription vitamins and mineral products, except prenatal vitamins and fluoride
	X	(f) nonprescription drugs (see specific information below)

Revised 04-01-13

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency OKLAHOMA

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation (s)		Provision (s)
1927(d)(2) and 1935(d)(2)	☐	(g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee

(f) **Nonprescription drugs**: The state maintains a complete listing of covered nonprescription (over-the-counter) drug categories on its public website found at http://www.okhca.org/rx

State: Oklahoma
Date Received: 31 March, 2014
Date Approved: 9 April, 2014
Date Effective: 1 January, 2014
Transmittal Number: OK 14-09

Revised 01-01-14

State: OKLAHOMA

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

The following ambulatory services are provided:

NOT APPLICABLE

THIS STATE PLAN DOES NOT INCLUDE THE MEDICALLY NEEDY

STATE Oklahoma	A
DATE REC'D 3-26-03	
DATE APPV'D 6-17-03	
DATE EFF 2-1-03	
HCFA 179 OK 03-06	

Attachment 3.1-C

Standards and Methods to Assure Care and Services of High Quality. By letter of designation under date of November 22, 1965, from the Honorable Henry Bellmon, Governor of the State of Oklahoma, to the Honorable John W. Gardner, Secretary of the Department of Health, Education, and Welfare, the Oklahoma State Health Department has been designated as the state authority which shall be responsible for establishing and maintaining standards for private and public institutions in which recipients of medical assistance under the plan may receive care and services.

A contract is held with the Oklahoma State Health Department to perform the functions of determining whether a facility meets the requirements of participation as a skilled and intermediate care facility. An institution shall be deemed to meet the standards for certification as a skilled nursing facility for purposes of Title XIX whenever the Secretary certifies such institution in the State to be qualified as a skilled nursing facility under Title XVIII.

of

3.1-C
Page 1

OFFICE OF THE GOVERNOR

EXECUTIVE ORDER

FILED
FEB 10 1967
JOHN ROGERS
SECRETARY OF STATE

TO: HONORABLE JOHN ROGERS
SECRETARY OF STATE
STATE CAPITOL BUILDING
OKLAHOMA CITY, OKLAHOMA

Dear Sir:

Please file for record the following Executive Order:

WHEREAS, medical facilities are required to meet and maintain State standards for the purposes of Title XIX of the Federal Social Security Act; and

WHEREAS, it is necessary that Federal Officials know what agency or agencies in Oklahoma can set such standards; and

WHEREAS, the State Board of Health is the proper agency to set standards for all medical facilities except those which, by law, have been placed under the jurisdiction of other public agencies;

NOW, THEREFORE, BY VIRTUE OF THE AUTHORITY VESTED IN ME AS GOVERNOR AND CHIEF EXECUTIVE OF THE STATE OF OKLAHOMA, I do hereby declare the State Board of Health as the official agency of the State of Oklahoma to set standards for medical facilities in the State of Oklahoma, except the medical facilities that are operated by the Department of Public Welfare and any other State agency, for which facilities the Oklahoma Public Welfare Commission, or the governing Board of such other State agency, is declared to be the standard-setting authority, the standards so set to be equal to or higher than those set by the State Board of Health for other medical facilities.

IN WITNESS WHEREOF, I, DEWEY F. BARTLETT, GOVERNOR OF THE STATE OF OKLAHOMA, have hereunto affixed my name and set my hand and caused to be affixed the GREAT SEAL OF THE STATE OF OKLAHOMA at Oklahoma City, Oklahoma, this 10th day of February, 1967.

BY THE GOVERNOR OF THE STATE OF OKLAHOMA

Dewey F. Bartlett
DEWEY F. BARTLETT

ATTEST:

John Rogers
Secretary of State

OFFICE OF THE SECRETARY OF STATE

STATE OF OKLAHOMA

CERTIFICATE OF TRANSCRIPT

I, the undersigned Secretary of State of the State of Oklahoma, do hereby certify that the annexed transcript has been compared with the record on file in my office of which it purports to be a copy, and that the same is a full, true and correct copy of:

EXECUTIVE ORDER

SETTING STANDARDS FOR MEDICAL FACILITIES

FILED: February 10, 1967

In testimony whereof, I have hereunto set my hand and affixed the Great Seal of the State of Oklahoma at the City of Oklahoma City, this 11 day of October, 1968

John Rogers
Secretary of State

By: L. L. Callahan
Assistant Secretary of State

3.1-C
Page 3

STATE OF OKLAHOMA
OKLAHOMA PUBLIC WELFARE COMMISSION

DEPARTMENT OF INSTITUTIONS, SOCIAL AND REHABILITATIVE SERVICES
(Department of Public Welfare)

L. E. Rader
Director of Institutions,
Social and Rehabilitative Services

Mailing Address: P.O. Box 25352

Sequoyah Memorial Office Building
OKLAHOMA CITY, OKLAHOMA - 73125

February 23, 1975

Honorable Floyd L. Brandon
Regional Commissioner
Social and Rehabilitation Service
Department of Health, Education and Welfare
1114 Commerce Street
Dallas, Texas 75202

Dear Commissioner Brandon:

On February 10, 1967, the Governor of the State of Oklahoma issued an Executive Order designating and appointing the Department of Public Welfare as the standard setting authority for medical facilities under the jurisdiction of the Oklahoma Public Welfare Commission.

This was transmitted to the Regional Office on March 13, 1967 on Submittal No. #365.

The purpose of this letter is to request of you in writing an approval of said Executive Order for the purpose of establishing that the Oklahoma Department of Public Welfare is the survey agency for those institutions operated by said Department.

In order to facilitate an answer, we are enclosing a copy of Budget Bureau No. 122-R068, Submittal No. 365, and a copy of the Executive Order.

Very truly yours,

L. E. Rader, Director
Institutions, Social and
Rehabilitative Services

Encls. 2

3-1-C
Page-4

September 9, 1975

Mr. L. E. Rader
Director
Department of Institutions, Social
and Rehabilitative Services
Post Office Box 25352
Oklahoma City, Oklahoma 73125

Dear Mr. Rader:

This letter will serve as approval of the Executive Order designating the Oklahoma Department of Public Welfare as the standard setting authority for medical facilities under the jurisdiction of the Oklahoma Public Welfare Commission as requested in your February 23, 1975 letter and clarified in your July 10, 1975 letter.

This material is officially accepted for incorporation in the approved Title XIX State Plan.

Sincerely yours,

James A. Adams
Associate Regional Commissioner

Enclosure

cc: Dr. Bertha Levy

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
Welfare Administration
Form PS-553
(Rev. 1/52)

(TO BE PREPARED IN SIX COPIES)

3.1-c
Pages

Budget Bureau No. 12

SUBMITTAL AND REPORT OF ACTION ON PUBLIC ASSISTANCE PLAN MATERIALS

DEPARTMENT OF HEALTH,
EDUCATION AND WELFARE

1. To: Department of Health, Education, and Welfare

Regional Office Dallas VIP[illegible] 14 AM 10 36
(Address)

Attention: Family Services Representative.

2. Date March 13, 1967

3. Submittal No. 365

4. From: Oklahoma Department of Public Welfare
(State public assistance agency)

Enclosed are six copies of the following materials submitted for approval by the State's for public assistance:

5. Signature [signature]
L. E. Rader

6. Title Director of Public Welfare

Identification of material and program affected	Outline reference	Effective date	Material superseded	Disposition 1/	
7	8	9	10	11	
1. Appendix M-5 - Fee Schedule for Nursing Homes	V	10-66	4-1-66	Superseded Item 2 of Submittal	
2. Appendix M-5 - Fee Schedule for Nursing Homes	V	1-67	10-66	O	
State Memo 67-17 - Extended Care Facility Services	IV	2-7-67	---	O (to 3/	
4. Form ABD-70 - Notification of Eligibility Status for Medical Services	V	1-26-67	New	O (to 3/	
5. Governor's Executive Order re Standard Setting Authority for Institutions	I	2-10-67		O	
6. State Memo 67-20 - Revision of Manual Sections 227.63 & 731.31, Items 8 and 9	II	2-27-67		NL	
7. State Memo 67-21 - Health Insurance Benefits	III	3-3-67		NL	
8. Manual Section 227.62 - 229.4 Pgs.18 25 - Personnel Unit	II	3-1-67	11-19-65	A (exc 17 & 1	

Mr. L. E. Rader, Director
13. To: Department of Public Welfare, Okla. City, Okla. 14. Date APR 1 3

Revised 4/67 P
Sub.366)

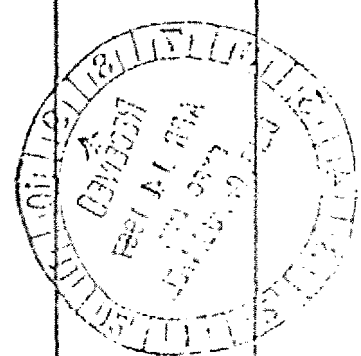
15. The above materials were received in the regional office on 3/14/67

16. Items A and AL accepted for incorporation. APR 1 8 1967 [signature]
(Date) Family Services Representati

1/ The symbols inserted indicate that the item:
(A) Has been accepted for incorporation into the State's approved plan.
(AL) Has been accepted for incorporation into the State's approved plan, comments in le
(O) Has been filed as other than plan material.
(NL) Is under consideration and notice of action will be sent later.

Department of
Health, Education and Welfare
Social Security Administration
Form PS-553 - Continuation Page 2

Identification of material and program affected	Outline Reference	Effective Date	Material Superseded	Disposition
7	8	9	10	11
9. Manual 731.31 - 760. pgs. 4 - 8 - Staff Development Unit	III	3-1-67	11-19-65; 9-26-66	A (exc 4 & 5 su w/o inc. 366)
10. Manual 321.31 - 321.32 - Pgs. 16 & 16 - Policy on Eligibility	IIII	3-6-67	11-1-66 1-1-67	A
11. Manual 331.33-331.4 & Pages 19 Policy on Eligibility	IIII	3-6-67	1-1-67	A
12. Manual 970 - 978 - Pgs. 1 -15 Finance	V	1-1-67	5-5-64; 9-1-65	A



3-1-C pg 7

Submittal of Medical Services Informational Materials

(1) TO: Department of Health, Education, and Welfare
1114 Commerce Street
Dallas, Texas 75202

(2) Date 6-26-75

(3) Inf. Sub. # 10

Attention: Medical Services

(4) State Agency: Oklahoma Department of Institutions, Social & Rehabilitative Services

Enclosed are ~~six~~ three copies each of the following informational materials:

(5) Signature Original Signed By: L. E. Rader

(6) Title Director of Institutions, Social and Rehabilitative Serv.

(7) Identification of Material	(8) Eff. Date	For Regional Office Use (9)	(10)
ician's Manual			
on I - Eligibility Requirements 3	5-15-75		
on II - Scope of Medical Care 4, 5, 6 and 7	5-15-75		
on IV-Notification and Billing	5-15-75		
VI - Exhibits			
dm-36, Medical Providers' Claim	9-1-74		
uctions	3-15-75		
Adm-37, In-Patient Hospital Claim	9-1-74		
uctions	3-15-75		
Adm-38, Hospital Outpatient and/or center Claim	9-1-74		
uctions	3-15-75		
on VII - Physician Correspondence 2	5-15-75		
cian Letter #42	12-2-74		
cian Letter #43	1-2-75		
cian Letter #44	2-28-75		
tal Manual			
on I - Eligibility Requirements 3	5-15-75		
on II - Scope of Medical Care 4, 5, 6 and 7	5-15-75		
on IV-Notification and Billing 1	5-15-75		

(11) Date Received in Regional Office _____

METHODS OF PROVIDING TRANSPORTATION

The State Plan assures that necessary transportation is available to individuals eligible for Title XIX benefits who are in need of medical services.

1. Categorically Needy

Payment for Transportation

- The agency is responsible for assuring that necessary transportation is available to members eligible for Title XIX benefits who are in need of medical services in accordance with 42 CFR 431.53. The agency contracts with a broker to provide statewide curb to curb coverage for non-emergency transportation. The broker provides the most appropriate and least costly mode of transportation necessary to meet the individual needs of Title XIX members. Attendant services, to include transportation and transportation related expenses, are available upon request by the member to the broker at no charge to the member. Payment for covered services to the broker is reimbursed under a capitated methodology.

- Secure behavioral health transportation to a treatment facility is provided to members presumed to be experiencing a behavioral health crisis. Payment for these transportation services is provided to qualified providers through a published fee schedule.

- The agency contracts with ambulance and air providers for all other transportation needs for eligible members. Ambulance and air providers are reimbursed a rate published statewide based on the Medicare-established rates for covered services. Transportation must be for a medically necessary treatment in accordance with 42 CFR 440.170.

2. Authorization for Transportation by Bus or Private Automobile

Transportation by bus or private automobile is administered through the broker when it is necessary for an eligible individual to receive medical services. Eligible members traveling by bus will need to be issued bus passes distributed by the broker and eligible members traveling by private automobile will be reimbursed for mileage by the broker.

3. Authorization for Out-of-State Transportation

Reimbursement for out-of-state transportation that is medically necessary is authorized through the agency when transportation exceeds 50 miles from the Oklahoma border. The broker will contact the agency for authorization when a request is received from a member for transportation that will exceed 50 miles from the Oklahoma border. The agency will verify the member's examination or treatment appointment and that out-of-state approval has been issued by the agency. The agency will contact the broker with a decision of approval or denial of the request. Upon the approval of the request, the broker will proceed with arrangement for the transportation. Upon denial of the request the broker will advise the member to contact the agency for coordination of closer providers for comparable services.

4. Authorization for Transportation by Taxi

Taxi services may be authorized through the broker as a subcontracted provider of the broker.

METHODS OF PROVIDING TRANSPORTATION

5. Authorization for Transportation by Ambulance

Transportation by ambulance is compensable for members eligible for Title XIX benefits when medically necessary and when other available transportation does not meet the medical needs of the member. Payment is made for ambulance transportation to and/or from the nearest medical facility that can appropriately treat the member.

6. Authorization for Transportation by Air
(Air Ambulance or Helicopter, Commercial Airfare)

Transportation by air may be made available when the member's medical condition is such that transportation by an air service provider is required. Approval for commercial airfare must be prior authorized by the agency and flight arrangements will be made by the agency.

7. Provider and Driver Requirements (1902(a)(87) of the SSA)

The state Medicaid agency attests that all of the minimum requirements outlined in 1902(a)(87) of the Act are met.

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

The following organ and tissue transplant procedures are covered:

1. bone marrow;
2. stem cells;
3. cornea;
4. heart;
5. kidney;
6. liver;
7. lung;
8. simultaneous pancreas-kidney (SPK);
9. pancreas after kidney (PAK);
10. heart-lung;
11. pancreas (alone);
12. intestinal (multivisceral and/or intestinal); and
13. other multi-organ transplants as deemed medically necessary.

The following standards apply to organ transplant services:

a. similarly situated individuals are treated alike;
b. any restriction, on the facilities or practitioners which may provide such procedures, is consistent with the accessibility of high quality care to individuals eligible for the procedures under the State plan; and
c. services are reasonable in amount, duration, and scope to achieve their purpose.

The following limitations apply to organ transplant services:

a. all transplantation services, except kidney and cornea, must be prior authorized;
b. all transplant procedures are reviewed and prior authorization is based upon appropriate medical criteria;
c. all organ transplants must be performed at a Medicare approved transplantation center;
d. procedures considered experimental or investigational are not covered; and
e. donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.

For the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) population of all Medicaid eligible children under the age of 21, services are furnished based on medical necessity.

OK - Submission Package - OK2021MS0002O - (OK-21-0022-B) - Health Homes

CMS-10434 OMB 0938-1188

Package Information

Package ID	OK2021MS0002O	**Submission Type**	Official
Program Name	MIGRATED_HH.OK HH - children	**State**	OK
SPA ID	OK-21-0022-B	**Region**	Dallas, TX
Version Number	3	**Package Status**	Approved
Submitted By	Sandra Puebla	**Submission Date**	7/6/2021
Package Disposition		**Approval Date**	9/24/2021 4:23 PM EDT
Priority Code	P1		

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Medicaid and CHIP Operations Group
601 E. 12th Street
Room 355
Kansas City, MO 64016

Center for Medicaid & CHIP Services

September 24, 2021

Melody Anthony
State Medicaid Director
Oklahoma Health Care Authority
4345 N Lincoln Blvd
Oklahoma City, OK 73105

Re: Approval of State Plan Amendment OK-21-0022-B MIGRATED_HH.OK HH - children

Dear Melody Anthony,

On July 06, 2021, the Centers for Medicare and Medicaid Services (CMS) received Oklahoma State Plan Amendment (SPA) OK-21-0022-B to migrate individuals currently being served in Health Homes to other care coordination models in the state.

We approve Oklahoma State Plan Amendment (SPA) OK-21-0022-B with an effective date(s) of October 01, 2021.

As a reminder, CMS expects that all quality measures for the Health Homes benefit be reported based on the termination date of the program.

If you have any questions regarding this amendment, please contact Deborah Read at deborah.read@cms.hhs.gov

Sincerely,

James G. Scott

Director, Division of Program Operations

Center for Medicaid & CHIP Services

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | OK2021MS0002O | OK-21-0022-B | MIGRATED_HH.OK HH - children

Package Header

Package ID OK2021MS0002O
SPA ID OK-21-0022-B
Submission Type Official
Initial Submission Date 7/6/2021
Approval Date 9/24/2021
Effective Date N/A
Superseded SPA ID N/A

State Information

State/Territory Name: Oklahoma
Medicaid Agency Name: Oklahoma Health Care Authority

Submission Component

- (•) State Plan Amendment

- (•) Medicaid
- ( ) CHIP

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | OK2021MS0002O | OK-21-0022-B | MIGRATED_HH.OK HH - children

Package Header

Package ID OK2021MS0002O

Submission Type Official

Approval Date 9/24/2021

Superseded SPA ID N/A

SPA ID OK-21-0022-B

Initial Submission Date 7/6/2021

Effective Date N/A

SPA ID and Effective Date

SPA ID OK-21-0022-B

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Health Homes Program Termination - Phase-Out Plan	10/1/2021	TN # 14-0011

Page Number of the Superseded Plan Section or Attachment (If Applicable):

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | OK2021MS0002O | OK-21-0022-B | MIGRATED_HH.OK HH - children

Package Header

Package ID OK2021MS0002O

SPA ID OK-21-0022-B

Submission Type Official

Initial Submission Date 7/6/2021

Approval Date 9/24/2021

Effective Date N/A

Superseded SPA ID N/A

Executive Summary

Summary Description Including Goals and Objectives The State is collaborating with the Oklahoma Department of Mental Health Substance Abuse Services (ODMHSAS) to terminate the health homes benefit for children effective October 1, 2021; however, other care coordination models will still be in place to still serve this population.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2022	$1122380
Second	2023	$984631

Federal Statute / Regulation Citation

Section 2703 of the Affordable Care Act (Public Law 111-148); Section 1945 of Social Security Act

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
No items available		

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | OK2021MS0002O | OK-21-0022-B | MIGRATED_HH.OK HH - children

Package Header

Package ID OK2021MS0002O

SPA ID OK-21-0022-B

Submission Type Official

Initial Submission Date 7/6/2021

Approval Date 9/24/2021

Effective Date N/A

Superseded SPA ID N/A

Governor's Office Review

- ○ No comment
- ○ Comments received
- ○ No response within 45 days
- ◉ Other

Describe Governor's office does not review state plan amendments.

Health Homes Program Termination - Phase-Out Plan

MEDICAID | Medicaid State Plan | Health Homes | OK2021MS0002O | OK-21-0022-B | MIGRATED_HH.OK HH - children

CMS-10434 OMB 0938-1188

Package Header

Package ID OK2021MS0002O

SPA ID OK-21-0022-B

Submission Type Official

Initial Submission Date 7/6/2021

Approval Date 9/24/2021

Effective Date 10/1/2021

Superseded SPA ID TN # 14-0011

User-Entered

Provide a description of the phase-out or transition plan for the Health Homes Program that is being terminated

Describe the reason for termination

Oklahoma Medicaid will terminate the Health Home program October 1, 2021. Other care coordination models currently in place will continue to serve the population impacted by the termination of the program.

Describe the overall approach the state will use to terminating the program

The Health Home population will continue to receive integrated behavioral and physical health care coordination from nurses and behavioral health case managers. This will be provided by Community Mental Health Centers (CMHCs) and through Certified Community Behavioral Health service delivery that were previously contracted as Health Homes.

Indicate method of termination

- (•) The state will terminate all participants from the Health Homes Program on the same date
- ( ) The state will phase-out the termination of participation in the Health Homes Program

Termination effective date

10/1/2021

Describe the process the state will use to transition all participants and how referrals will be made to other health care providers

Oklahoma currently has coordinated care delivery for children with serious emotional disturbance (SED) through Patient Centered Medical Homes (PCMH), Health Access Networks (HANs), Health Management Program (HMP), and Certified Community Behavioral Health (CCBH) service delivery. Care coordination will be a seamless transition for members receiving Health Home (HH) services through CMHCs CCBH services. Most CMHCs will become an eligible organization to provide CCBH services. Current HH members who do not choose a CMHC or a CCBH provider to continue services can access physical and behavioral health integration services through the PCMH, CMHC, and/or CCBHs.

The State previously reported that as of July 1, 2021 there were 1,626 children enrolled in the HH program. Most HH providers are transitioning to the CCBH model; therefore, care coordination, provider standards, health information technology (HIT), and provider capacity will remain the same and there is no need for health record transmission. Of the current enrollees, it was found that there were 617 children attributed to private behavioral health organizations or state sponsored Program of Assertive Community Treatment (PACT) teams; thus, will not transition to the CCBH model when the HH program terminates. The State has planned outreach activities to current HH enrollees to inform them that the program is ending and they have free choice of providers for integrated health care, including Patient Center Medical Home (PCMH).

There are no concerns related to care coordination, provider standards, HIT, nor health record transmission for enrollees who are currently aligned with private providers that do not choose to pursue CCBH provider certification. CCBH providers (as well as OU IMPACT) have protocols and procedures in place with area hospitals for identifying and engaging at-risk consumers who are admitted to emergency departments, inpatient hospitals, urgent recovery and crisis centers. These protocols also apply when consumers are discharged, unless there is a formal transfer of care to a non-CCBH provider or non-PACT entity. Protocols include: the transfer of medical records of services received; active follow-up after discharge; a plan for suicide prevention and safety as appropriate; and a provision for peer services.

The State believes that with the Prospective Payment System (PPS) reimbursement method and CCBH provider expansion funding, CCBH providers will have the capacity to provide access and continued quality services to transitioning HH enrollees.

Over the past few years, many members have shifted from the HH program to CCBH providers causing a shift from the HH program financial line to that of CCBHC providers. The budget impact to sunset health home services for adults and children is not inclusive of expansion adults and the estimated budget savings for expansion adults is $0 because there is no utilization for the program by this population.

Questions regarding this transition can be directed to Malissa McIntire, Director of Integrated Care, ODMHSAS, at (405) 248-9341.

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see

below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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OK - Submission Package - OK2021MS0001O - (OK-21-0022-A) - Health Homes

CMS-10434 OMB 0938-1188

Package Information

Package ID	OK2021MS0001O	**Submission Type**	Official
Program Name	MIGRATED_HH.OK HH - adults	**State**	OK
SPA ID	OK-21-0022-A	**Region**	Dallas, TX
Version Number	3	**Package Status**	Approved
Submitted By	Sandra Puebla	**Submission Date**	7/6/2021
Package Disposition		**Approval Date**	9/24/2021 4:23 PM EDT
Priority Code	P1		

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Medicaid and CHIP Operations Group
601 E. 12th Street
Room 355
Kansas City, MO 64106

Center for Medicaid & CHIP Services

September 24, 2021

Melody Anthony
Chief Executive Officer / State Medicaid Director
Oklahoma Health Care Authority
4345 N Lincoln Blvd
Oklahoma City, OK 73105

Re: Approval of State Plan Amendment OK-21-0022-A MIGRATED_HH.OK HH - adults

Dear Melody Anthony,

On July 06, 2021, the Centers for Medicare and Medicaid Services (CMS) received Oklahoma State Plan Amendment (SPA) OK-21-0022-A for migrating individuals currently receiving Health Homes services to other care coordination models in place to serve this population.

We approve Oklahoma State Plan Amendment (SPA) OK-21-0022-A with an effective date(s) of October 01, 2021.

As a reminder, CMS expects that all quality measures for the Health Homes benefit be reported based on the termination date of the program.

If you have any questions regarding this amendment, please contact Deborah Read at deborah.read@cms.hhs.gov

Sincerely,

James G. Scott

Director, Division of Program Operations

Center for Medicaid & CHIP Services

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | OK2021MS0001O | OK-21-0022-A | MIGRATED_HH.OK HH - adults

Package Header

Package ID OK2021MS0001O
SPA ID OK-21-0022-A
Submission Type Official
Initial Submission Date 7/6/2021
Approval Date 9/24/2021
Effective Date N/A
Superseded SPA ID N/A

State Information

State/Territory Name: Oklahoma
Medicaid Agency Name: Oklahoma Health Care Authority

Submission Component

- (•) State Plan Amendment

- (•) Medicaid
- ( ) CHIP

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | OK2021MS0001O | OK-21-0022-A | MIGRATED_HH.OK HH - adults

Package Header

Package ID OK2021MS0001O

Submission Type Official

Approval Date 9/24/2021

Superseded SPA ID N/A

SPA ID OK-21-0022-A

Initial Submission Date 7/6/2021

Effective Date N/A

SPA ID and Effective Date

SPA ID OK-21-0022-A

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Health Homes Program Termination - Phase-Out Plan	10/1/2021	TN # 14-0012

Page Number of the Superseded Plan Section or Attachment (If Applicable):

Attachment 3.1-H

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | OK2021MS0001O | OK-21-0022-A | MIGRATED_HH.OK HH - adults

Package Header

Package ID OK2021MS0001O

Submission Type Official

Approval Date 9/24/2021

Superseded SPA ID N/A

SPA ID OK-21-0022-A

Initial Submission Date 7/6/2021

Effective Date N/A

Executive Summary

Summary Description Including Goals and Objectives The State is collaborating with the Oklahoma Department of Mental Health Substance Abuse Services (ODMHSAS) to terminate the health homes benefit for adults effective October 1, 2021; however, other care coordination models will still be in place to still serve this population.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2022	$846708
Second	2023	$737328

Federal Statute / Regulation Citation

Section 2703 of the Affordable Care Act (Public Law 111-148); Section 1945 of Social Security Act

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
No items available		

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | OK2021MS0001O | OK-21-0022-A | MIGRATED_HH.OK HH - adults

Package Header

Package ID OK2021MS0001O

SPA ID OK-21-0022-A

Submission Type Official

Initial Submission Date 7/6/2021

Approval Date 9/24/2021

Effective Date N/A

Superseded SPA ID N/A

Governor's Office Review

- ○ No comment
- ○ Comments received
- ○ No response within 45 days
- ◉ Other

Describe Governor's office does not review State Plan amendments

Health Homes Program Termination - Phase-Out Plan

MEDICAID | Medicaid State Plan | Health Homes | OK2021MS0001O | OK-21-0022-A | MIGRATED_HH.OK HH - adults

CMS-10434 OMB 0938-1188

Package Header

Package ID OK2021MS0001O

SPA ID OK-21-0022-A

Submission Type Official

Initial Submission Date 7/6/2021

Approval Date 9/24/2021

Effective Date 10/1/2021

Superseded SPA ID TN # 14-0012

User-Entered

Provide a description of the phase-out or transition plan for the Health Homes Program that is being terminated

Describe the reason for termination

Oklahoma Medicaid will terminate the Health Home program October 1, 2021. Other care coordination models currently in place will continue to serve the population impacted by the termination of the program.

Describe the overall approach the state will use to terminating the program

The Health Home population will continue to receive integrated behavioral and physical health care coordination from nurses and behavioral health case managers. This will be provided by Community Mental Health Centers (CMHCs) and through Certified Community Behavioral Health service delivery that were previously contracted as Health Homes.

Indicate method of termination

- (•) The state will terminate all participants from the Health Homes Program on the same date
- ( ) The state will phase-out the termination of participation in the Health Homes Program

Termination effective date

10/1/2021

Describe the process the state will use to transition all participants and how referrals will be made to other health care providers

Oklahoma currently has coordinated care delivery for adults with Serious Mental Illness (SMI) through Patient Centered Medical Homes (PCMH), Health Access Networks (HANs), Health Management Program (HMP), and Certified Community Behavioral Health (CCBH) service delivery. Care coordination will be a seamless transition for members receiving Health Home (HH) services through CMHCs CCBH services. Most CMHCs will become an eligible organization to provide CCBH services. Current HH members who do not choose a CMHC or a CCBH provider to continue services can access physical and behavioral health integration services through the PCMH, CMHC, and/or CCBHs.

The State previously reported that as of July 1, 2021 there were 3,581 adults enrolled in the HH program. Most HH providers are transitioning to the CCBH model; therefore, care coordination, provider standards, health information technology (HIT), and provider capacity will remain the same and there is no need for health record transmission. Of the current enrollees, it was found that there were 117 adults attributed to private behavioral health organizations or state sponsored Program of Assertive Community Treatment (PACT) teams; thus, will not transition to the CCBH model when the HH program terminates. Forty-seven (47) of the 117 current adult enrollees will transition to the University of Oklahoma-sponsored PACT team (OU IMPACT). The State has planned outreach activities to current HH enrollees to inform them that the program is ending and they have free choice of providers for integrated health care, including Patient Center Medical Home (PCMH).

There are no concerns related to care coordination, provider standards, HIT, nor health record transmission for enrollees who are currently aligned with private providers that do not choose to pursue CCBH provider certification. CCBH providers (as well as OU IMPACT) have protocols and procedures in place with area hospitals for identifying and engaging at-risk consumers who are admitted to emergency departments, inpatient hospitals, urgent recovery and crisis centers. These protocols also apply when consumers are discharged, unless there is a formal transfer of care to a non-CCBH provider or non-PACT entity. Protocols include: the transfer of medical records of services received; active follow-up after discharge; a plan for suicide prevention and safety as appropriate; and a provision for peer services.

The State believes that with the Prospective Payment System (PPS) reimbursement method and CCBH provider expansion funding, CCBH providers will have the capacity to provide access and continued quality services to transitioning HH enrollees.

Over the past few years, many members have shifted from the HH program to CCBH providers causing a shift from the HH program financial line to that of CCBHC providers. The budget impact to sunset health home services for adults and children is not inclusive of expansion adults and the estimated budget savings for expansion adults is $0 because there is no utilization for the program by this population.

Questions regarding this transition can be directed to Malissa McIntire, Director of Integrated Care, ODMHSAS, at (405) 248-9341.

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Alternative Benefit Plan

State Name: Oklahoma Attachment 3.1-L- OMB Control Number: 0938-1148

Transmittal Number: OK - 21 - 0002

Alternative Benefit Plan Populations — ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name: Adult Expansion Alternative Benefit Plan (ABP)

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

Add	Eligibility Group:	Enrollment is mandatory or voluntary?	Remove
Add	Adult Group	Mandatory	Remove

Enrollment is available for all individuals in these eligibility group(s). Yes

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory. Yes

Any other information the state/territory wishes to provide about the population (optional)

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20181119

Alternative Benefit Plan

State Name: Oklahoma Attachment 3.1-L- [ ] OMB Control Number: 0938-1148

Transmittal Number: OK - 21 - 0002

Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act	ABP2a

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan.

Yes

Explain how the state has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements.

The benefits offered within Oklahoma's Alternative Benefit Plan are equal to or greater than the benefits offered via the approved Oklahoma Medicaid State Plan; therefore and per CMS guidance, the benefit packages are considered to be in alignment. For this eligibility group, the state will cover additional habilitative and comprehensive preventive services as described in ABP5.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722

Alternative Benefit Plan

State Name: Oklahoma Attachment 3.1-L- OMB Control Number: 0938-1148

Transmittal Number: OK - 21 - 0002

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package ABP3.1

Select one of the following:

- ○ The state/territory is amending one existing benefit package for the population defined in Section 1.
- ◉ The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package: Adult Expansion Alternative Benefit Plan (ABP)

Selection of EHB-Benchmark Plan

The state/territory must select an EHB-benchmark plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

EHB-benchmark plan name: BCBS of Oklahoma/Blue Options Gold 002 plan

The EHB-benchmark plan is the same as the Section 1937 Coverage option: No

Indicate the EHB-benchmark option as described at 45 CFR 156.111(b)(2)(B) the state/territory will use as its EHB-benchmark plan:

State/Territory is selecting one of the below options to design an EHB package that complies with the requirements for the individual insurance market under 45 CFR 156.100 through 156.125.

- ◉ State/Territory is selecting the EHB-benchmark plan used by the state/territory for the 2017 plan year.
- ○ State/Territory is selecting one of the EHB-benchmark plans used for the 2017 plan year by another state/territory.
- ○ State/ Territory selects the following EHB-benchmark plan used for the 2017 plan year but will replace coverage of one or more of the categories of EHB with coverage of the same category from the 2017 EHB-benchmark plan of one or more other states
- ○ Select a set of benefits consistent with the 10 EHB categories to become the new EHB-benchmark plan. (Complete and submit the ABP5: Benefits Description form to describe the set of benefits.)

Type of EHB-benchmark plan:

- ◉ Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- ○ Any of the largest three state employee health benefit plans by enrollment.
- ○ Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- ○ Largest insured commercial non-Medicaid HMO.

Alternative Benefit Plan

Assurances

☑ The state/territory assures the EHB plan meets the scope of benefits standards at 45 CFR 156.111(b), does not exceed generosity of most generous among a set of comparison plans, provides appropriate balance of coverage among 10 EHB categories, and the scope of benefits is equal to, or greater than, the scope of benefits provided under a typical employer plan as defined at 45 CFR 156.111(b)(2).

☑ The state/territory assures that all services in the EHB-benchmark plan have been accounted for throughout the benefit chart found in ABP 5.

☑ The state/territory assures the accuracy of all information in ABP5 depicting amount, duration and scope parameters of services authorized in the currently approved Medicaid State Plan.

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

◉ Benchmark Benefit Package.

○ Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

○ The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).

○ State employee coverage that is offered and generally available to state employees (State Employee Coverage):

○ A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):

◉ Secretary-Approved Coverage.

◉ The state/territory offers benefits based on the approved state plan.

○ The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.

◉ The state/territory offers the benefits provided in the approved state plan.

○ Benefits include all those provided in the approved state plan plus additional benefits.

○ Benefits are the same as provided in the approved state plan but in a different amount, duration and/or scope.

○ The state/territory offers only a partial list of benefits provided in the approved state plan.

○ The state/territory offers a partial list of benefits provided in the approved state plan plus additional benefits.

Please briefly identify the benefits, the source of benefits and any limitations:

Please refer to ABP 5 for description of services

Other Information Related to Selection of the Section 1937 Coverage Option and the EHB-Benchmark Plan (optional):

The Alternative Benefit Plan will include the same services that are traditionally available in through the State's approved State Plan. In addition, the ABP will offer habilitative services as defined in ABP5

PRA Disclosure Statement

Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) for the purpose of standardizing data. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20190813

Alternative Benefit Plan

State Name: Oklahoma

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: OK - 21 - 0002

Alternative Benefit Plan Cost-Sharing — ABP4

☑ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A. No

Other Information Related to Cost Sharing Requirements (optional):

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722

Alternative Benefit Plan

State Name: Oklahoma

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: OK - 22 - 0004

Benefits Description ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Blue Cross Blue Shield of Oklahoma/Blue Options Gold 002 plan

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary-approved

Alternative Benefit Plan

☑ 1. Essential Health Benefit: Ambulatory patient services Collapse All ☐

Benefit Provided: Primary Care Visits to Treat Injury or Illness
Source: State Plan 1905(a)
Remove

Authorization: Authorization required in excess of limitation
Provider Qualifications: Medicaid State Plan

Amount Limit: 4 visits/month
Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-A, section 5.
Amount limits can be exceeded based on medical necessity.

Benefit Provided: Specialty Visits
Source: State Plan 1905(a)
Remove

Authorization: Authorization required in excess of limitation
Provider Qualifications: Medicaid State Plan

Amount Limit: 4 visits/month
Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-A, section 5.
Amount limits can be exceeded based on medical necessity.

Benefit Provided: Other Practitioner Office Visits
Source: State Plan 1905(a)
Remove

Authorization: Authorization required in excess of limitation
Provider Qualifications: Medicaid State Plan

Amount Limit: 4 visits/month for PA and APRN visits
Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-A, section 6.d.

Amount limits can be exceeded based on medical necessity.

Benefit Provided: Outpatient Facility (ambulatory surgery ctr)
Source: State Plan 1905(a)
Remove

Authorization: No
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-A, section 2.a.

Benefit Provided: Dialysis
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-A, section 2.a.

Benefit Provided: Allergy Testing
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: 60 tests/3 years
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 5
Reference approved State Plan, Attachment 3.1-A, section 6.d.
Amount limits can be exceeded based on medical necessity.

Remove

Benefit Provided: Chemotherapy

Source: State Plan 1905(a)

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 2.a.

Remove

Benefit Provided: Radiation

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 2.a.

Remove

Benefit Provided: Outpatient Surgery Physician/Surgical Services

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 2.a.

Benefit Provided:

Hospice

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

See “other information" box

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Hospice care in accordance with section 1905(o) of the Social Security Act

Hospice services are provided as a comprehensive, holistic program of palliative and/or comfort care and support for terminally ill members and his/her families when a physician certifies that the member has a terminal illness and has a life expectancy of six months or less. The hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional, and spiritual stresses which are experienced during the final stages of illness and death. Hospice services must be related to the palliation and management of the member's illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills.

Hospice services are performed under the direction of the physician as per the member’s plan of care and in an approved hospital hospice facility, in-home hospice program, or nursing facility. A participating hospice provider must meet Medicare’s conditions of participation for hospices and have a valid provider agreement with the State Medicaid Agency.

A. Election periods
Hospice care is initially available for two 90-day certification periods then for an unlimited number of 60-day certification periods during the remainder of the member's lifetime.

Prior authorization
Each certification period requires a new prior authorization.

B. Election statement
The form must be completed, dated, and signed by the member or legal representative. The election of benefits stays in effect as long as the participant remains in hospice, does not revoke the election, and is not discharged from hospice for other reasons. Reasons for discharge may include: the participant is no longer considered terminally ill, the participant transfers to another hospice, the participant moves out of the hospice service area, or the participant is not receiving the required or expected care from the hospice provider.

The election statement waives a member's right to other Medicaid benefits, except for care not related to the terminal illness and care provided by the attending physician.

Expansion adults under age 21 who elect hospice care will receive it concurrently with curative care for the terminal condition/illness, in accordance with section 2302 of the Affordable Care Act.

An individual or representative may revoke the election of hospice care at any time. Upon revoking the election of Medicaid coverage of hospice care for a particular election period, an individual resumes Medicaid coverage of the benefits waived when hospice care was elected. An individual may at any time elect to receive hospice coverage for any other hospice election periods for which he or she is eligible.

C. Requirements for coverage for each certification period

Certification of terminal illness
Certification of terminal illness is and includes a medical prognosis with a life expectancy of 6 months or less if the illness runs its normal course. The certificate of terminal illness is completed by the member's attending physician or the medical director of an interdisciplinary group and is supported by clinical information and other documentation in the medical record. The nurse practitioners serving as the attending physician may not certify the terminal illness.

Plan of care
A plan of care developed by the hospice interdisciplinary team must be established before services are provided. To be covered, services must be consistent with the plan of care. The plan of care should be submitted with the prior authorization request.

Re-evaluation for continuation for services
Re-evaluation by physician or nurse practitioner is required for continuation of services for each subsequent 90-day and/or 60-day certification periods. The hospice physician or nurse practitioner must have a face-to-face encounter with the member to determine if the member's terminal illness necessitates continuing hospice care services. The encounter must take place prior to the 180th day recertification and each subsequent recertification thereafter.

D. Covered Services
Hospice care includes nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide services; personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. Services must be prior authorized. Bereavement counseling services are required but are not reimbursable.

Levels of Care

1. Routine hospice care
Member is at home and is not receiving continuous care

2. Continuous Home Care
Member is not in an inpatient facility and receives hospice on a continuous basis at home (consists primarily of nursing care to achieve palliation and management of acute medical symptoms during a brief period of crisis only as necessary to maintain the terminally ill patient at home.) If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine hospice care.

3. Inpatient respite care

Member receives care in an approved facility on a short-term basis for respite. Inpatient respite care is not provided to individuals residing in a nursing home."

4. General inpatient care
Member receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management that cannot be managed at home. In this situation, at home can mean a member's personal home, an assisted living facility, or a nursing home.

TN-21-0018, effective 10/01/21

Benefit Provided:

Source:

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

☑ 2. Essential Health Benefit: Emergency services Collapse All ☐

Remove

Benefit Provided: Emergency Room Services

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 2.a.

Remove

Benefit Provided: Emergency Transportation/Ambulance

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-D.

Remove

Benefit Provided: Urgent Care Center

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 9.

Add

Alternative Benefit Plan

☑ 3. Essential Health Benefit: Hospitalization — Collapse All ☐

Benefit Provided: Inpatient Hospital Services (Inpatient Stay)
Source: State Plan 1905(a)
Remove

Authorization: No
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-A, section 1.

Benefit Provided: Inpatient Physician & Surgical Services
Source: State Plan 1905(a)
Remove

Authorization: Authorization required in excess of limitation
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit:
Inpatient physician services: one visit per day per physician.
Inpatient surgical services: no limit.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-A, section 5.
Reference approved State Plan, Attachment 3.1-A, section 1.
Amount limits can be exceeded based on medical necessity.

Benefit Provided: Organ Transplants
Source: State Plan 1905(a)
Remove

Authorization: Authorization required in excess of limitation
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: All transplantation services, except kidney and cornea, must be prior authorized.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-E.

Benefit Provided: Reconstructive Surgery

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Non-cosmetic; breast reconstruction/implantation/removal is covered only when it is a direct result of a mastectomy which is medically necessary.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 1.

Benefit Provided:

Source:

Remove

Authorization: Other

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

☑ 4. Essential Health Benefit: Maternity and newborn care — Collapse All ☐

Benefit Provided: Prenatal & Postnatal care
Source: State Plan 1905(a)
Remove

Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 3.
Reference approved State Plan, Attachment 3.1-A, section 5.
Reference approved State Plan, Attachment 3.1-A, section 6.d.
Reference approved State Plan, Attachment 3.1-A, section 17.
Reference approved State Plan, Attachment 3.1-A, section 20 and section 21.

Benefit Provided: Delivery & Inpatient Services for Maternity Care
Source: State Plan 1905(a)
Remove

Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 1.
Reference approved State Plan, Attachment 3.1-A, section 3.
Reference approved State Plan, Attachment 3.1-A, section 5.
Reference approved State Plan, Attachment 3.1-A, section 6.d.
Reference approved State Plan, Attachment 3.1-A, section 17.
Reference approved State Plan, Attachment 3.1-A, section 20.

Benefit Provided:
Source:
Remove

Authorization: No
Provider Qualifications:
Amount Limit:
Duration Limit:

Alternative Benefit Plan

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Source:

Remove

Authorization:

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

Collapse All ☐

☑ 5. Essential Health Benefit: Mental health and substance use disorder services including behavioral health treatment

☑ The state/territory assures that it does not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

Remove

Benefit Provided: Mental/Behavioral Health Outpatient Services

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 13.d.1.
Amount limits can be exceeded based on medical necessity.

Remove

Benefit Provided: Mental/Behavioral Health Inpatient Services

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 1.
Amount limits can be exceeded based on medical necessity.

Remove

Benefit Provided: Substance Use Disorder Outpatient Services

Source: State Plan 1905(a)

Authorization: No

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 13.d.1.
Amount limits can be exceeded based on medical necessity.
Revised within TN-21-0014, effective 07/01/21

Remove

Benefit Provided:

Substance Use Disorder Inpatient Services

Source:

State Plan 1905(a)

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 13.d.5.
Revised within TN-21-0014, effective 07/01/21

Remove

Benefit Provided:

Source:

Authorization:

Other

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

■ 6. Essential Health Benefit: Prescription drugs

☑ The state/territory assures that the ABP prescription drug benefit plan is the same as under the approved Medicaid State Plan for prescribed drugs.

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
☒ Limit on days supply	No	State licensed
☒ Limit on number of prescriptions		
☒ Limit on brand drugs		
☐ Other coverage limits		
☒ Preferred drug list		

Coverage that exceeds the minimum requirements or other:

The state's ABP prescription drug benefit is the same as the approved Medicaid state plan for prescribed drugs.

Alternative Benefit Plan

■ 7. Essential Health Benefit: Rehabilitative and habilitative services and devices — Collapse All ☐

☑ The state/territory assures that it is not imposing limits on habilitative services and devices that are more stringent than limits on rehabilitative services (45 CFR 156.115(a)(5)(ii)). Further, the state/territory understands that separate coverage limits must also be established for rehabilitative and habilitative services and devices. Combined rehabilitative and habilitative limits are allowed, if these limits can be exceeded based on medical necessity.

Remove

Benefit Provided: Outpatient Rehabilitation Services

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: 15 visits/year for each OT, PT, & ST

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 2.a.
The benefit amount limits exceed the quantity limits within the base benchmark.

Remove

Benefit Provided: Home Health

Source: State Plan 1905(a)

Authorization: No

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Provided by Home Health agencies

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 7.

Remove

Benefit Provided: Durable Medical Equipment

Source: State Plan 1905(a)

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Some items may require prior authorization.
Reference approved State Plan, Attachment 3.1-A, section 12.c.
Reference approved State Plan, Attachment 3.1-A, section 7.

Remove

Benefit Provided:

Prosthetic Devices

Source:

State Plan 1905(a)

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Some items may require prior authorization.
Reference approved State Plan, Attachment 3.1-A, section 12.c.

Remove

Benefit Provided:

Orthotic Devices

Source:

State Plan 1905(a)

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Some items may require prior authorization.
Reference approved State Plan, Attachment 3.1-A, section 12.c.

Remove

Benefit Provided:

Habilitation Services

Source:

State Plan 1905(a)

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Alternative Benefit Plan

Amount Limit:
15 visits/year for each OT, PT, & ST

Duration Limit:
None

Scope Limit:
Provided only in outpatient hospitals

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-A, section 2.a.
The benefit amount limits exceed the quantity limits within the base benchmark.

Benefit Provided:
Inpatient Rehab Hospital

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
90 days per individual per State Fiscal Year (SFY)

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-A, section 1.
Amount limits can be exceeded based on medical necessity. Revised within TN-22-0004, effective 01/01/22.

Benefit Provided:

Source:

Remove

Authorization:
Authorization required in excess of limitation

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

☑ 8. Essential Health Benefit: Laboratory services Collapse All ☐

Benefit Provided: Imaging (CT/PET scans, MRIs)
Source: State Plan 1905(a)
Remove

Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-A, section 2.a.
Reference approved State Plan, Attachment 3.1-A, section 3.

Benefit Provided: Laboratory Outpatient & Professional Services
Source: State Plan 1905(a)
Remove

Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-A, section 2.a.
Reference approved State Plan, Attachment 3.1-A, section 3.

Benefit Provided: X-rays & Diagnostic Imaging
Source: State Plan 1905(a)
Remove

Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-A, section 2.a.

Alternative Benefit Plan

Reference approved State Plan, Attachment 3.1-A, section 3.

Add

Alternative Benefit Plan

■ 9. Essential Health Benefit: Preventive and wellness services and chronic disease management Collapse All ☐

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided: Diabetes Education

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: 10 hours/first year; 2 hours/subsequent year

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 6.d.
Amount limits can be exceeded based on medical necessity.

Benefit Provided: Preventive Care/Screening/Immunization

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 5.
Reference approved State Plan, Attachment 3.1-A, section 6.d.

Benefit Provided: Nutritional Services

Source: State Plan 1905(a)

Remove

Authorization: No

Provider Qualifications: Medicaid State Plan

Amount Limit: 6 hours/year

Duration Limit: None

Alternative Benefit Plan

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 6.d.
Amount limits can be exceeded based on medical necessity.

Benefit Provided:

Source:

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

☑ 10. Essential Health Benefit: Pediatric services including oral and vision care — Collapse All ☐

Benefit Provided: Medicaid State Plan EPSDT Benefits

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 4.b.

Add

☐ 11. Other Covered Benefits from Base Benchmark Collapse All ☐

Alternative Benefit Plan

☒ 12. Base Benchmark Benefits Not Covered due to Substitution or Duplication Collapse All ☐

Base Benchmark Benefit that was Substituted: Hospice - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Hospice services are a base benchmark benefit covered within EHB 1, Ambulatory patient services. Services are for expansion adults only.
Revised within TN-21-0018, effective 10/01/21

Base Benchmark Benefit that was Substituted: Private Duty Nursing (PDN) - Substitution
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

PDN services are a base benchmark benefit substituted with skilled nursing under the home health services benefit covered under the State Plan, Attachment 3.1-A, section 7 and are within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted: Chiropractic Services - Substitution
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Chiropractic services are a base benchmark benefit substituted with rehabilitation occupational therapy, physical therapy, and speech therapy services in the outpatient hospital setting covered under the State Plan, Attachment 3.1-A, section 2.a. and are within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted: Substance Use Disorder Outpatient Services - Dup
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substance use disorder outpatient services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 13.d.1. and are within EHB 5, mental health and substance use disorder services including behavioral health treatment.

Base Benchmark Benefit that was Substituted: Substance Use Disorder Inpatient Services - Dup
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substance use disorder inpatient services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 13.d.5. and are within EHB 5, mental health and substance use disorder services including behavioral health treatment.

Base Benchmark Benefit that was Substituted: Accidental Dental - substitution
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Accidental Dental is a base benchmark benefit substituted with medically necessary extractions covered under the State Plan, Attachment 3.1-A, section 10 and are within 14, other 1937 covered benefits that are not essential health benefits.

Base Benchmark Benefit that was Substituted: Primary Care Visit to Treat Injury/Illness - Dup
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Primary care visits to treat injury or illness are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 5 and are within EHB 1, ambulatory patient services.

Base Benchmark Benefit that was Substituted: Specialist Visits - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Specialty visits are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 5 and are within EHB 1, ambulatory patient services.

Base Benchmark Benefit that was Substituted: Other Practitioner Office Visits - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Other practitioner office visits are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 6.d. and are within EHB 1, ambulatory patient services.

Base Benchmark Benefit that was Substituted: Outpatient Facility (Ambulatory Surgery Ctr) - Dup
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Outpatient facility fee (e.g., ambulatory surgery center) services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. and are within EHB 1, ambulatory patient services.

Base Benchmark Benefit that was Substituted: Outpatient Surgery Physician/Surgical - Dup
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Outpatient surgery physician/surgical services are a base benchmark benefit covered under the State Plan,

Attachment 3.1-A, Section 2.a. and are within EHB 1, ambulatory patient services.

Base Benchmark Benefit that was Substituted: Urgent Care Centers or Facilities - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Urgent care centers or facilities services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 9 and are within EHB 2, emergency services.

Base Benchmark Benefit that was Substituted: Home Health Care Services - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Home health care services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 7 and are within EHB 7, rehabilitation and habilitative services and devices.

Base Benchmark Benefit that was Substituted: Emergency Room Services - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Emergency room services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. and are within EHB 2, emergency services.

Base Benchmark Benefit that was Substituted: Emergency Transportation/Ambulance - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Emergency transportation/ambulance services are a base benchmark benefit covered under the State Plan, Attachment 3.1-D and are within EHB 2, emergency services.

Base Benchmark Benefit that was Substituted: Inpatient Hospital Services - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Inpatient hospital services (inpatient stay) are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 1 and are within EHB 3, hospitalization.

Base Benchmark Benefit that was Substituted: Inpatient Physician & Surgical Services - Dup
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Inpatient physician & surgical services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 1 & section 5 and are within EHB 3, hospitalization.

Base Benchmark Benefit that was Substituted: Inpatient Rehab - Dup

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Inpatient rehab services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 1 and are within EHB 7, rehabilitative and habilitative services and devices. Revised within TN-22-0004, effective 01/01/22.

Base Benchmark Benefit that was Substituted: Prenatal and Postnatal Care - Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Prenatal and postnatal care is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 3, section 5, section 6.d., section 17, section 20, & section 21 and is within EHB 4, maternity and newborn care.

Base Benchmark Benefit that was Substituted: Delivery & Inpatient Services for Maternity - Dup

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Delivery & all inpatient services for maternity care is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 1, section 3, section 5, section 6.d., section 17, & section 20 and is within EHB 4, maternity and newborn care.

Base Benchmark Benefit that was Substituted: Mental/Behavioral Health Outpatient Services - Dup

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Mental/behavioral health outpatient services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 13.d.1. and are within EHB 5, mental health and substance use disorder services including behavioral health treatment.

Base Benchmark Benefit that was Substituted: Mental/Behavioral Health Inpatient Services - Dup

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Mental/behavioral health inpatient services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 1. and are within EHB 5, mental health and substance use disorder services

including behavioral health treatment.

Base Benchmark Benefit that was Substituted: Habilitation Services - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Habilitation services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. and are within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted: Durable Medical Equipment - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Durable medical equipment is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 12.c. & section 7 and is within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted: Hearing Aids for Children - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Hearing aids for children are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 4.b. and are within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted: Imaging (CT/PET Scans, MRIs) - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Imaging (CT/PET Scans, MRIs) services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. & section 3 and are within EHB 8, laboratory services.

Base Benchmark Benefit that was Substituted: Preventive Care/Screening/Immunization - Dup
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Preventive care/screening/immunization services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 5 & section 6.d. and are within EHB 9, preventive and wellness services and chronic disease management.

Base Benchmark Benefit that was Substituted: Routine Eye Exam for Children - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Routine eye exams for children are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 4.b. and are within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted: Eye Glasses for Children - Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Eye glasses for children are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 4.b. and are within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted: Dental Check-Up for Children - Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Dental check-up for children are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 4.b. and are within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted: Well Baby Visits and Care - Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Well baby visits and care are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 4.b. and are within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted: Lab Outpatient & Professional Services - Dup

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Laboratory outpatient & professional services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. & section 3 and are within EHB 8, laboratory services.

Base Benchmark Benefit that was Substituted: X-rays and Diagnostic Imaging - Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

X-rays and diagnostic imaging services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. & section 3 and are within EHB 8, laboratory services.

Base Benchmark Benefit that was Substituted: Basic Dental Care – Child - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 4.b. and are within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted: Orthodontia – Child - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Basic dental care for children is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 4.b. and is within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted: Major Dental Care – Child - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Major dental care for children is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 4.b. and is within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted: Transplant - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Transplant services are a base benchmark benefit covered under the State Plan, Attachment 3.1-E and are within EHB 3, hospitalization.

Base Benchmark Benefit that was Substituted: Dialysis - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Dialysis is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. and is within EHB 1, ambulatory services.

Base Benchmark Benefit that was Substituted: Allergy Testing - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Allergy testing is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 5 & section 6.d. and is within EHB 1, ambulatory services.

Base Benchmark Benefit that was Substituted: Chemotherapy - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Chemotherapy is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. and is within EHB 1, ambulatory services.

Base Benchmark Benefit that was Substituted: Radiation - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Radiation is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. and is within EHB 1, ambulatory services.

Base Benchmark Benefit that was Substituted: Diabetes Education - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Diabetes education is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 6.d. and is within EHB 9, preventive and wellness services and chronic disease management.

Base Benchmark Benefit that was Substituted: Prosthetic Devices - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Prosthetic devices is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 12.c. and is within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted: Nutritional Counseling - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Nutritional counseling is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 6.d. and is within EHB 9, preventive and wellness services and chronic disease management.

Base Benchmark Benefit that was Substituted: Reconstructive Surgery - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Reconstructive surgery is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 1 and is within EHB 3, hospitalization.

Base Benchmark Benefit that was Substituted: Rehabilitation Speech Therapy - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Rehabilitation speech therapy services are a base benchmark benefit duplicated with outpatient rehabilitation services covered under the State Plan, Attachment 3.1-A, section 2.a. and are within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted: Rehab Occupational & Physical Therapy - Dup
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Rehabilitation occupational and physical therapy services are a base benchmark benefit duplicated with outpatient rehabilitation services covered under the State Plan, Attachment 3.1-A, section 2.a. and are within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted: Outpatient Rehabilitation Services - Dup
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Outpatient rehabilitation services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. and are within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted: Orthotic Devices - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Orthotic devices is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 12.c. and is within EHB 7, rehabilitative and habilitative services and devices.

Add

☒ 13. Other Base Benchmark Benefits Not Covered Collapse All ☐

Base Benchmark Benefit not Included in the Alternative Benefit Plan: Orthodontia - Adult

Source: Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit: It is not a mandatory benefit

Add

☒ 14. Other 1937 Covered Benefits that are not Essential Health Benefits Collapse All ☐

Other 1937 Benefit Provided: Nursing facility services
Source: Section 1937 Coverage Option Benchmark Benefit Package
Remove
Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other: Reference approved State Plan, Attachment 3.1-A, section 4.a.
Revised within TN-21-0014, effective 07/01/21.

Other 1937 Benefit Provided: Medically Necessary Extractions - Adult
Source: Section 1937 Coverage Option Benchmark Benefit Package
Remove
Authorization: No
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other: Reference approved State Plan, Attachment 3.1-A, section 10.

Other 1937 Benefit Provided: Family planning
Source: Section 1937 Coverage Option Benchmark Benefit Package
Remove
Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: See below
Duration Limit: None
Scope Limit: None
Other: Reference approved State Plan, Attachment 3.1-A, section 4.c.

Other 1937 Benefit Provided:
Bariatric Surgery

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Bariatric surgery is not covered for the treatment of obesity alone.

Other:
Reference approved State Plan, Attachment 3.1-A, section 1.
Reference approved State Plan, Attachment 3.1-A, section 5.

Other 1937 Benefit Provided:
Non-emergency transportation

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:

Other:
Reference approved State Plan, Attachment 3.1-A, section 24a.
Reference approved State Plan, Attachment 3.1-D .

Other 1937 Benefit Provided:
Podiatric services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
4 office visits/month

Duration Limit:
None

Scope Limit:
None

Other:
Reference approved State Plan, Attachment 3.1-A, section 6.a.

Other 1937 Benefit Provided:
Eye care to treat a medical or surgical condition

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Authorization required in excess of limitation

Provider Qualifications:
Medicaid State Plan

Amount Limit:
4 office visits/month

Duration Limit:
None

Scope Limit:
Services are to treat to treat a medical or surgical condition only.

Other:
Reference approved State Plan, Attachment 3.1-A, section 6.b.

Other 1937 Benefit Provided:
Meals and Lodging

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Authorization required in excess of limitation

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Payment for lodging and/or meals assistance for an eligible member and an approved medical escort, if needed, is provided only when medically necessary in connection with transportation to and from SoonerCare compensable services.

Other:
Reference approved State Plan, Attachment 4.19-B, transportation, section C, meals and lodging.

Other 1937 Benefit Provided:
Personal Care Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Reference approved State Plan, Attachment 3.1-A, section 24.f.

Other 1937 Benefit Provided:
Medication-Assisted Treatment Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Reference approved State Plan, Attachment 3.1-A, section 29.
Revised within TN-21-0014, effective 07/01/21

Other 1937 Benefit Provided:
Infusion Therapy

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Reference approved State Plan, Attachment 3.1-A, section 2.a. and section 5.
Revised within TN-21-0014, effective 07/01/21

Other 1937 Benefit Provided:
Diagnostic Dental - Adult

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Reference approved State Plan, Attachment 3.1-A, section 10.
Revised within TN-21-0014, effective 07/01/21

Other 1937 Benefit Provided:
Preventive Dental - Adult

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Reference approved State Plan, Attachment 3.1-A, section 10.
Revised within TN-21-0014, effective 07/01/21

Other 1937 Benefit Provided:
Restorative Dental - Adult

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Reference approved State Plan, Attachment 3.1-A, section 10.
Revised within TN-21-0014, effective 07/01/21

Other 1937 Benefit Provided:
Non-surgical Periodontal Therapy - Adult

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Reference approved State Plan, Attachment 3.1-A, section 10.
Revised within TN-21-0014, effective 07/01/21

Other 1937 Benefit Provided:
Removable Prosthetics Dental - Adult

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Reference approved State Plan, Attachment 3.1-A, section 10.
Revised within TN-21-0014, effective 07/01/21

Other 1937 Benefit Provided:
PCCM/PCMH Service Delivery Model

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
The Primary Care Case Management (PCCM)/ Patient Centered providers Medical Home (PCMH) is a service delivery model in which the State contracts directly with primary care providers (PCPs) throughout the state to provide basic health care services. The PCCM is a managed care service delivery system and follows managed care rules. As part of the SoonerCare Choice coordinated care delivery service system, eligible members select a PCMH for primary care and care coordination. Providers are eligible to receive a per month (PMPM) care coordination payment for each enrolled beneficiary, based upon the services provided at the medical home.

American Indian/Alaskan Native (AI/AN) individuals eligible as Expansion Adult members who do not opt-in to the SoonerSelect managed care program may elect to enroll the in the PCCM with a SoonerCare Choice provider, or an Indian Health Services (IHS), tribal, or urban Indian (I/T/U) clinic SoonerCare Choice provider as their primary care provider. Additionally, these members are eligible to receive Health Management Program (HMP) and Health Access Network (HAN) support based on their health status and coordinated care needs.

Eligible members are enrolled into the PCCM other than during a period of presumptive eligibility.

Revised within TN-21-0031, effective 07/01/21
Revised within TN-23-0007, effective 02/01/24

Other 1937 Benefit Provided: ICF/IID services

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other: Reference approved State Plan Section 3.1-A, section 15. Revised within TN-22-0004, effective 01/01/22.

Other 1937 Benefit Provided: Alternative Treatment for Pain Management

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: 48 units for PT; 12 visits for chiropractic

Duration Limit: None

Scope Limit: None

Other: Reference approved State Plan, Attachment 3.1-A, section 13.d.6.
Amount limits can be exceeded based on medical necessity. Revised within TN-22-0004, effective 01/01/22.

Other 1937 Benefit Provided: Routine Patient Cost in Qualifying Clinical Trials

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Alternative Benefit Plan

Authorization:
Authorization required in excess of limitation

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Reference approved State Plan, Attachment 3.1-A, section 30.
Revised within TN-22-0004, effective 01/01/22.

Other 1937 Benefit Provided:

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

Other:

Add

☐ 15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.) Collapse All ☐

PRA Disclosure Statement

Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) for the purpose of standardizing data. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20190808

Alternative Benefit Plan

State Name: Oklahoma Attachment 3.1-L- [ ] OMB Control Number: 0938-1148

Transmittal Number: OK - 21 - 0002

Benefits Assurances — ABP7

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. Yes

☑ The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

☑ The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

○ Through an Alternative Benefit Plan.

◉ Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Per 42 CFR 440.345, please describe how the additional benefits will be provided, how access to additional benefits will be coordinated and how beneficiaries and providers will be informed of these processes in order to ensure individuals have access to the full EPSDT benefit.

Indicate whether additional EPSDT benefits will be provided through fee-for-service or contracts with a provider:

◉ State/territory provides additional EPSDT benefits through fee-for-service.

○ State/territory contracts with a provider for additional EPSDT services.

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age (optional):

Prescription Drug Coverage Assurances

☑ The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

☑ The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.

☑ The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.

☑ The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Alternative Benefit Plan

Other Benefit Assurances

- ☑ The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.
- ☑ The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.
- ☑ The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.
- ☑ The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.
- ☑ The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.
- ☑ The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.
- ☑ The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.
- ☑ The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: “A” and “B” services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722

Alternative Benefit Plan

State Name: Oklahoma Attachment 3.1-L- [ ] OMB Control Number: 09381148

Transmittal Number: OK - 23 - 0007

Service Delivery Systems — ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

- [x] Managed care.
  - [x] Managed Care Organizations (MCO).
  - [ ] Prepaid Inpatient Health Plans (PIHP).
  - [x] Prepaid Ambulatory Health Plans (PAHP).
  - [x] Primary Care Case Management (PCCM).
- [x] Fee-for-service.
- [ ] Other service delivery system.

Managed Care Options

Managed Care Assurance

- [x] The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

The OHCA began a 14-day expedited tribal and public notice process on June 16 2021 and concluded the process on June 30, 2021. ITU notice 2021-10 informed tribal partners of the proposal on June 16, 2021; the State also posted a public notice on the public website on June 16, 2021. A copy of the public notice and instructions about the public comment process is available at oklahoma.gov/ohca/policies-and-rules/public-notices. Further discussions with ITUs within the state will occur on July 6, 2021 at the bimonthly consultation.

Revised within TN-21-0031, effective 07/01/21

The State engaged stakeholders as part of its planning process for the new managed care delivery system, SoonerSelect Medical. The transition to a medical managed care delivery system was discussed at stakeholder meetings held on June 20, 2022, August 31, 2022, September 15, 2022, September 20, 2022, September 22, 2022, September 29, 2022, October 5, 2022, October 26, 2022, October 27, 2022, and November 5, 2022. Additional press conferences took place on June 23, 2022, July 26, 2022, August 31, 2022.

The State's SoonerSelect Medical and Children's Specialty RFPs were drafted in accordance with state procurement policies and the SoonerSelect MCE RFP was released on the State's Office of Management & Enterprise Services public website on November 10, 2022 with opportunities for managed care entities (MCEs) to submit bids through February 8, 2023.

The Agency conducted formal tribal consultation during the bi-monthly meeting on January 3, 2023; the State also posted a public notice on the public website on May 11, 2023. A copy of the public notice and instructions about the public comment process is

available at oklahoma.gov/ohca/policies-and-rules/public-notices.

Revised within TN-23-0007, effective 04/01/24

MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program. No

☐ The Alternative Benefit Plan will be provided through primary care case management (PCCM) consistent with applicable managed care requirements (42 CFR Part 438, section 1903(m) of the Social Security Act, and section 1932 of the Social Security Act).

#type# Procurement or Selection Method

Indicate the method used to select #type#s:

◉ Competitive procurement method (RFP, RFA).

○ Other procurement/selection method.

Describe the method used by the state/territory to procure or select the MCOs:

Other MCO-Based Service Delivery System Characteristics

One or more of the Alternative Benefit Plan benefits or services will be provided apart from the managed care organization. Yes

List the benefits or services that will be provided apart from the #type#, and explain how they will be provided. Add as many rows as needed.

Add	Name	Description	Remove
Add	Orthodontia – Child	Dental PAHP or Traditional State-Managed Fee-For-Service (FFS)	Remove
Add	Major Dental Care – Child	Dental PAHP or Traditional State-Managed FFS	Remove
Add	Tobacco Cessation 5-As Counseling 5-As Counseling – Child	Dental PAHP or Traditional State-Managed FFS	Remove
Add	Medically Necessary Extractions – Adult	Dental PAHP or Traditional State-Managed FFS	Remove
Add	Diagnostic Dental – Adult	Dental PAHP or Traditional State-Managed FFS	Remove
Add	Preventive Dental – Adult	Dental PAHP or Traditional State-Managed FFS	Remove
Add	Restorative Dental – Adult	Dental PAHP or Traditional State-Managed FFS	Remove
Add	Non-surgical Periodontal Therapy – Adult	Dental PAHP or Traditional State-Managed FFS	Remove
Add	Removable Prosthetics Dental – Adult	Dental PAHP or Traditional State-Managed FFS	Remove
Add	Outpatient Surgery Dentist/Surgical Services – Adult	Dental PAHP or Traditional State-Managed FFS	Remove

Add	Tobacco Cessation 5-As Counseling 5-As Counseling – Adult	Dental PAHP or Traditional State-Managed FFS	Remove
Add	PCCM/PCMH Service Delivery Model	Traditional State-Managed FFS	Remove

MCO service delivery is provided on less than a statewide basis. No

#type# Participation Exclusions

Individuals are excluded from MCO participation in the Alternative Benefit Plan: Yes

Select all that apply:

- ☐ Individuals with other medical insurance.
- ☐ Individuals eligible for less than three months.
- ☐ Individuals in a retroactive period of Medicaid eligibility.
- ☒ Other:

General #type# Participation Requirements

Indicate if participation in the managed care is mandatory or voluntary:

- ◉ Mandatory participation.
- ○ Voluntary participation. Indicate the method for effectuating enrollment:

Describe method of enrollment in MCOs:

Expansion adults will be mandatorily enrolled with a medical MCE; however, American Indian/Alaskan Native (AI/AN) expansion adults will have the option to voluntarily enroll in the SoonerSelect Medical program through an opt-in process.

Expansion adults will have sixty (60) days to select a medical MCE prior to the start of coverage under the SoonerSelect Medical program. Subsequent to program implementation, expansion adults will have an opportunity to select a medical MCE on their application. Expansion adults who do not make an election within the allowed timeframe will be automatically assigned to a medical MCE.

Expansion adults who apply within the first (1st) day of the month through the fifteenth (15th) day of the month will be enrolled effective on the first (1st) day of the following month. Expansion adults who select or are assigned to a dental PAHP on the sixteenth (16th) day of the month through the last day of the month will be enrolled effective on the first day of the second following month.

Expansion adults may change their assigned medical MCE within ninety (90) days of enrollment or ninety (90) days within receiving notification of enrollment, whichever is later and may also change their medical MCE during the annual open enrollment period.

A medical MCE may not refuse an assignment or seek to disenroll an enrollee or otherwise discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and may not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin, sex, sexual orientation, gender identity, or disability. A medical MCE may not discriminate against an enrollee in enrollment, disenrollment, or re-enrollment on the basis of expectations that the individual will require frequent or high-cost care, or on the basis of health status or need for health care services or due to an adverse change in the individual's health.

Individuals during a period of presumptive eligibility are excluded from MCO enrollment.

Individuals that remain enrolled due to the continuous enrollment and maintenance of effort (MOE) requirement of Section 6008(b)(3) of the Families First Coronavirus Response Act (FFCRA) are excluded from MCO enrollment.

Populations excluded from this ABP and MCO enrollment include: Medicare dual eligible individuals; Individuals enrolled in the Medicare Savings Program; individuals determined eligible for Medicaid on the basis of age, blindness, or disability; Medicaid beneficiaries who reside in nursing facilities (NF) or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), with the exception of beneficiaries with a pending level of care determination; participants of a in Home and Community Based Services (HCBS) Waiver program; individuals infected with tuberculosis eligible for tuberculosis-related services under 42 C.F.R. § 435.21; individuals determined eligible for SoonerCare on the basis of needing treatment for breast or cervical cancer under 42 C.F.R. § 435.213; undocumented persons eligible for Emergency Services only in accordance with 42 C.F.R. § 435.139; Insure Oklahoma Employee Sponsored Insurance (ESI) dependent Children in accordance with the Oklahoma Title XXI Children's Health Insurance Program (CHIP) State Plan; and Individuals within the Title XIX Soon-to-be-Sooners Separate CHIP (STBS S-CHIP) program.

Revised within TN-23-0007, effective 04/01/24

Additional Information: #type# (Optional)

Provide any additional details regarding this service delivery system (optional):

PAHP: Prepaid Ambulatory Health Plan

The managed care delivery system is the same as an already approved managed care program. No

☐ The Alternative Benefit Plan will be provided through primary care case management (PCCM) consistent with applicable managed care requirements (42 CFR Part 438, section 1903(m) of the Social Security Act, and section 1932 of the Social Security Act).

#type# Procurement or Selection Method

Indicate the method used to select #type#s:

◉ Competitive procurement method (RFP, RFA).

○ Other procurement/selection method.

Describe the method used by the state/territory to procure or select the PAHPs:

Other PAHP-Based Service Delivery System Characteristics

One or more of the Alternative Benefit Plan benefits or services will be provided apart from the PAHP. Yes

List the benefits or services that will be provided apart from the #type#, and explain how they will be provided. Add as many rows as needed.

Add	Name	Description	Remove
Add	Primary Care Visits to Treat Injury or Illness	MCO or Traditional State-Managed FFS	Remove
Add	Specialty Visits	MCO or Traditional State-Managed FFS	Remove
Add	Other Practitioner Office Visits	MCO or Traditional State-Managed FFS	Remove

Add	Outpatient Facility (ambulatory surgery ctr)	MCO or Traditional State-Managed FFS	Remove
Add	Dialysis	MCO or Traditional State-Managed FFS	Remove
Add	Allergy Testing	MCO or Traditional State-Managed FFS	Remove
Add	Chemotherapy	MCO or Traditional State-Managed FFS	Remove
Add	Radiation	MCO or Traditional State-Managed FFS	Remove
Add	Outpatient Surgery Physician/Surgical Services	MCO or Traditional State-Managed FFS	Remove
Add	Hospice	MCO or Traditional State-Managed FFS	Remove
Add	Emergency Room Services	MCO or Traditional State-Managed FFS	Remove
Add	Emergency Transportation/Ambulance	MCO or Traditional State-Managed FFS	Remove
Add	Urgent Care Center	MCO or Traditional State-Managed FFS	Remove
Add	Inpatient Hospital Services (Inpatient Stay)	MCO or Traditional State-Managed FFS	Remove
Add	Inpatient Physician & Surgical Services	MCO or Traditional State-Managed FFS	Remove
Add	Organ Transplants	MCO or Traditional State-Managed FFS	Remove
Add	Reconstructive Surgery	MCO or Traditional State-Managed FFS	Remove
Add	Prenatal & Postnatal care	MCO or Traditional State-Managed FFS	Remove
Add	Delivery & Inpatient Services for Maternity Care	MCO or Traditional State-Managed FFS	Remove
Add	Mental/Behavioral Health Outpatient Services	MCO or Traditional State-Managed FFS	Remove
Add	Mental/Behavioral Health Inpatient Services	MCO or Traditional State-Managed FFS	Remove
Add	Substance Use Disorder Outpatient Services	MCO or Traditional State-Managed FFS	Remove
Add	Substance Use Disorder Inpatient Services	MCO or Traditional State-Managed FFS	Remove
Add	Prescription drugs	MCO or Traditional State-Managed FFS	Remove
Add	Outpatient Rehabilitation Services	MCO or Traditional State-Managed FFS	Remove

Add	Home Health	MCO or Traditional State-Managed FFS	Remove
Add	Durable Medical Equipment	MCO or Traditional State-Managed FFS	Remove
Add	Prosthetic Devices	MCO or Traditional State-Managed FFS	Remove
Add	Orthotic Devices	MCO or Traditional State-Managed FFS	Remove
Add	Habilitation Services	MCO or Traditional State-Managed FFS	Remove
Add	Inpatient Rehab Hospital	MCO or Traditional State-Managed FFS	Remove
Add	Imaging (CT/PET scans, MRIs)	MCO or Traditional State-Managed FFS	Remove
Add	Laboratory Outpatient & Professional Services	MCO or Traditional State-Managed FFS	Remove
Add	X-rays & Diagnostic Imaging	MCO or Traditional State-Managed FFS	Remove
Add	Diabetes Education	MCO or Traditional State-Managed FFS	Remove
Add	Preventive Care/Screening/Immunization	MCO or Traditional State-Managed FFS	Remove
Add	Nutritional Services	MCO or Traditional State-Managed FFS	Remove
Add	State Plan EPSDT Benefits	MCO or Traditional State-Managed FFS	Remove
Add	Nursing facility services	MCO (for up to 60 days pending a level of care determination) or Traditional State-Managed FFS	Remove
Add	Family planning	MCO or Traditional State-Managed FFS	Remove
Add	Bariatric Surgery	MCO or Traditional State-Managed FFS	Remove
Add	Non-emergency transportation	MCO or Traditional State-Managed FFS	Remove
Add	Podiatric services	MCO or Traditional State-Managed FFS	Remove
Add	Eye care to treat a medical or surgical condition	MCO or Traditional State-Managed FFS	Remove
Add	Meals and Lodging	MCO or Traditional State-Managed FFS	Remove
Add	Personal Care Services	MCO or Traditional State-Managed FFS	Remove
Add	Medication-Assisted Treatment Services	MCO or Traditional State-Managed FFS	Remove

Add	Infusion Therapy	MCO or Traditional State-Managed FFS	Remove
Add	PCCM/PCMH Service Delivery Model	MCO or Traditional State-Managed FFS	Remove
Add	ICF/IID services	MCO (for up to 60 days pending a level of care determination) or Traditional State-Managed FFS	Remove
Add	Alternative Treatment for Pain Management	MCO or Traditional State-Managed FFS	Remove
Add	Routine Patient Cost in Qualifying Clinical Trials	MCO or Traditional State-Managed FFS	Remove

PAHP service delivery is provided on less than a statewide basis. No

#type# Participation Exclusions

Individuals are excluded from PAHP participation in the Alternative Benefit Plan: Yes

Select all that apply:

☐ Individuals with other medical insurance.

☐ Individuals eligible for less than three months.

☐ Individuals in a retroactive period of Medicaid eligibility.

☒ Other:

General #type# Participation Requirements

Indicate if participation in the managed care is mandatory or voluntary:

◉ Mandatory participation.

○ Voluntary participation. Indicate the method for effectuating enrollment:

Describe method of enrollment in PAHPs:

Expansion adults will be mandatorily enrolled with a dental PAHP; however, American Indian/Alaskan Native (AI/AN) expansion adults will have the option to voluntarily enroll in the SoonerSelect Dental program through an opt-in process.

Expansion adults will have sixty (60) days to select a dental PAHP prior to the start of coverage under the SoonerSelect Dental program. Subsequent to program implementation, expansion adults will have an opportunity to select a CE on their application. Expansion adults who do not make an election within the allowed timeframe will be automatically assigned to a dental PAHP.

Expansion adults who applies within the first (1st) day of the month through the fifteenth (15th) day of the month will be enrolled effective on the first (1st) day of the following month. Expansion adults who select or are assigned to a dental PAHP on the sixteenth (16th) day of the month through the last day of the month will be enrolled effective on the first day of the second following month.

Expansion adults may change their assigned dental PAHP within ninety (90) days of enrollment or ninety (90) days within receiving notification of enrollment, whichever is later and may also change their dental PAHP during the annual open enrollment period.

A dental PAHP may not refuse an assignment or seek to disenroll an enrollee or otherwise discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and may not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin, sex, sexual orientation, gender identity, or disability. A dental PAHP may not discriminate against an enrollee in enrollment, disenrollment, or re-enrollment on the basis of

expectations that the individual will require frequent or high-cost care, or on the basis of health status or need for health care services or due to an adverse change in the individual's health.

Individuals during a period of presumptive eligibility are excluded from PAHP enrollment.

Individuals that remain enrolled due to the continuous enrollment and maintenance of effort (MOE) requirement of Section 6008(b)(3) of the Families First Coronavirus Response Act (FFCRA) are excluded from PAHP enrollment.

Populations excluded from this ABP and PAHP enrollment include: Medicare dual eligible individuals; Individuals enrolled in the Medicare Savings Program; individuals determined eligible for Medicaid on the basis of age, blindness, or disability; Medicaid beneficiaries who reside in nursing facilities (NF) or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), with the exception of beneficiaries with a pending level of care determination; participants of a in Home and Community Based Services (HCBS) Waiver program; individuals infected with tuberculosis eligible for tuberculosis-related services under 42 C.F.R. § 435.21; individuals determined eligible for SoonerCare on the basis of needing treatment for breast or cervical cancer under 42 C.F.R. § 435.213; undocumented persons eligible for Emergency Services only in accordance with 42 C.F.R. § 435.139; Insure Oklahoma Employee Sponsored Insurance (ESI) dependent Children in accordance with the Oklahoma Title XXI Children's Health Insurance Program (CHIP) State Plan; and Individuals within the Title XIX Soon-to-be-Sooners Separate CHIP (STBS S-CHIP) program.

Revised within TN-23-0007, effective 02/01/24

Additional Information: #type# (Optional)

Provide any additional details regarding this service delivery system (optional):

The State is seeking to establish the PAHP delivery model for the provision of dental services. Medical services will continue to be provided via the traditional state-managed fee-for-service delivery system.

Revised within TN-23-0007, effective 02/01/24

PCCM: Primary Care Case Management

The PCCM delivery system is the same as an already approved PCCM program. No

☑ The Alternative Benefit Plan will be provided through primary care case management (PCCM) consistent with applicable managed care requirements (42 CFR Part 438, section 1903(m) of the Social Security Act, and section 1932 of the Social Security Act).

#type# Procurement or Selection Method

Indicate the method used to select #type#s:

○ Competitive procurement method (RFP, RFA).

◉ Other procurement/selection method.

Describe the method used by the state/territory to procure or select the PCCMs:

Primary care case managers (PCCM) contract directly with the State as primary care providers to furnish case management services to AI/AN expansion adult members who do not opt-in to managed care.

Revised within TN-23-0007, effective 02/01/24

Other PCCM-Based Service Delivery System Characteristics

One or more of the Alternative Benefit Plan benefits or services will be provided apart from the PCCM. Yes

List the benefits or services that will be provided apart from the #type#, and explain how they will be provided. Add as many rows as needed.

Add	Name	Description	Remove
Add	Primary Care Visits to Treat Injury or Illness	MCO or Traditional State-Managed FFS	Remove
Add	Specialty Visits	MCO or Traditional State-Managed FFS	Remove
Add	Other Practitioner Office Visits	MCO or Traditional State-Managed FFS	Remove
Add	Outpatient Facility (ambulatory surgery ctr)	MCO or Traditional State-Managed FFS	Remove
Add	Dialysis	MCO or Traditional State-Managed FFS	Remove
Add	Allergy Testing	MCO or Traditional State-Managed FFS	Remove
Add	Chemotherapy	MCO or Traditional State-Managed FFS	Remove
Add	Radiation	MCO or Traditional State-Managed FFS	Remove
Add	Outpatient Surgery Physician/Surgical Services	MCO or Traditional State-Managed FFS	Remove
Add	Hospice	MCO or Traditional State-Managed FFS	Remove
Add	Emergency Room Services	MCO or Traditional State-Managed FFS	Remove
Add	Emergency Transportation/Ambulance	MCO or Traditional State-Managed FFS	Remove
Add	Urgent Care Center	MCO or Traditional State-Managed FFS	Remove
Add	Inpatient Hospital Services (Inpatient Stay)	MCO or Traditional State-Managed FFS	Remove
Add	Inpatient Physician & Surgical Services	MCO or Traditional State-Managed FFS	Remove
Add	Organ Transplants	MCO or Traditional State-Managed FFS	Remove
Add	Reconstructive Surgery	MCO or Traditional State-Managed FFS	Remove
Add	Prenatal & Postnatal care	MCO or Traditional State-Managed FFS	Remove
Add	Delivery & Inpatient Services for Maternity Care	MCO or Traditional State-Managed FFS	Remove
Add	Mental/Behavioral Health Outpatient Services	MCO or Traditional State-Managed FFS	Remove

Add	Mental/Behavioral Health Inpatient Services	MCO or Traditional State-Managed FFS	Remove
Add	Substance Use Disorder Outpatient Services	MCO or Traditional State-Managed FFS	Remove
Add	Substance Use Disorder Inpatient Services	MCO or Traditional State-Managed FFS	Remove
Add	Prescription drugs	MCO or Traditional State-Managed FFS	Remove
Add	Outpatient Rehabilitation Services	MCO or Traditional State-Managed FFS	Remove
Add	Home Health	MCO or Traditional State-Managed FFS	Remove
Add	Durable Medical Equipment	MCO or Traditional State-Managed FFS	Remove
Add	Prosthetic Devices	MCO or Traditional State-Managed FFS	Remove
Add	Orthotic Devices	MCO or Traditional State-Managed FFS	Remove
Add	Habilitation Services	MCO or Traditional State-Managed FFS	Remove
Add	Inpatient Rehab Hospital	MCO or Traditional State-Managed FFS	Remove
Add	Imaging (CT/PET scans, MRIs)	MCO or Traditional State-Managed FFS	Remove
Add	Laboratory Outpatient & Professional Services	MCO or Traditional State-Managed FFS	Remove
Add	X-rays & Diagnostic Imaging	MCO or Traditional State-Managed FFS	Remove
Add	Diabetes Education	MCO or Traditional State-Managed FFS	Remove
Add	Preventive Care/Screening/Immunization	MCO or Traditional State-Managed FFS	Remove
Add	Nutritional Services	MCO or Traditional State-Managed FFS	Remove
Add	State Plan EPSDT Benefits	MCO or Traditional State-Managed FFS	Remove
Add	Nursing facility services	MCO (for up to 60 days pending a level of care determination) or Traditional State-Managed Fee-For-Service	Remove
Add	Family planning	MCO or Traditional State-Managed FFS	Remove
Add	Bariatric Surgery	MCO or Traditional State-Managed FFS	Remove
Add	Non-emergency transportation	MCO or Traditional State-Managed FFS	Remove

Add	Podiatric services	MCO or Traditional State-Managed FFS	Remove
Add	Eye care to treat a medical or surgical condition	MCO or Traditional State-Managed FFS	Remove
Add	Meals and Lodging	MCO or Traditional State-Managed FFS	Remove
Add	Personal Care Services	MCO or Traditional State-Managed FFS	Remove
Add	Medication-Assisted Treatment Services	MCO or Traditional State-Managed FFS	Remove
Add	Infusion Therapy	MCO or Traditional State-Managed FFS	Remove
Add	ICF/IID services	MCO (for up to 60 days pending a level of care determination) or Traditional State-Managed Fee-For-Service	Remove
Add	Alternative Treatment for Pain Management	MCO or Traditional State-Managed FFS	Remove
Add	Routine Patient Cost in Qualifying Clinical Trials	MCO or Traditional State-Managed FFS	Remove
Add	Orthodontia – Child	Dental PAHP or Traditional State-Managed FFS	Remove
Add	Major Dental Care – Child	Dental PAHP or Traditional State-Managed FFS	Remove
Add	Tobacco Cessation 5-As Counseling 5-As Counseling – Child	Dental PAHP or Traditional State-Managed FFS	Remove
Add	Medically Necessary Extractions – Adult	Dental PAHP or Traditional State-Managed FFS	Remove
Add	Diagnostic Dental – Adult	Dental PAHP or Traditional State-Managed FFS	Remove
Add	Preventive Dental – Adult	Dental PAHP or Traditional State-Managed FFS	Remove
Add	Restorative Dental – Adult	Dental PAHP or Traditional State-Managed FFS	Remove
Add	Non-surgical Periodontal Therapy – Adult	Dental PAHP or Traditional State-Managed FFS	Remove
Add	Removable Prosthetics Dental – Adult	Dental PAHP or Traditional State-Managed FFS	Remove
Add	Outpatient Surgery Dentist/Surgical Services – Adult	Dental PAHP or Traditional State-Managed FFS	Remove
Add	Tobacco Cessation 5-As Counseling 5-As Counseling – Adult	Dental PAHP or Traditional State-Managed FFS	Remove

PCCM service delivery is provided on less than a statewide basis. No

PCCM Payments

Specify how payment for services is handled:

- (•) Per member/per month case management fee paid to PCCM provider.
- ( ) Other:

Additional Information: #type# (Optional)

Provide any additional details regarding this service delivery system (optional):

Fee-For-Service Options

Indicate whether the state/territory offers traditional fee-for-service and/or services managed under an administrative services organization:

- (•) Traditional state-managed fee-for-service
- ( ) Services managed under an administrative services organization (ASO) arrangement

Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, fee-for-service care management models/non-risk, contractual incentives as well as the population served via this delivery system.

With the exception of medical services provided by medical MCOs and dental services provided by dental PAHPs, the services provided under the ABP are provided under the Medicaid State Plan and are paid in the same manner as those services provided in the Medicaid state plan, Attachment 4.19.

Revised within TN-23-0007, effective 02/01/24

Additional Information: Fee-For-Service (Optional)

Provide any additional details regarding this service delivery system (optional):

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Alternative Benefit Plan

State Name: Oklahoma Attachment 3.1-L- [ ] OMB Control Number: 0938-1148

Transmittal Number: OK - 21 - 0002

Employer Sponsored Insurance and Payment of Premiums	ABP9
The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package.	No
The state/territory otherwise provides for payment of premiums.	No

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722

Alternative Benefit Plan

State Name: Oklahoma Attachment 3.1-L- [ ] OMB Control Number: 0938-1148

Transmittal Number: OK - 21 - 0002

General Assurances — ABP10

Economy and Efficiency of Plans

☑ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services. Yes

Compliance with the Law

☑ The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.

☑ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).

☑ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722

Alternative Benefit Plan

State Name: Oklahoma Attachment 3.1-L- [ ] OMB Control Number: 0938-1148

Transmittal Number: OK - 21 - 0002

Payment Methodology — ABP11

Alternative Benefit Plans - Payment Methodologies

☑ The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Hospice Care

With the exception of payment for physician services, reimbursement for hospice care will be made at one (1) of five (5) predetermined rates for each day in which an individual receives the respective type and intensity of the services furnished under the care of the hospice. A description of the payment for each level of care is as follows:

1. **Routine home care.** The hospice will be paid one of two routine home care rates for each day the patient is in residence, under the care of the hospice, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day. The two-rate payment methodology will result in a higher based payment for days one (1) through sixty (60) of hospice care and a reduced rate for days sixty-one (61) to infinity. A minimum of sixty (60) days gap in hospice services is required to reset the counter, which determines the payment category for the service.

2. **Continuous home care.** Continuous home care is to be provided only during a period of crisis. A period of crisis is the period in which a patient requires continuous care which is primarily nursing care to achieve palliation and management of acute medical symptoms. Either a registered nurse or a licensed practical nurse must provide care and a nurse must provide care for at least half the total period of care. A minimum of eight (8) hours of care must be provided during a twenty-four (24) hour day, which begins and ends at midnight. This care need not be continuous and uninterrupted. If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine home care.

3. **Inpatient respite care.** The hospice will be paid at the inpatient respite care rate for each day the recipient is in an approved inpatient facility and is receiving respite care. Payment for respite care may be made for a maximum of five (5) days including the date of admission but not counting the date of discharge in any monthly election period. Payment for the sixth and any subsequent day is to be made at the appropriate rate: routine, continuous, or general inpatient rate. Inpatient respite care may be provided in hospital or nursing facility.

4. **General inpatient care.** Payment at the inpatient rate will be made when general inpatient care is provided. No other fixed payment rates will be applicable for a day on which the recipient receives hospice general inpatient care except as described in the section of this plan which discusses payment of physician services.

5. **Service intensity add-on.** Payment for the Service Intensity Add-On (SIA) will be made for a visit by a registered nurse (RN) or Social Worker when provided in the last seven (7) days of life. Payment for the SIA will be equal to the continuous home care incremental rate multiplied by the increments of nursing provided (up to four [4] hours/sixteen [16] increments total) per day for each day in the last seven (7) days of life.

Hospice care payment rates. Effective October 1, 2021, the adult hospice rates are paid the greater of 96.53% of the annually published CMS Medicaid daily hospice rates that are effective October 1 annually, or the CMS established floor. The floor rates are calculated by taking the Medicaid Hospice rates provided by CMS, applying the wage index to the wage component subject to index, and adding the non-weighted amount.

Under the Medicaid hospice benefit, no cost sharing may be imposed with respect to hospice services rendered to Medicaid recipients.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Hospice Services *(continued)*

Other General Reimbursement Items

1. **Date of discharge.** For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the patient dies as an inpatient. When the patient is discharged as deceased, the inpatient rate, either general or respite, is to be paid for the discharge date.

2. **Inpatient Day cap.** Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning October 1 of each year and ending September 30, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed 20% of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. This limitation is applied once each year, at the end of the hospices' cap period.

3. **Obligation of continuing care.** After the member's Medicare hospice benefit expires, the patient's Medicaid hospice benefits do not expire. The hospice must continue to provide the recipient's care until the patient expires or until the member revokes the election of hospice care.

4. **Payment for physician services.** The basic rates for hospice care represent full reimbursement to the hospice for the costs of all covered services related to the treatment of the member's terminal illness, including the administrative and general activities performed by physicians who are employees of or working under arrangements made with the hospice. The physician serving as the medical director and the physician member of the hospice interdisciplinary group would generally perform these activities.

   Group activities include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies. The costs for these services are included in the reimbursement rates for routine home care, continuous home care, and inpatient respite care.

   Reimbursement for an independent physician's direct patient services is made in accordance with the usual SoonerCare reimbursement methodology for physician services. These services will not be billed by the hospice under the hospice provider number. The only services to be billed by an attending physician are the physician's personal professional services. Costs for services such as laboratory or x-rays are not to be included on the attending physician's billed charges to the Medicaid program. The aforementioned charges are included in the daily rates paid and are expressly the responsibility of the hospice.

5. **Nusing Facility/Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) care.** Hospice nursing facility or ICF-IID room and board per diem rates are reimbursed to the in-home hospice provider at a rate equal to 95% of the skilled nursing facility rate. The hospice provider is responsible for passing the room and board payment through to the nursing facility or ICF-IID.

Revision: HCFA-Region VI
January 1989

ATTACHMENT 3.2-A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OKLAHOMA

COORDINATION OF TITLE XIX WITH PART A AND PART B OF TITLE XVIII

The following method is used to provide benefits under Part A and Part B of title XVIII to the groups of Medicare-eligible individuals indicated:

A. Part B buy-in agreements with the Secretary of HHS. This agreement covers:

1. [ ] Individuals receiving SSI under title XVI or State supplementation, who are categorically needy under the State's approved title XIX plan.

   Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

   Yes [ ] No [ ]

2. [X] Individuals receiving SSI under title XVI, State supplementation, or a money payment under the State's approved title IV-a plan, who are categorically needy under the State's approved title XIX plan.

   Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

   Yes [X] No [ ]

3. [ ] All individuals eligible under the State's approved title XIX plan.

4. [X] Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

B. Part A group premium payment billing with HCFA arrangement ~~entered into with the Social Security Administration~~. This arrangement covers the following groups:

Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

C. Payment of Part A and Part B deductible and coinsurance costs. Such payments are made in behalf of the following groups:

1. Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

2. Categorically Needy - Part A & Part B

3. Medically Needy - Part B

with State in correspondence dated 6/27/89 and 8/19/89

STATE OK
DATE RECD 3/31/89
DATE APPR 9/19/89
DATE EFF 1/1/89
HCFA 179 89-2
Revised 01-01-89

A

TN No. 89-2
Supersedes
TN No. 87-9

Approval Date 9/19/89 Effective Date 1/1/89

PROPOSED SECTION 4 - GENERAL PROGRAM ADMINISTRATION

4.5 Medicaid Recovery Audit Contractor Program

Citation	
Section 1902(a)(42)(B)(i) of the Social Security Act	___ The State has established a program under which it will contract with one or more recovery audit contractors (RACs) for the purpose of identifying underpayments and overpayments of Medicaid claims under the State plan and under any waiver of the State plan. _X_ The State is seeking an exception to establishing such program for the following reasons: • The State is seeking to discontinue its RAC program because Oklahoma has robust and effective program integrity procedures in place to combat fraud, waste, and abuse (FWA) for the state's Medicaid program, including: o Individual provider – claim analysis reports; o Individual provider – prepayment review capabilities; o Clinical provider audits – medical record review audits (21 person unit consisting of Registered Nurses, Certified Professional Coders, and a Dental Hygienist); o Clinical provider audits with extended capabilities utilizing third party software applications; o Behavioral health audits – record review audits (unit consists of Licensed Professional Counselors and Licensed Marital and Family Therapists); o Advanced program integrity data analytics proven effective in identifying FWA; o Federal Unified Program Integrity Contractor (UPIC). • The Payment Error Rate Measurement (PERM) program has shown that Oklahoma's Medicaid program error rate has been far less than the national average. • The exception will be granted by CMS for a two (2) year period.
Section 1902(a)(42)(B)(ii)(I) of the Act	__The State/Medicaid agency will implement contracts of the type(s) listed in section 1902(a)(42)(B)(ii)(I) of the Act. All contracts meet the requirements of the statute. RACs are consistent with the statute. Place a check mark to provide assurance of the following: __The State will make payments to the RAC(s) only from amounts recovered. __The State will make payments to the RAC(s) on a contingent basis for collecting overpayments.
Section 1902(a)(42)(B)(ii)(ll)(aa) of the Act	The following payment methodology shall be used to determine State payments to Medicaid RACs for identification and recovery of overpayments (e.g., the percentage of the contingency fee):

PROPOSED SECTION 4 - GENERAL PROGRAM ADMINISTRATION

4.5 Medicaid Recovery Audit Contractor Program

Section 1902 (a)(42)(B)(ii)(ll)(bb) of the Act	___The State attests that the contingency fee rate paid to the Medicaid RAC will not exceed the highest rate paid to Medicare RACs, as published in the Federal Register. ___The State attests that the contingency fee rate paid to the Medicaid RAC will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will only submit for FFP up to the amount equivalent to that published rate.
Section 1902 (a)(42)(B)(ii)(lll) of the Act	___The contingency fee rate paid to the Medicaid RAC that will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will submit a justification for that rate and will submit for FFP for the full amount of the contingency fee.
Section 1902 (a)(42)(B)(ii)(IV)(aa) of the Act	____The following payment methodology shall be used to determine State payments to Medicaid RACs for the identification of underpayments (e.g., amount of flat fee, the percentage of the contingency fee).
Section 1902(a)(42)(B)(ii)(IV(bb) of the Act	____The State has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RAC(s).
Section 1902 (a)(42)(B)(ii)(IV)(cc) Of the Act	___The State assures that the amounts expended by the State to carry out the program will be amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan.
State: Oklahoma Date Received: 22 May, 2018 Date Approved: 20 July, 2018 Effective Date: 1 April, 2018 Transmittal Number: 18-11	____The State assures that the recovered amounts will be subject to a State's quarterly expenditure estimates and funding of the State's share. ____Efforts of the Medicaid RAC(s) will be coordinated with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, and/or State and Federal law enforcement entities and the CMS Medicaid Integrity Program.

Standards for Institutions

The standards developed and imposed for skilled nursing facilities and hospitals in which recipients of medical assistance under Title XVIII may receive care and services, are utilized as the standards for skilled nursing facilities and hospitals in which recipients under the plan may receive care or services under Title XIX.

An Executive Order, signed on February 10, 1967, by the Governor of the State of Oklahoma, declared the State Board of Health as the official standard-setting agency for medical facilities in this State, except that the Oklahoma Public Welfare Commission is declared to be the standard-setting authority for medical facilities that are operated by the Department of Public Welfare, "the standards so set to be equal to or higher than those set by the State Board of Health for other medical facilities." Filed February 10, 1967, by the Secretary of State.

Under the authority of the above order, the Department of Institutions, Social and Rehabilitative Services as the standard-setting authority for the intermediate care facilities in the three schools for the mentally retarded is also the certibying authority for compliance with Title XIX regulations.

Effective July 1, 1975, in accordance with an agreement between the Department of Institutions, Social and Rehabilitative Services and the State Department of Health, the State Department of Health will be responsible for licensing and certification of medical facilities in the schools for the mentally retarded. These facilities may include intermediate care facilities, skilled nursing facilities, and hospitals in the schools for the mentally retarded.

Standard-Setting Authority for Institutions

(1) The types or kinds of institutions which may provide intermediate care services are those public or private institutions which:
- (a) are licensed under State law as intermediate care facilities;
- (b) meet such standards of safety and sanitation as are applicable to nursing homes under State law;
- (c) do not provide the degree of care required to be provided by a skilled nursing home furnishing services under a State plan approved under Title XIX; and
- (d) regularly provide a level of care and service beyond room and board and as such provide the residents thereof, on a regular basis, the range or level of care and services which are suitable to the needs of individuals who:
  - (i) because of their physical or mental limitation or both, require living accommodations and care which, as a practical matter, can be made available to them only through institutional facilities; and
  - (ii) do not have such an illness, disease, injury, or other condition as to require the degree of care and treatment which a hospital or skilled nursing home (as that term is employed in Title XIX) is designed to provide.

The term "intermediate care facility", also includes a Christian Science sanatorium operated or listed and certified by the First Church of Christ, Scientist, Boston, Massachusetts, but only with respect to institutional services deemed appropriate by the State.

The term "intermediate care facility", also includes a public institution (or distinct part thereof) for the mentally retarded or a private institution providing specialized intermediate care services

<u>if</u>

the primary purpose of such institution is to provide health or rehabilitative services which meet such standards as may be prescribed by the Secretary; and the individual with respect to whom a request for payment is made under a plan approved under this title is receiving active treatment under such a program. The definition of active treatment is "Daily participation, in accordance with an individual treatment plan, in activities, experiences or therapies which are part of a professionally developed and supervised program of health, social or rehabilitative services offered by or procured by the institution for its residents."

OFFICE OF THE SECRETARY OF STATE

STATE OF OKLAHOMA

CERTIFICATE OF TRANSCRIPT

I, the undersigned Secretary of State of the State of Oklahoma, do hereby certify that the annexed transcript has been compared with the record on file in my office of which it purports to be a copy, and that the same is a full, true and correct copy of:

EXECUTIVE ORDER

SETTING STANDARDS FOR MEDICAL FACILITIES

FILED: February 10, 1967

In testimony whereof, I have hereunto set my hand and affixed the Great Seal of the State of Oklahoma at the City of Oklahoma City this 11 *day of* October, *19*68

John Rogers
Secretary of State

By: L L Calloway
Assistant Secretary of State

OFFICE OF THE GOVERNOR

EXECUTIVE ORDER

FILED
FEB 10 1967
JOHN ROGERS
SECRETARY OF STATE

TO: HONORABLE JOHN ROGERS
SECRETARY OF STATE
STATE CAPITOL BUILDING
OKLAHOMA CITY, OKLAHOMA

Dear Sir:

Please file for record the following Executive Order:

WHEREAS, medical facilities are required to meet and maintain State standards for the purposes of Title XIX of the Federal Social Security Act; and

WHEREAS, it is necessary that Federal Officials know what agency or agencies in Oklahoma can set such standards; and

WHEREAS, the State Board of Health is the proper agency to set standards for all medical facilities except those which, by law, have been placed under the jurisdiction of other public agencies;

NOW, THEREFORE, BY VIRTUE OF THE AUTHORITY VESTED IN ME AS GOVERNOR AND CHIEF EXECUTIVE OF THE STATE OF OKLAHOMA, I do hereby declare the State Board of Health as the official agency of the State of Oklahoma to set standards for medical facilities in the State of Oklahoma, except the medical facilities that are operated by the Department of Public Welfare and any other State agency, for which facilities the Oklahoma Public Welfare Commission, or the governing Board of such other State agency, is declared to be the standard-setting authority, the standards so set to be equal to or higher than those set by the State Board of Health for other medical facilities.

IN WITNESS WHEREOF, I, DEWEY F. BARTLETT, GOVERNOR OF THE STATE OF OKLAHOMA, have hereunto affixed my name and set my hand and caused to be affixed the GREAT SEAL OF THE STATE OF OKLAHOMA at Oklahoma City, Oklahoma, this 10th day of February, 1967.

BY THE GOVERNOR OF THE STATE OF OKLAHOMA

Dewey F. Bartlett
DEWEY F. BARTLETT

ATTEST:

John Rogers
Secretary of State

Trans 75-24

The State Department of Mental Health is the State Mental Health Authority in accordance with Title 43-A, Section 24, and such Agency has authority to establish regulations for a statewide system of pre-care and after-care services to the mentally ill, under Title 43-A, Section 152, and is mandated by SJR-22 of the 39th Oklahoma Legislature, Second Session, to certify providers of Community Mental Health services. The following are applicable standards excerpted from the "Oklahoma State Department of Mental Health Standards and Criteria, Mental Health Programs in Oklahoma."

Outpatient Mental Health Clinics

1. Psychiatric outpatient mental health clinic refers to a program which provides a range of services which enables an individual to obtain psychiatric treatment for emotional, mental, or behavioral problems.

2. The program shall have a written plan which specifically describes the organization of outpatient services and the service delivery methods designed for use in meeting various client/patient needs as related to the population being served.

3. The clinical services plan shall include criteria which specifically delineates the program's admission and/or intake, treatment, discharge, and follow-up policies and procedures.

4. There shall be a written treatment plan for each patient which is based upon assessment and evaluation.

5. The program shall employ staff whose skills are of the highest quality.

6. The program shall have sufficient clinical and/or professional staff who have the necessary training or experience and demonstrated competence to make initial decisions related to screening.

7. Planned staff development contributes to effective, meaningful delivery of quality care and service.

8. A program shall establish and implement a system of program, policy, and case review which shall be conducted at least on an annual basis.

9. Medical care within a mental health clinic must be under the professional and clinical direction of a physician, usually a qualified psychiatrist.

10. The clinic shall develop a written referral plan for use when patients are being referred to other community agencies, organizations, and/or individuals.

11. A written plan shall be devised by the program which establishes criteria for discharge of a patient.

12. Staff of the program shall take necessary steps for assisting the client/patient and his/her family in preparation for termination of services.

APPROVED BY DHHS/HCFA/DPO
DATE: 9-25-84
TRANSMITTAL NO: 84-5

Community Mental Health Clinics

1. A comprehensive community mental health center shall refer to a program which provides a variety of services and continuity of care for patients with mental illness and emotional disease.

2. The components of comprehensive mental health services which shall be provided through a community mental health center shall include: outpatient services, partial hospitalization services, and crisis intervention services.

3. Each community mental health center shall develop a program which is multidisciplinary in nature which utilizes psychiatrists, psychologists, social workers, nurses, activity therapists, and other mental health workers as necessary for its program and catchment area.

4. Written policies and procedures for the provision of outpatient services shall be described.

5. The community mental health center shall have a sufficient number of appropriately qualified staff and necessary supporting personnel to provide the full range of necessary services.

6. Medical care within a community mental health center must be under the professional and clinical direction and supervision of a physician, usually a qualified psychiatrist.

7. The center and its satellite units shall develop a written referral plan for use when patients are being referred to other community agencies, organizations, and/or individuals.

8. Laboratory and pathology services shall be provided either within the community mental health center or by written agreement with an outside program which will meet client/patient care needs.

9. Planned staff development contributes to effective, meaningful delivery of quality care and service.

10. A program shall establish and implement a system of program, policy, and case review which shall be conducted at least on an annual basis.

11. A written plan shall be devised by the program which establishes criteria for discharge of a patient.

12. Staff of the program shall take necessary steps for assisting the client/ patient and his/her family in preparation for termination of services.

A physician certifies as to each patient's need for in-patient services prior to or at the time of admission or, if later, the time the patient applies for medical assistance. This is done by a special form designed for this. The local social worker completes the medical social summary and submits it with the physician's form. The information on these forms is reviewed by a team consisting of a physician and a social worker in the Medical Evaluation Unit. If additional medical information, such as specialist reports, is required, this is secured prior to the final decision on the request for medical care. Recertification of need is accomplised each 60 days.

For each patient, the services are furnished under a plan established and periodically reviewed and reevaluated by a physician. Established on-site survey procedures have significantly improved documentation in facility medical records of medical care plans: Specific treatment and medication orders and related therapeutic regimens that are to be followed in the care of the patient, based on the physician's evaluation. The survey team endeavors to ensure that the plan of care states treatment goals, estimates the prognosis and possible length of stay, and anticipates the probable kind of after-care that may be appropriate for meeting the patient's needs when his condition reaches a point where the care recommended initially no longer is necessary. The medical record review seeks to assure a nursing plan of care, in conjunction with the physician's orders and plan for medical care, which is kept current, and includes observation of the patient and information elicited from him.

The utilization review program is continuous in nature. Each patient's admission to and continued stay in the institution are reviewed and evaluated through established procedures. Recertification is made in the same manner as the admission procedure described in paragraph one above, each 60 days and patient on-site review is carried out each twelve months. Certification and recertification forms are maintained in the patient's medical chart in the institution.

The claim which each non-hospital medical care facility, skilled and intermediate care, submits each month for payment lists all patients and the number of days each is provided care. This information is computerized and reported monthly to the Medical Evaluation Unit where it is closely analyzed in relation, in part, to total usage, admissions, levels of care, and discharges. This form also shows total occupancy of each facility, which information is sent to the State Department of Health, the State Licensing Authority, for use in evaluating requests for certificates of need for such health care facilities in any given area of the State.

A patient on-site review is conducted each twelve months to ensure the provision of a range and quality of medical and nursing management and social work support commensurate with clinical and physical needs and optimum social functioning of Title XIX nursing home patients. Individual forms are completed by the survey team at each scheduled review. The summary interview permits the survey team to discuss management and compliance problems with the administrative staff of the facility. Although consideration is given to the possible effects of any changes in care arrangements on health and functional status of the patients, the feasibility of alternate care where appropriate is evaluated. A copy of the summary interview report is left with the administrator to serve as a guide to improved management. Reports on each individual patient are submitted to the Medical Evaluation Unit, which staff gives final approval to the type of care required, based on the recommendation of the patient on-site review team or, if deemed necessary, with additional medical and/or social information which has been secured following receipt of the patient on-site review report. In case of an appeal of the decision by the

patient, a hearing is held by an appeals referee in the same procedure as is followed for an appeal of any other action taken by the agency.

Annually, or more often if indicated, members of the staff of the Special Medical Services Unit visit each skilled nursing facility and intermediate care facility to ensure compliance with the Department's agreement with such facilities to provide non-hospital medical care. The Patient On-Site Review Unit has been established to conduct timely medical reviews for Title XIX patients in skilled nursing facilities and professional reviews in intermediate care facilities. Survey team composition for skilled care is a physician, a social worker, and a registered nurse; for intermediate care, a social worker and a registered nurse under the supervision of a physician. Twelve to fourteen such teams are regularly scheduled for reviews of approximately 8,500 patients in 365 licensed non-hospital medical care facilities. Valuable utilization guidelines are available to the administrative staff involved in policy and procedure design for continuance of appropriate patient care and for the best use of available funds. The review frequency so involves facility management in the necessity for constant improvement in medical care and nursing care practices that significant changes for the better have been made.

Methods used are effective in that they assure appropriate care and proper use of funds made on behalf of these patients. Since nurses and social workers, who are employees of the agency, see these patients frequently, continuity of care and plans for alternate care are carried out without interruption.

Relationship with Health, Vocational Rehabilitation and Crippled Children's Program

The Department of Institutions, Social and Rehabilitative Services has a working relationship with the State Department of Health with respect to licensing and classification of intermediate care facilities and with respect to joint participation in Crippled Children's Clinics held in various communities.

Effective July 1, 1975, in accordance with the revised agreement, the State Department of Health will license and certify the medical facilities which are a part of the schools for the mentally retarded.

The State Department of Health, in its certification surveys of hospitals participating in the Title XVIII and Title XIX Programs, will assure that the Title XIX patients are included in the hospital's utilization review process.

The State Crippled Children's Program and the State Vocational Rehabilitation Program are administered by the Department of Institutions, Social and Rehabilitative Services, and services of both programs are utilized to the maximum in the Medical Assistance Program.

BETWEEN THE

OKLAHOMA STATE DEPARTMENT OF INSTITUTIONS, SOCIAL AND REHABILITATIVE SERVICES

AND THE

OKLAHOMA STATE DEPARTMENT OF HEALTH

RELATING TO THE

OKLAHOMA STATE MEDICAL ASSISTANCE PROGRAM (TITLE XIX)

This Agreement made and entered into this 1st day of July, 1975, by and between the Oklahoma State Department of Health, party of the first part, hereinafter referred to as Health Department, and the Department of Institutions, Social and Rehabilitative Services of the State of Oklahoma, party of the second part, hereinafter referred to as DISRS, witnesseth:

WHEREAS, the United States Department of Health, Education, and Welfare has promulgated regulations concerning the certification of hospitals, skilled nursing facilities and intermediate care facilities, which impose duties and responsibilities upon the parties hereto;

WHEREAS, the Oklahoma State Department of Institutions, Social and Rehabilitative Services and the Oklahoma State Department of Health have both mutual and individual responsibility and interest in the Oklahoma Medical Assistance Program (Title XIX), and whereas the relationship between these two Departments in the specific program under Title XIX of the Social Security Act, must be clearly defined, the following sections constitute a formal agreement between the two Departments;

NOW, THEREFORE, it is hereby mutually agreed by and between the parties hereto as follows:

SECTION I

RESPONSIBILITIES OF THE OKLAHOMA STATE DEPARTMENT OF HEALTH

It is hereby agreed that Health Department shall:

1. Perform the following duties in accordance with standards established by 45 CFR, Chapter II, Section 249.33 for Skilled Nursing Facilities and Intermediate Care Facilities participating in the Oklahoma Medical Assistance Program (Title XIX):

a. Accumulate, maintain, and furnish or verify to DISRS, upon request, full and complete information on the ownership of each licensed skilled nursing homes and intermediate facility, including the identity of each person having ten (10) percent or more interest; and if organized as a corporation, information as to the officers and the director; and if organized as a partnership, information of each of the partners.

b. Validate licensure status and report each such action to DISRS on each home licensed and eligible to participate in the Oklahoma Medical Assistance Program (Title XIX), and certify in writing, the level of compliance of each licensed skilled nursing home with reference to the standards set forth in 45 CFR, Chapter II, Section 249.33.

c. Validate licensure status and report each such action to DISRS on each intermediate care facility licensed and eligible to participate in the Title XIX Program and certify in writing the level of compliance of each such facility with the standards established by Federal and State Regulations.

d. Survey and certify all skilled nursing facilities or intermediate care facilities located in the State institutions for the mentally retarded as to compliance with the provisions of Title XIX and the Federal Regulations applicable to such facilities.

2. Make a written report to DISRS for any Skilled Nursing Facility or Intermediate Care Facility which meets the requirements established by DISRS for participation in Title XIX but which fails to meet any or all of the requirements set out in the applicable Federal Regulations. Said report shall include: (1) the skilled nursing homes' or intermediate care facilities' areas of deficiency, (2) the reasonable prospects for correction of the deficiency(s) within a six (6) month period; (3) the plan for correction of the deficiency(s); and (4) the official opinion with any supporting information of the Health Department as to whether the deficiency does or does not jeopardize the health and safety of the patients residing in each such licensed skilled nursing home or intermediate care facility.

3. Make on-site inspections, with qualified personnel, at least once during the term of the provider agreement, or more frequently if there is a question of compliance. With respect to such on-site inspection or survey made within one of the facilities operated by DISRS, a designated staff member from DISRS shall accompany the team making the inspection. Any differences of opinion, as to a question of compliance, will be resolved between the two agencies before a formal written report is compiled. After such an agreement is reached, Health Department will complete a written report setting forth any deficiencies and send it to the State Director, DISRS. When there is a question as to compliance, the deficiency will be discussed with the administrator of the facility and a formal letter regarding the plans for correcting the deficiency and meeting the required standards will be sent to the facility by the State Director, DISRS.

For all other on-site inspections, Health Department will file a report with DISRS, which report shall:

(1) ascertain whether the item(s) of deficiency has been corrected or is in the process of being corrected; (2) indicate the progress being made by the skilled nursing home or intermediate care facility in correcting the deficiency(s); and, render an official opinion, with any supporting information, as to whether the deficiency(s) does or does not jeopardize the health and safety of the patients.

4. Survey and certify hospital facilities operated by DISRS as to compliance with the provisions of Title XVIII and Title XIX of the Social Security Act of 1974, as amended, and the Federal Regulations applicable to such facilities.

5. In its certification survey of hospitals participating in the Title XVIII and Title XIV program, the Health Department will assure that the Title XIX patients are included in the hospital's utilization review process.

6. Employ adequate qualified personnel to perform the functions set forth in paragraph #3 above. Adequate shall be defined to include one team of surveyors for every 100 skilled nursing homes or intermediate care facilities. Qualified personnel shall mean those personnel who satisfy the Federal Surveyor Qualifications standards as specified in the Medical Services Administration Medical Assistance Manuel.

7. As to maintenance of information and reports, Health Department shall:

a. Maintain all information and reports used in determining whether a skilled nursing home or intermediate care facility meets the requirements set forth in the Federal Regulations, for a period of not less than three (3) years, or provide, by separate agreement, for the transferral of all such information to DISRS.

b. Make such reports in such form and containing such information as DISRS may require and will comply with such instructions issued to insure the correctness of such reports, including provisions made for the inspection and review at all reasonable times, or fiscal, statistical, and other records for the review of operations within the scope of this Agreement.

c. Keep DISRS informed of questions arising about failure of skilled nursing homes and intermediate care facilities to comply with Federal Regulations. When Health Department learns or is informed by DISRS of the failure of a facility to maintain the prescribed standards, Health Department will take effective action to correct the situation and will keep DISRS informed of progress being made in correcting the deficiency.

8. Provide consultative services as described in Section 1902(a)(24) of the Social Security Act. Such consultative service shall be provided as indicated and will be directed toward assisting the facility in meeting the prescribed Federal Regulations.

9. Provide such staff as is necessary to assist the DISRS in drafting informational and instructional materials to be used for the purposes of training staff. Such training shall not be limited to surveying and certification but shall include indepth training as to the nature and scope of the Title XIX Program including policies, procedures, and requirements.

AMOUNT DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED CATEGORICALLY NEEDY

A. A lien may be filed and enforced against the real property of a recipient who is an inpatient in a nursing facility, ICF/MR or other medical institution in certain instances after notice and opportunity for a hearing has been provided.

STATE Oklahoma A
DATE REC'D 10-12-94
DATE APPV'D 11-04-94
EFF DATE 07-01-94
HCFA 179

1. No lien may be filed on the home property if the client's family includes any of the following:

   a. A surviving spouse residing in the home, or
   b. A child or children age 20 or less lawfully residing in the home, or
   c. A disabled child or children lawfully residing in the home, or
   d. A brother or sister of the recipient who has an equity interest in the home and has been residing in the home for at least one (1) year immediately prior to the recipient's admission to the nursing facility and who has continued to live there on a continuous basis since that time.

2. A lien may be filed only after it has been determined, after notice and opportunity for a hearing, that the recipient cannot reasonably be expected to be discharged and return to the home. To return home means the recipient leaves the nursing facility and resides in the home on which the lien has been placed for a period of at least 90 days without being readmitted as an inpatient to a medical or nursing facility.

3. When enforcing a lien would create an undue hardship, it will not be enforced. Undue hardship exists when enforcing the lien would deprive the individual of medical care such that his/her life would be endangered. Undue hardship does not exist, however, where the individual or his/her family is merely inconvenienced or where their lifestyle is restricted because of the lien or estate recovery being enforced.

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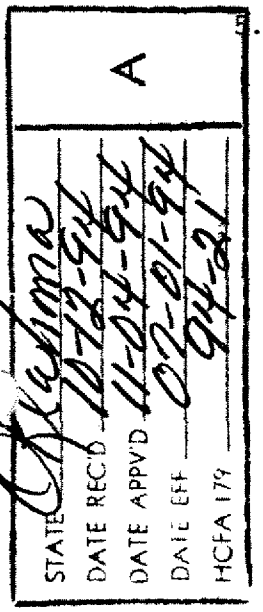
4. The lien filed by the Agency for medical assistance correctly received may be enforced before or after the death of the recipient. But it may be enforced only:

   a. After the death of the surviving spouse of the recipient,
   b. When there is no child of the recipient, natural or adopted, who is twenty (20) years of age or less residing in the home,

AMOUNT DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED CATEGORICALLY NEEDY

c. When there is no adult child of the recipient, natural or adopted, who is blind or disabled residing in the home.

d. When no brother or sister of the recipient is lawfully residing in the home, who has resided there for at least one (1) year immediately before the date of the recipient's admission to the nursing facility, and has resided there on a continuous basis since that time.



5. The lien remains on the property even after transfer of the title by conveyance, sale, succession, inheritance or will unless one of the following events occur:

a. It remains until the lien is satisfied. The recipient or recipient's representative may discharge the lien at any time by paying the amount of lien to the Agency. By statute, a fine may be levied against the lien holder if it is not released in a timely manner.

b. After a lien is filed against the real property, it will be dissolved if the client leaves the nursing facility and resides in the property to which the lien is attached for a period of more than 90 days without being readmitted as an inpatient to a medical or nursing facility, even though there may have been no reasonable expectation that this would occur. If the recipient is readmitted to a nursing or medical facility during this period, and does return to his/her home after being released, another 90 days must be completed before the lien can be dissolved.

6. If a recipient was age 55 or older when the nursing care was received, adjustment or recovery may be made only after the death of the individual's spouse, if any, and at a time when there are no surviving children age 20 or less and no surviving disabled children of any age living in the home.

7. The estate consists of all real and personal property and other assets included in recipient's estate as defined by Title 58 of the Oklahoma statutes and any other real and personal property and other assets in which the recipient has any legal title or interest at the time of death (to the extent of that interest), including such assets conveyed to survivor, heir or any other party through joint tenancy, tenancy in common, survivorship, life estate, living trust or other arrangements.

Medicaid Premiums and Cost Sharing

State Name: Oklahoma

OMB Control Number: 0938-1148

Transmittal Number: OK - 14 - 0014

Cost Sharing Requirements — G1

1916
1916A
42 CFR 447.50 through 447.57 (excluding 447.55)

The state charges cost sharing (deductibles, co-insurance or co-payments) to individuals covered under Medicaid. Yes

☑ The state assures that it administers cost sharing in accordance with sections 1916 and 1916A of the Social Security Act and 42 CFR 447.50 through 447.57.

General Provisions

☑ The cost sharing amounts established by the state for services are always less than the amount the agency pays for the service.

☐ No provider may deny services to an eligible individual on account of the individual's inability to pay cost sharing, except as elected by the state in accordance with 42 CFR 447.52(e)(1).

☐ The process used by the state to inform providers whether cost sharing for a specific item or service may be imposed on a beneficiary and whether the provider may require the beneficiary to pay the cost sharing charge, as a condition for receiving the item or service, is (check all that apply):

- ☒ The state includes an indicator in the Medicaid Management Information System (MMIS)
- ☐ The state includes an indicator in the Eligibility and Enrollment System
- ☒ The state includes an indicator in the Eligibility Verification System
- ☐ The state includes an indicator on the Medicaid card, which the beneficiary presents to the provider
- ☐ Other process

☐ Contracts with managed care organizations (MCOs) provide that any cost-sharing charges the MCO imposes on Medicaid enrollees are in accordance with the cost sharing specified in the state plan and the requirements set forth in 42 CFR 447.50 through 447.57.

Cost Sharing for Non-Emergency Services Provided in a Hospital Emergency Department

The state imposes cost sharing for non-emergency services provided in a hospital emergency department. No

Cost Sharing for Drugs

The state charges cost sharing for drugs. Yes

The state has established differential cost sharing for preferred and non-preferred drugs. No

☐ All drugs will be considered preferred drugs.

State: Oklahoma
Date Received: 30 September, 2014
Date Approved: 4 October, 2019
Date Effective: 1 July, 2014
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Beneficiary and Public Notice Requirements

☑ Consistent with 42 CFR 447.57, the state makes available a public schedule describing current cost sharing requirements in a manner that ensures that affected applicants, beneficiaries and providers are likely to have access to the notice. Prior to submitting a SPA which establishes or substantially modifies existing cost sharing amounts or policies, the state provides the public with advance notice of the SPA, specifying the amount of cost sharing and who is subject to the charges, and provides reasonable opportunity for stakeholder comment. Documentation demonstrating that the notice requirements have been met are submitted with the SPA. The state also provides opportunity for additional public notice if cost sharing is substantially modified during the SPA approval process.

Other Relevant Information

When changes to cost sharing are made and to meet the notice requirements to alert providers of changes in cost sharing policy, the State will initiate a notice process that is consistent with the process described in 42 CFR 447.205, which is used to inform providers and the public of any payment rate changes. This process will inform providers of any changes in Statewide method or standards for setting payment rates. To engage stakeholders, State Plan amendments and/or changes in policy are presented at regularly scheduled, bi-monthly Tribal Consultations and the proposed SPA page, noting the changes in red-line, are posted for a 30-day public review period on the Agency's website. Significant changes in rates and methodology are considered by the State Plan Rate Committee as well as the OHCA Board of Directors. In accordance with 42 CFR 447.57, member letter OHCA 2014-03 regarding the changes in co-pays was sent to all SoonerCare members and the current cost sharing public schedule is available on the Agency's public website at http://okhca.org/benefitcomparison.

PRA Disclosure Statement

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State: Oklahoma
Date Received: 30 September, 2014
Date Approved: 4 October, 2019
Date Effective: 1 July, 2014
Transmittal Number: 14-0014

Medicaid Premiums and Cost Sharing

State Name: Oklahoma

OMB Control Number: 09381148

Transmittal Number: OK - 23 - 0006

Cost Sharing Amounts - Categorically Needy Individuals G2a

1916
1916A
42 CFR 447.52 through 54

The state charges cost sharing to all categorically needy (Mandatory Coverage and Options for Coverage) individuals. Yes

Services or Items with the Same Cost Sharing Amount for All Incomes

Add	Service or Item	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Inpatient Hospital Services	10.00	$	Day	Up to $75.00 maximum	Remove
Add	Outpatient Hospital Services	4.00	$	Visit		Remove
Add	Organized Outpatient Clinic Services	4.00	$	Visit		Remove
Add	Ambulatory Surgery Services	4.00	$	Visit		Remove
Add	Physicians Services	4.00	$	Visit	$0 copay for the administration of Advisory Committee on Immunization Practices (ACIP) recommended Vaccines	Remove
Add	Physician Assistant/ Anesthesiologist Assistant	4.00	$	Visit		Remove
Add	Advanced Practice Nurse Services	4.00	$	Visit		Remove
Add	Optometrist Services	4.00	$	Visit		Remove
Add	Dental Services	4.00	$	Visit		Remove
Add	Durable Medical Equipment Services	4.00	$	Item	Blood glucose testing supplies & insulin syringes have $0 copay.	Remove
Add	Home Health Agency Services	4.00	$	Visit		Remove
Add	Rural Health Clinic (RHC) Services	4.00	$	Visit		Remove
Add	Federally Qualified Health Center (FQHC) Services	4.00	$	Visit		Remove
Add	Medicare Part B Crossover Claims	1.00	$	Visit		Remove
Add	Behavioral health and substance abuse services - inpatient	10.00	$	Day	Up to $75.00 maximum	Remove

Add	Service or Item	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Behavioral health and substance abuse services - outpatient	3.00	$	Visit		Remove
Add	Laboratory and X-ray Services	4.00	$	Visit		Remove
Add	Prescription Drugs	4.00	$	Prescription	Limited to the drug benefit under the state plan. Tobacco cessation products have $0 copay. Prenatal vitamins have $0 copay. Birth control has a $0 copay. Naloxone have $0 copay. Medication assisted treatments for opioid use have $0 copay.	Remove
Add	Preferred generic drugs for HCBS waiver members	0.00	$	Prescription	HCBS waiver members incur tiered copays for prescription drugs through an additional benefit that is supplied through the 1915(c) HCBS waivers.	Remove
Add	Prescription Drugs drug valued between $0 - $10.00 for HCBS waiver members	0.65	$	Prescription	HCBS waiver members incur tiered copays for prescription drugs through an additional benefit that is supplied through the 1915(c) HCBS waivers.	Remove
Add	Prescription Drugs drug valued between $10.01 - $25.00 for HCBS waiver members	1.20	$	Prescription	HCBS waiver members incur tiered copays for prescription drugs through an additional benefit that is supplied through the 1915(c) HCBS waivers.	Remove
Add	Prescription Drugs drug valued between $25.01 - $50.00 for HCBS waiver members	2.40	$	Prescription	HCBS waiver members incur tiered copays for prescription drugs through an additional benefit that is supplied through the 1915(c) HCBS waivers.	Remove
Add	Prescription Drugs drug valued at $50.01 or more for HCBS waiver members	3.50	$	Prescription	HCBS waiver members incur tiered copays for prescription drugs through an additional benefit that is supplied through the 1915(c) HCBS waivers.	Remove
Add	State Plan Personal Care Services	4.00	$	Visit		Remove
Add	Physical Therapy/Occupational Therapy/Speech and Audiologist Therapy (PT/OT/ST)	4.00	$	Visit		Remove
Add	Alternative Treatment for Pain Mangement	4.00	$	Visit		Remove
Add	Prosthetics and Orthotics	4.00	$	Prescription		Remove

Services or Items with Cost Sharing Amounts that Vary by Income

Service or Item: Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

Add	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add							Remove

Add Service or Item

Cost Sharing for Non-preferred Drugs Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-preferred drugs (entered above), answer the following question:

The state charges cost sharing for non-preferred drugs to otherwise exempt individuals.

Cost Sharing for Non-emergency Services Provided in the Hospital Emergency Department Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-emergency services provided in the hospital emergency department (entered above), answer the following question:

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals.

PRA Disclosure Statement

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V.20181119

Medicaid Premiums and Cost Sharing

State Name: Oklahoma

OMB Control Number: 0938-1148

Transmittal Number: OK - 14 - 0014

Cost Sharing Amounts - Medically Needy Individuals	G2b
1916 1916A 42 CFR 447.52 through 54	
The state charges cost sharing to all medically needy individuals.	No

PRA Disclosure Statement

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V.20181119

State: Oklahoma
Date Received: 30 September, 2014
Date Approved: 4 October, 2019
Date Effective: 1 July, 2014
Transmittal Number: 14-0014

Medicaid Premiums and Cost Sharing

State Name: Oklahoma

OMB Control Number: 0938-1148

Transmittal Number: OK - 14 - 0014

Cost Sharing Amounts - Targeting	G2c
1916 1916A 42 CFR 447.52 through 54	
The state targets cost sharing to a specific group or groups of individuals.	No

PRA Disclosure Statement

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V.20181119

State: Oklahoma
Date Received: 30 September, 2014
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Medicaid Premiums and Cost Sharing

State Name: Oklahoma

OMB Control Number: 0938-1148

Transmittal Number: OK - 14 - 0014

Cost Sharing Limitations

G3

State: Oklahoma
Date Received: 30 September, 2014
Date Approved: 4 October, 2019
Date Effective: 1 July, 2014
Transmittal Number: 14-0014

42 CFR 447.56
1916
1916A

☑ The state administers cost sharing in accordance with the limitations described at 42 CFR 447.56, and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act, as follows:

Exemptions

Groups of Individuals - Mandatory Exemptions

The state may not impose cost sharing upon the following groups of individuals:

☐ Individuals ages 1 and older, and under age 18 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118).

☐ Infants under age 1 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118), whose income does not exceed the higher of:

- ☐ 133% FPL; and
- ☐ If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act, up to 185 percent.

☐ Disabled or blind individuals under age 18 eligible for the following eligibility groups:

- ☐ SSI Beneficiaries (42 CFR 435.120).
- ☐ Blind and Disabled Individuals in 209(b) States (42 CFR 435.121).
- ☐ Individuals Receiving Mandatory State Supplements (42 CFR 435.130).

☐ Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age.

☐ Disabled children eligible for Medicaid under the Family Opportunity Act (1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act).

☐ Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends, except for cost sharing for services specified in the state plan as not pregnancy-related.

☐ Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.

☐ An individual receiving hospice care, as defined in section 1905(o) of the Act.

☐ Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services.

☐ Individuals who are receiving Medicaid because of the state's election to extend coverage to the Certain Individuals Needing Treatment for Breast or Cervical Cancer eligibility group (42 CFR 435.213).

Groups of Individuals - Optional Exemptions

The state may elect to exempt the following groups of individuals from cost sharing:

The state elects to exempt individuals under age 19, 20 or 21, or any reasonable category of individuals 18 years of age or over. Yes

Indicate below the age of the exemption:

- ○ Under age 19
- ○ Under age 20
- ◉ Under age 21
- ○ Other reasonable category

State: Oklahoma
Date Received: 30 September, 2014
Date Approved: 4 October, 2019
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The state elects to exempt individuals whose medical assistance for services furnished in a home and community-based setting is reduced by amounts reflecting available income other than required for personal needs. No

Services - Mandatory Exemptions

The state may not impose cost sharing for the following services:

- ☐ Emergency services as defined at section 1932(b)(2) of the Act and 42 CFR 438.114(a).
- ☐ Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which the state claims or could claim federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies.
- ☐ Preventive services, at a minimum the services specified at 42 CFR 457.520, provided to children under 18 years of age regardless of family income, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics.
- ☐ Pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p), and counseling and drugs for cessation of tobacco use. All services provided to pregnant women will be considered pregnancy-related, except those services specificially identified in the state plan as not being related to pregnancy.
- ☐ Provider-preventable services as defined in 42 CFR 447.26(b).

Enforceability of Exemptions

The procedures for implementing and enforcing the exemptions from cost sharing contained in 42 CFR 447.56 are (check all that apply):

- ☐ To identify that American Indians/Alaskan Natives (AI/AN) are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services in accordance with 42 CFR 447.56(a)(1)(x), the state uses the following procedures:
  - ☒ The state accepts self-attestation
  - ☒ The state runs periodic claims reviews
  - ☐ The state obtains an Active or Previous User Letter or other Indian Health Services (IHS) document
  - ☒ The Eligibility and Enrollment and MMIS systems flag exempt recipients

☐ Other procedure

Additional description of procedures used is provided below (optional):

The State undertakes the following processes to ensure individuals who meet cost sharing exemptions as per 42 CFR 447.56(a)(1)(x) are not assessed cost sharing:
• An automatic, periodic claims review which examines members' claims to verify if they have incurred a paid claim from an Indian Health facility or contracted health services provider. When applicable, the information is loaded into MMIS to ensure no cost sharing is applied.

• The Agency's accepts self-attestation in accordance with 42 CFR 447.56(a)(1)(x) in the following way:
- From September 1, 2019 to June 30, 2020, the State will accept verbal self-attestation (i.e., via telephone) for individuals who meet the requirements for cost sharing exemptions as per the federal regulation noted above during the interim period while the State makes necessary changes to the online application for self-attestation cost sharing exemptions. Individuals will need to verbally respond “yes” when asked if they are AI/AN and must also respond “yes” when asked if they are eligible to receive, is currently receiving, or has ever received an item or service furnished by an Indian health care provider or through referral under contract health services. In order to be exempt from cost sharing, there must be an affirmative answer to both questions from the individual(s). The State accepts verbal self-attestation at face value based on the aforementioned process and will not conduct or require any other verification. The verbal self-attestation mirrors the self-attestation process that the online application will apply beginning July 1, 2020.
- Beginning July 1, 2020, the online SoonerCare application will ask the applicant(s) whether they are AI/AN; if the applicant(s) responds "yes", a follow-up question will require an answer as to whether the applicant(s) is eligible to receive, is currently receiving, or has ever received an item or service furnished by an Indian health care provider or through referral under contract health services. If the applicant(s) responds "yes" to the second question, the applicant(s) will be exempt from all cost sharing. In order to be exempt from cost sharing, there must be an affirmative answer to both questions from the applicant(s). The State accepts self-attestation at face value based on the aforementioned process and will not conduct or require any other verification.

☐ To identify all other individuals exempt from cost sharing, the state uses the following procedures (check all that apply):

☒ The MMIS system flags recipients who are exempt

☐ The Eligibility and Enrollment System flags recipients who are exempt

☐ The Medicaid card indicates if beneficiary is exempt

☐ The Eligibility Verification System notifies providers when a beneficiary is exempt

☐ Other procedure

State: Oklahoma
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Additional description of procedures used is provided below (optional):

MMIS is programmed not to deduct copayments from claims for Medicaid recipients and services that are exempt from cost sharing as identified in 42 CFR 447.56(a).

Payments to Providers

☑ The state reduces the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing, except as provided under 42 CFR 447.56(c).

Medicaid Premiums and Cost Sharing

Payments to Managed Care Organizations

The state contracts with one or more managed care organizations to deliver services under Medicaid. No

Aggregate Limits

☑ Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household do not exceed an aggregate limit of 5 percent of the family's income applied on a quarterly or monthly basis.

☑ The percentage of family income used for the aggregate limit is:

- (•) 5%
- ( ) 4%
- ( ) 3%
- ( ) 2%
- ( ) 1%
- ( ) Other: [ ] %

State: Oklahoma
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☑ The state calculates family income for the purpose of the aggregate limit on the following basis:

- ( ) Quarterly
- (•) Monthly

The state has a process to track each family's incurred premiums and cost sharing through a mechanism that does not rely on beneficiary documentation. Yes

☑ Describe the mechanism by which the state tracks each family's incurred premiums and cost sharing (check all that apply):

☒ As claims are submitted for dates of services within the family's current monthly or quarterly cap period, the state applies the incurred cost sharing for that service to the family's aggregate limit. Once the family reaches the aggregate limit, based on incurred cost sharing and any applicable premiums, the state notifies the family and providers that the family has reached their aggregate limit for the current monthly or quarterly cap period, and are no longer subject to premiums or cost sharing.

☐ Managed care organization(s) track each family's incurred cost sharing, as follows:

☒ Other process:

The agency considers all cost sharing to be paid by the beneficiary in the calculation of whether a beneficiary has incurred out-of-pocket expenses up to the family's aggregate limit. The State's MMIS calculates family income for the purpose of the aggregate limit on a monthly basis. To accommodate households in different delivery systems (i.e., ABD and TANF combined families; MCO and PCCM or different forms of managed care combined families; managed care and fee-for-service combined families), cost sharing is tracked for each beneficiary and a report is provided to Agency staff to analyze and ensure the beneficiary out-of-pocket expenses do not exceed the family's aggregate limit.

Describe how the state informs beneficiaries and providers of the beneficiaries' aggregate family limit and notifies beneficiaries and providers when a beneficiary has incurred premiums and cost sharing up to the aggregate family limit and individual family members are no longer subject to premiums or cost sharing for the remainder of the family's current monthly or quarterly cap period:

The Agency informs beneficiaries of their aggregate household cost sharing cap amount upon eligibility determination via a member letter or a secure e-message. A separate notification will be issued to beneficiaries when they have incurred premiums and cost sharing up to the aggregate family limit and are no longer subject to premiums or cost-sharing on a monthly basis. Beneficiaries of households in different delivery systems (i.e., ABD and TANF combined families; MCO and PCCM or different forms of managed care combined families; managed care and fee-for-service combined families) are informed via a member letter or a secure e-message of their aggregate household cost sharing cap amount as well as when they have incurred premiums and cost sharing up to the aggregate family limit and are no longer subject to premiums or cost sharing during any monthly cap period.

Providers have access to a secure electronic portal which allows them to determine if a member is subject to a copay. When individual family members are no longer subject to cost sharing for the remainder of the family's monthly cap period, the secure electronic portal will reflect that the member should not be charged a copay prompting the provider to notify the member. A zero dollar copay is indicated for those members/services not subject to cost sharing.

The state has a documented appeals process for families that believe they have incurred premiums or cost sharing over the aggregate limit for the current monthly or quarterly cap period. Yes

Describe the appeals process used:

Members can appeal the calculation of the aggregate cap; members are also notified of appeal rights at the initial eligibility determination and upon redetermination of the member's eligibility. Members may contact the SoonerCare Helpline at 1-800-987-7767. A representative will review the Member Cost Sharing information in the MMIS to be able to determine the amount of cost sharing that has been processed in the current review period and verify if the member has made over payments in cost sharing. Member Services and Provider Services Representatives educate providers to refund members who have overpaid cost sharing. Members have the right to appeal the decision through the official OHCA member appeals process as per Oklahoma Administrative Code (OAC): 317:2-1-2.

Describe the process used to reimburse beneficiaries and/or providers if the family is identified as paying over the aggregate limit for the month/quarter:

The MMIS system tracks cost sharing expenditures incurred across household members and re-sets at the beginning of each month. Systematic tracking of cost sharing occurs in real time as claims are adjudicated in MMIS. Providers have access through a secure electronic portal to information that the member should not be charged a copay. Further, if the member is identified as paying over the aggregate limit for the month, the provider will issue reimbursement to the member. If the State is responsible for reimbursement to the provider, the State will re-process the claim with provider and notify provider to reimburse the member.

Describe the process for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium:

Members can request a reassessment of their 5% aggregate cap when they update information regarding their change in circumstances at any time using Oklahoma's online application or they can call the SoonerCare Helpline to have a representative update their information.

The state imposes additional aggregate limits, consistent with 42 CFR 447.56(f)(5). No

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V.20160722

State: Oklahoma
Date Received: 30 September, 2014
Date Approved: 4 October, 2019
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Transmittal Number: 14-0014

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Oklahoma

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State: Oklahoma
Date Received: 30 September, 2014
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Effective Date: 1 July, 2014
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Oklahoma

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State: Oklahoma
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Oklahoma

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Effective Date: 1 July, 2014
Transmittal Number: 14-0014

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Oklahoma

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State: Oklahoma
Date Received: 30 September, 2014
Date Approved: 4 October, 2019
Effective Date: 1 July, 2014
Transmittal Number: 14-0014

State: Oklahoma

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State: Oklahoma
Date Received: 30 September, 2014
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Transmittal Number: 14-0014

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Date Received: 30 September, 2014
Date Approved: 4 October, 2019
Effective Date: 1 July, 2014
Transmittal Number: 14-0014

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES INPATIENT HOSPITAL SERVICES

The Oklahoma Title XIX Program reimburses appropriately licensed and certified hospitals for inpatient services as outlined in this plan. Procedures and policies governing state licensure, certification of providers, utilization review, and any other aspect of State regulation of the Title XIX Program not relating to the method of computing payment rates for inpatient services are affected by this plan.

I. PUBLIC PROCESS

The state has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

II. GENERAL REIMBURSEMENT POLICY

The Oklahoma Health Care Authority (hereafter called the OHCA) will reimburse inpatient hospital services rendered on or after October 1, 2005, in the following manner:

A. Covered inpatient services (including organ transplants) provided to eligible Medicaid recipients admitted to in-state acute care hospitals and acute care inpatient units will be reimbursed by the methodology set forth in Section VI of this plan, unless the hospital or unit is classified into one of the categories outlined in subsections C through F below.

B. Covered inpatient services provided to eligible recipients of the Oklahoma Medicaid program, when treated in out-of-state hospitals will be reimbursed in the same manner as in-state hospitals by the methodology set forth in Section VI of this plan, unless the hospital is classified in the category in subsection F below. Reimbursement for inpatient hospital services shall not exceed the rate paid by Medicare.

i. In the event an out-of-state provider will not accept the payment rate established under Section VI of this plan, the state will either: a) negotiate a reimbursement rate equal to the rate paid by Medicare, unless otherwise specified in the plan; or b) services that are not covered by Medicare, but are covered by the plan, will be reimbursed as determined by the State.

C. Inpatient services provided in Freestanding Rehabilitation and Freestanding Psychiatric Hospitals will be reimbursed using the per diem system outlined in Section III of this plan. Pediatric, psychiatric, substance abuse, and rehabilitation cases treated in Medicare PPS non-exempt general acute care hospitals or non-PPS exempt units will be included in the DRG PPS in Section VI of this plan. Freestanding Rehabilitation and Freestanding Psychiatric hospitals operated by units of government and Children's Hospitals included in the DRG PPS in Section VI of this plan may receive an additional payment not to exceed 100% of their allowable costs under Medicare payment principles.

D. Long Term Care Hospitals serving children will be reimbursed using the per diem system outlined in Section IV of this plan.

E. Indian Health Services hospitals will be reimbursed using a per diem rate published by the Office of Management and Budget.

State: Oklahoma
Date Received: August 9, 2019
Date Approved: SEP 09 2019
Date Effective: September 1, 2019
Transmittal Number: 19-0009

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES INPATIENT HOSPITAL SERVICES

II. GENERAL REIMBURSEMENT POLICY (continued)

F. Covered inpatient services provided in out-of-state specialty hospitals may be reimbursed at a negotiated rate not to exceed 100% of the cost to provide the service. Negotiation of rates will only be allowed when the OHCA determines that the specialty hospital or specialty unit provides a unique (non-experimental) service required by Medicaid recipients and the provider will not accept the payment rate established under Section V of this plan. Prior Authorization is required.

G. New providers entering the Medicaid program will be assigned a peer group and will be reimbursed at the peer group base rate for the DRG PPS payment method or the statewide median rate for per diem methods.

H. All hospitals which meet the criteria in Section VI of this plan will be eligible for graduate medical education payments.

I. All hospitals which meet the criteria in Section VIII of this plan will be eligible for a disproportionate share adjustment.

J. Effective for services provided on or after February 1, 2010, approved inpatient hospital rates will not be paid for three national coverage determinations which relate to serious, preventable errors in medical care. These errors include surgery performed on wrong body part, surgery performed on wrong patient, and wrong surgery performed on patient.

K. Effective for services provided on or after April 1, 2010, approved inpatient hospital rates will not be paid for Hospital Acquired Conditions (HACs) that are identified as non-payable by Medicare.

III. PAYMENT METHODOLOGY FOR FREESTANDING REHABILITATION, AND FREESTANDING PSYCHIATRIC HOSPITALS

Effective October 1, 2005, reimbursement to freestanding rehabilitation and psychiatric hospitals for inpatient hospital services is paid on a prospective per diem level of care payment system. There are two distinct payment components under this system. Total per diem reimbursement will equal the sum of:

Level of care operating per diem
+
Fixed capital per diem

A. Level of Care Operating Per Diem Rates

1. The level of care per diem rates are payments for allowable operating costs and movable capital costs as defined in HCFA publication 15-1 for Medicare cost reporting purposes and reported on the HCFA 2552. No return on equity is included in the per diem rate. There are eight levels of care. For each level of care category, the payment rate was established based on the statewide rate in effect on September 30, 2005, for providing services within that level of care.

STATE Oklahoma
DATE REC'D. 2-1-10
DATE APPV'D 5-5-10
DATE EFF 2-1-10
HCFA 179 10-03
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

III. PAYMENT METHODOLOGY FOR FREESTANDING REHABILITATION, AND FREESTANDING PSYCHIATRIC HOSPITALS (continued)

A. Level of Care Operating Per Diem Rates (continued)

2. When submitted for payments, claims are classified into these levels of care based on revenue codes, diagnosis codes, and/or procedure codes.

Each of these levels of care, and the basis used to assign claims into a particular level of care are listed below:

Level of Care	Basis of Assignment
1. Burn Care	Presence of burn unit revenue code charges
2. Neonatal Intensive Care Unit (NICU)	Presence of neonatal intensive care revenue code charges on NICU claims from Level III NICU providers
3. Maternity Care	Diagnosis Codes
4. Surgical Care	Presence of surgical revenue code charges including C-Sections. Specified routine inpatient surgical procedures are excluded.
5. Rehabilitation Care	Range of primary and secondary diagnosis codes
6. Psychiatric Care	Range of primary diagnosis codes
7. Intensive Care Unit	Presence of Intensive Care Unit/Coronary Care Unit revenue code charges
8. Routine Care	All remaining days and specified routine inpatient surgical procedures

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

III. PAYMENT METHODOLOGY FOR FREESTANDING REHABILITATION, AND FREESTANDING PSYCHIATRIC HOSPITALS (continued)

A. Level of Care Operating Per Diem Rates (continued)

3. Claims are classified into each of these levels of care based on the hierarchy shown above, with claims potentially classifying into Level 1 first, then Level 2, and so forth. Payment for claims classified into Levels 1-6 and Level 8 is made at a single level of care rate. Reclassifications of surgical procedures between levels 4 and 8 would be considered a change in the payment methods and standards requiring a state plan amendment.

4. All claims from freestanding inpatient psychiatric hospitals will be paid at the Psychiatric Level of Care Rate of Level 6.

5. These levels of care rates are calculated from 1988 claims and uniform cost report data from each provider's fiscal year ending in calendar 1988. Costs were inflated to a common point of time prior to calculation of the median cost per day.

B. Fixed Capital Per Diem Rate

The fixed capital per diem rate is payment for allowable fixed capital costs as defined in HCFA publication 15-1 for Medicare cost reporting purposes and reported on the HCFA 2552. No return on equity is included in the per diem rate. The fixed capital rates were established at the statewide rate in effect on September 30, 2005, for providing services. The rate is calculated separately for freestanding rehabilitation hospitals and freestanding psychiatric hospitals using different methodologies.

1. Fixed capital per diem methodology for freestanding rehabilitation inpatient hospitals.
Inpatient hospital fixed capital per diem cost will be reimbursed using a peer group fixed capital weighted payment method. The weighted fixed capital component will be calculated as follows:

Step 1. Hospitals (including general acute care hospitals) will be divided into categories based on level of care of the services offered using the statewide or peer group medians. As of February 1, 1993, there are five categories:

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

III. PAYMENT METHODOLOGY FOR FREESTANDING REHABILITATION, AND FREESTANDING PSYCHIATRIC HOSPITALS (continued)

B. Fixed Capital Per Diem Rate (continued)

1. Fixed capital per diem methodology for freestanding rehabilitation inpatient hospitals. (continued)

a. Teaching hospitals with burn and NICU units.
b. Teaching hospitals with NICU units, but no burn unit.
c. Teaching hospitals without NICU or burn unit.
d. Non-teaching hospitals with NICU units, but no burn unit.
e. Non-teaching hospitals with no burn or NICU unit.

There are five peer groups based on level of care of the service offered. Additional categories will be determined for hospitals that do not fall within the categories listed in Step 1 above. A new plan page will be submitted if it is determined that additional categories are needed.

Step 2. The sum of each level of care offered within a category will be divided by the number of patient levels of care offered within a category to arrive at an average per diem for each category.

Step 3. A value factor for each patient level of care within a category will be determined by dividing the operating (level of care) prospective rate for each level of care by the average operating (level of care) prospective rate for each category.

Step 4. The value factor (from Step 3) will be multiplied by the statewide median.

The statewide median per diem capital amount is calculated from 1989 uniform cost report data from each fiscal year ending in calendar 1989. Costs were inflated to a common point in time prior to the calculation of the median cost per day

2. Fixed capital per diem methodology for freestanding psychiatric hospitals.
Inpatient psychiatric hospitals fixed rate capital cost will be reimbursed using the average fixed rate capital cost of all Medicaid enrolled freestanding psychiatric inpatient hospitals from calendar year 1991 cost reports.

00-14

STATE Oklahoma
DATE RECD 7-12-05
DATE APP'D 9-27-05
DATE EFF 10-1-05
TN # 05-06

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

III. PAYMENT METHODOLOGY FOR FREESTANDING REHABILITATION AND FREESTANDING PSYCHIATRIC HOSPITALS *(continued)*

C. Updates

1. The level of care operating and fixed capital per diem rates in effect on December 31, 2006, for psychiatric hospitals will be updated by a factor of 9.76% and 22.9% for rehabilitation hospitals. The rates in effect on December 31, 2007 will be updated by a factor of 3.2%.

2. Effective 05-01-09, Valir Rehab Hospital will be paid at a fixed rate per-diem based on its reported cost per day reported on the 12-31-07 cost report brought forward to the base rate period of Calendar year 2009 by the latest available Global Insight published "2002 Based CMS Hospital Prospective Reimbursement Market Basket" forecasts.

3. The rates will be reviewed annually and any annual updates will not exceed the marketbasket increase in rehabilitation, psychiatric, and long term care facilities (RPL) marketbasket index for the current rate year.

4. Effective 04-01-10, the rate in effect as of 03-31-10 will be decreased by 3.25%.

5 Effective 07-01-14, the rate in effect as of 06-30-14 will be decreased by 7.75%.

6. Effective for services provided on or after 01-01-16, the rate in effect as of 12-31-15 will be decreased by 3% for freestanding rehabilitation hospitals only.

7. Effective for services provided on or after 05-01-16, the rate in effect as of 04-30-16 will be decreased by 3% for freestanding psychiatric hospitals only.

8. Effective for services provided on or after 07-01-18, the rate in effect as of 06-30-18 will be increased by 3% for freestanding psychiatric hospitals only.

9. Effective for services provided on or after 10-01-18, the rate in effect as of 09-30-18 will be increased by 3% for freestanding rehabilitation hospitals only.

10. Effective for services provided on or after 10-01-19, the rate in effect as of 09-30-19 will be increased by 5% for freestanding rehabilitation hospitals only.

IV. PAYMENT METHODOLOGY FOR LONG TERM CARE HOSPITALS SERVING CHILDREN (LTCHs-C)

Effective for services provided on or after July 1, 2012, payment will be made to freestanding long term care hospitals serving children for sub-acute care level of services.

A. Definitions

1. Ancillary Services. Refers to those services that are not considered inpatient routine services. Ancillary services include laboratory, radiology, and prescription drugs. Ancillary services may also include other special items and services for which charges are customarily made in addition to a routine VI service charge.

2. Average Length of Stay. To be determined a long term care hospital, the hospital must have a Medicaid average length of stay of greater than 25 days.

3. Children. For the purpose of this reimbursement rate, children are defined as individuals under the age of 21.

4. Routine Services. Services include but are not limited to: regular room, dietary and nursing services, minor medical and surgical supplies, over-the-counter medications, transportation, and the use and maintenance of equipment and facilities essential to the provision of routine care. Routine services should be patient specific and in accordance with standard medical care.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

IV. PAYMENT METHODOLOGY FOR LONG TERM CARE HOSPITALS SERVING CHILDREN (LTCHs-C) (continued)

A. Definitions (continued)

5. Sub-acute Level of Care. Skilled care provided by a long term care hospital to patients with medically complex needs. Patients receiving treatment include: children with complex pulmonary problems; children requiring long term care to improve or maintain their physical condition or prevent deterioration; children who are terminally ill; and children who are experiencing severe developmental disabilities and multi-handicaps.

B. Eligible Providers

To be eligible for reimbursement, a long term care hospital must:

1. be Medicare certified and have a current contract on file with the Oklahoma Health Care Authority;
2. be designated as a long term care facility by the CMS and be licensed by the Oklahoma State Health Department as a Children's Specialty Hospital.
3. be engaged in providing sub-acute nursing and rehabilitative services to children.
4. maintain an average daily census of 85% children to remain eligible for reimbursement rate. The census must be based on the entire facility and not a distinct part.

C. Reimbursement

1. Base Rate - Effective July 1, 2012, LTCH-C will be paid an interim rate based on the previous year's cost report (CMS 2552) data and settled to total allowable costs based on the current year's cost report. Total allowable cost will be determined in accordance with Medicare principles of reimbursement.

2. Hospital Leave and Therapeutic Leave - LTCH-Cs providing sub-acute routine level of care services will not be eligible for acute hospital leave or therapeutic leave.

3. Ancillary Services - May be billed separately to the Oklahoma Medicaid Program, unless reimbursement is available from Medicare or other insurance or benefits programs.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

V. APPEALS – PER DIEM PAYMENTS

A. Any hospital wishing to appeal its prospective rate shall submit a written request to the OHCA within 30 days of receipt of the letter notifying the hospital of its level of care rate. This time period may be extended: (i) upon agreement between the OHCA and the hospital or (ii) by the OHCA upon the hospital's submission of a request for an extension of time, within the thirty-day period, showing good cause for the extension.

B. The request must specify: (i) the nature of the adjustment sought; (ii) the amount of the adjustment sought; and (iii) the reasons or factors that the hospital believes justify an adjustment.

C. In addition, the request must include an analysis demonstrating the extent to which the hospital is incurring or expects to incur a marginal loss as defined below in providing covered services to Title XIX Medicaid clients.

D. "Marginal loss" as used in this plan means the amount by which the hospital's marginal cost exceeds the total Title XIX Medicaid reimbursement (excluding any disproportionate share payment adjustments) paid to the hospital for inpatient services. For purposes of this plan, "marginal cost" means a hospital's total variable costs incurred in providing covered inpatient services to Title XIX Medicaid clients. In calculating marginal cost, a hospital shall assume that the ratio of variable costs to total allowable costs is 70%.

E. The written request for an exception or other rate adjustment must contain the information specified in paragraph V.B. The OHCA will acknowledge receipt of the written request within 30 days after actual receipt. The OHCA may request additional documentation or information from the hospital as may be necessary for the OHCA to render a decision. The OHCA shall make a decision upon the hospital's request for an exception or adjustment within 90 days after receipt of all additional documentation or information requested.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

VI. PER DISCHARGE PROSPECTIVE PAYMENT METHODOLOGY FOR HOSPITALS

Payment for admissions for all covered inpatient services rendered to Title XIX recipients admitted to acute care hospitals (other than those identified in Section II, subsections C through E) on or after October 1, 2005, shall be either the lesser of billed charges or based on a prospective payment approach which compensates hospitals an amount per discharge for discharges classified according to the Diagnosis Related Group (DRG) methodology. For each Medicaid recipient's stay, a peer group base rate is multiplied by the relative weighting factor for DRG which applies to the hospital stay. The result is the DRG payment to the hospital for the specific stay. In addition to the DRG payment, an "outlier" payment may be made to the hospital for very high cost cases.

The prospective rates for each hospital's Medicaid discharges will be determined by the OHCA in the manner described in the following subsections.

A. Services Included in or Excluded from the Prospective Rate

1. Prospective payment rates shall constitute payment in full for each Medicaid discharge. Hospitals may not separately bill the patient or the Medicaid program for medical services rendered during an inpatient stay, except as described below. Hospitals may submit a claim for payment only upon the final discharge of a patient or upon completion of the transfer of the patient to another acute care hospital or a rehabilitation level of care.

2. The prospective payment rate shall include all services provided to the hospital inpatients, including:

   All items and non-physician services furnished directly or indirectly to hospital inpatients including but not limited to: (1) laboratory services; (2) pacemakers and other prosthetic devices including lenses and artificial limbs, knees, and hips; (3) radiology services; (4) transportation, (including transportation by ambulance), to and from another hospital or freestanding facility to receive specialized diagnostic or therapeutic services.

State: Oklahoma
Date Received: September 26, 2015
Date Approved: MAR 22 2016
Date Effective: July 1, 2015
Transmittal Number: 15-05

Revised 07-01-2015

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

VI. PER DISCHARGE PROSPECTIVE PAYMENT METHODOLOGY FOR HOSPITALS
(continued)

A. Services Included in or Excluded from the Prospective Rate *(continued)*

3. Services which may be billed separately include:
   a. Ambulance service when the patient is transferred from one hospital to another and is admitted as an inpatient in the second hospital
   b. Physician services furnished to individual patients
   c. Long Acting Reversible Contraception (LARC)
   d. High-investment drugs
      i. High-investment drugs are reimbursed under the methodology described in Attachment 4.19-B, Page 7a. A list of high-investment drugs is found on www.okhca.org.

The agency's fee schedule rate is updated annually in July. All rates are published on the agency's website at www.okhca.org. A uniform rate is paid to governmental and non-governmental providers.

B. Computation of DRG Relative Weights

1. Relative weights used for determining rates for cases paid by DRG under the State Plan shall be derived, to the greatest extent possible, from Oklahoma hospital claim data. All such claims are included in the relative weight computation, except as described below.

2. Hospital fee-for-service (FFS) claims and adjusted managed care encounter data for discharges occurring from July 1, 2000, through June 30, 2003, are included in the computation and prepared as follows:

   a. All interim and final claims for single inpatient stay were combined into a single record per discharge.

   b. All Medicaid inpatient discharges were classified using the Diagnostic Related Group (DRG) methodology, a patient classification system that reflects clinically cohesive groupings of inpatient resources. Input files were created for the Medicare Version 22 grouper software. Lines containing detail ICD-9 procedure codes were transposed and attached to the claim header record to produce a single claim record per line. Historical diagnosis and procedure codes that are no longer valid and not recognized by the CMS Medicare Version 22 grouper were updated to reflect their placement codes.

   c. Claims that were grouped into Major Diagnostic Category 15 "Newborns and other Neonates with Conditions Originating in the Perinatal Period" were further grouped using enhanced neonate logic. The enhanced neonate logic creates 20 groupings. The groupings are hierarchical based on discharge state, transfer status, neonate weight, major operating room procedure performed, and the existence of a major or minor diagnosis.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

VI. PER DISCHARGE PROSPECTIVE PAYMENT METHODOLOGY FOR HOSPITALS (continued)

B. Computation of DRG Relative Weights (continued)

d. Claims included in the computation of DRG relative weights were restricted to those claims for cases to be included in the proposed PPS. Claims for services otherwise exempt from the PPS were not used to compute DRG relative weights.

3. Claim "charges" were converted to "cost" using the overall cost-to-charge ratios from the most recently available cost reports or from CMS' Health Care Cost Report Information System (HCRIS). No adjustments were made to remove medical education costs prior to establishing the DRG weights.

4. Average cost per stay was computed for all claims. Costs were inflated forward to the final quarter of the projected payment year using Inpatient Hospital Prospective Reimbursement market basket indices produced by Global Insight. Due to the variety of cost report time periods and discharge dates, the schedule below was used to inflate total costs.

Qtr (yyqtr)	Total Index (TI)	Qtr Inflation Factor (1.372/TI)	Qtr 2006:2 Inflation Factor 1.372
003	1.1060	1.25407	
004	1.1170	1.24172	
011	1.1320	1.22527	
012	1.1440	1.21241	
013	1.1550	1.20087	
014	1.1640	1.19158	
021	1.1760	1.17942	
022	1.1850	1.17046	
023	1.1970	1.15873	
024	1.2080	1.14818	
031	1.2240	1.13317	
032	1.2300	1.12764	

90-21

STATE Oklahoma
DATE REC'D 1-12-05
DATE APPVD 9-27-05
DATE EFF 10-1-05
HCFA 179 05-06

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

VI. PER DISCHARGE PROSPECTIVE PAYMENT METHODOLOGY FOR HOSPITALS (continued)

B. Computation of DRG Relative Weights (continued)

5. Average cost within each DRG was also calculated. Claims with costs and costs per day that were outside of three standard deviations from the mean of the log distribution within each DRG were excluded from the weight calculation.

6. Initial relative weights were computed by calculation of the average Medicaid costs of discharges for each DRG category divided by the average costs for all discharges.

7. The relative weights computed as described above shall remain in effect until the next year. At that time, the relative weights will be recalibrated using whatever DRG Grouper version is currently in use by Medicare.

C. Computation of Hospital Base Rates

1. Each hospital is assigned a "base rate peer group". Five base rate peer groups were computed for small groups of hospitals that all share common cost-related characteristics.

2. Five classification variables were obtained from the Centers for Medicare and Medicaid Services (CMS) Healthcare Cost Report Information System (HCRIS):
   a. Bed Size
   b. Urban
   c. Teaching
   d. Sole Community Hospital (SCH)
   e. Critical Access Hospital (CA)

3. Hospital bed size is defined into two groups: "Big" (greater than 200 beds) and "Small" (less than or equal to 200 beds). Hospitals with missing data received a default classification of "not" urban, "not" big, "not" teaching, "not" CA, not SCH.

90-21

STATE Oklahoma
DATE REC'D 7-12-05
DATE APPVD 9-27-05
DATE EFF 10-1-05
HCFA ID 05-06

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

VI. PER DISCHARGE PROSPECTIVE PAYMENT METHODOLOGY FOR HOSPITALS *(continued)*

C. Computation of Hospital Base Rates *(continued)*

4. The five hospital classification variables were joined to claim and encounter records that had been assigned a DRG by the DRG diagnosis grouper. Due to underreporting of encounter records, discharges that were reported as managed care encounters were given greater weight (1.335) than discharges reported as FFS claims (1.0) to account for the estimated likelihood that denied encounters would have been revised and resubmitted if providers had a financial incentive to do so. A multiple regression equation was estimated from the claim and encounter data to determine the expected cost associated with each of the five classification variables, controlling for DRG and length of stay.

5. The five classification variables formed 32 possible combinations, or classes. Impossible combinations were eliminated. The expected cost for each remaining class was computed with the regression equation. Expected costs were totaled over all classes and the cumulative proportion of expected cost computed. Classes were grouped into five quintiles, such that each group accounts for 20% of the total expected cost.

6. For each group, the discharge-weighted average expected cost was calculated. After computing the discharge-weighted average expected cost for each peer group, the overall discharge weighted average was computed. The relative base rate was computed for each group as the ratio of the group-specific average to the over-all average.

7. The base year expected cost for each group was updated by the method in Section VI.B.4. of this plan.

8. The OHCA will determine the peer group assignment and appeal of assignment will be allowed only through the methods described in Section VI. F. of this Plan.

D. Updates

The DRG rates will be updated annually using the above described method.

Effective 4-01-10, the rate in effect on 03-31-10 is reduced by 3.25%.

Effective 7-01-14, the rate in effect on 06-30-14 is reduced by 7.75%.

Effective for services provided on or after 01-01-16, the rate in effect as of 12-31-15 will be decreased by 3% for DRG hospitals only.

Effective for services provided on or after 10-01-18, the rate in effect as of 09-30-18 will be increased by 3% for DRG hospitals only.

Effective for services provided on or after 10-01-19, the rate in effect as of 09-30-19 will be increased by 5% for DRG hospitals only.

E. Special Prospective Payment Provisions

1. Cost Outlier Adjustment

a. Effective for discharges on or after October 1, 2005, and in accordance with Section 4605 of the Omnibus Budget Reconciliation Act (OBRA) of 1990, the OHCA provides for an outlier adjustment in payment amounts for medically necessary inpatient services involving exceptionally high costs for children who have not attained the age of six years in disproportionate share hospitals, and for infants under age one in all hospitals.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

VI. PER DISCHARGE PROSPECTIVE PAYMENT METHODOLOGY FOR HOSPITALS (continued)

State: Oklahoma
Date Received: September 26, 2015
Date Approved: MAR 22 2016
Date Effective: July 1, 2015
Transmittal Number: 15-05

E. Special Prospective Payment Provisions (continued)

1. Cost Outlier Adjustment (continue)

b. For children and adults, hospitals receive an additional "outlier" payment to compensate for discharges with exceptionally high costs. Hospitals qualify for an outlier payment if costs exceed DRG payment by $50,000 or more. The payment is equal to 70% of costs in excess of the $50,000 threshold. Outlier amount is computed with this formula:

Outlier Amount = [(claim total amount billed) X (billing provider's CCR
- (DRG Weight X Peer Group Base Rate)
- (threshold of $50,000)] X (marginal cost factor 70%).

2. Day Outlier Adjustment

Effective December 1, 2005, the OHCA will make an outlier payment adjustment to general medical/surgical hospitals with children's specialty units paid under DRG methodology, for covered inpatient hospital services involving exceptionally long lengths of stay.

a. Eligibility for this payment shall be determined as follows:

i. First calculate the average Medicaid inpatient length of stay for children's hospitals contracted with Oklahoma Medicaid for the base year. This shall be determined by averaging the mean length of stay for all Children's Hospitals contracted with Oklahoma Medicaid.
ii. Second, calculate the standard deviation for the Medicaid inpatient length of stay statistics in step 2ai.
iii. Third, add one and one-half times the state wide standard deviation for Medicaid inpatient length-of-stay, to the state wide average Medicaid Children's hospital inpatient length of stay. Any stay equal to or lengthier than the sum of these two numbers shall constitute an exceptionally long length of stay for purposes of payment adjustment under this section.

b. Payment will be made from an annual pool of funds not to exceed $1,000,000. Payment will made from the pool of funds for each qualifying inpatient stay that does not reach DRG high-cost outlier status. The day outlier will be based on the number of days that exceed the day outlier threshold, multiplied by an administrative day rate.

3. Payment for Transfer Cases

a. Cases which indicate transfer from one acute care hospital to another will be monitored under a retrospective utilization review policy to help ensure that payment is not made by OHCA for inappropriate transfers.

Revised 07-01-2015

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

VI. PER DISCHARGE PROSPECTIVE PAYMENT METHODOLOGY FOR HOSPITALS (continued)

E. Special Prospective Payment Provisions (continued)

3. Payment for Transfer Cases (continued)

a. The following methodology will be used to reimburse the transferring and discharging hospitals for appropriate transfer if both hospitals and any hospital units involved are included in the PPS:

1. A hospital inpatient shall be considered "transferred" when he or she has been moved from one inpatient facility to another inpatient facility. Movement of a patient from one unit to another unit within the same hospital shall not constitute a transfer, unless the patient is being moved to a different Medicare certified unit within the hospital.

2. The transferring hospital will be paid the lesser of the calculated transfer fee or the DRG base payment amount for a non-transfer case. Should the stay in the transferring hospital qualify for an outlier payment, then the care may be paid as an outlier as described in Attachment 4.19-A, Pages 13 and 13.1 of this plan. In the case of a transfer, the Transfer Allowable Fee for the Transferring Facility shall be calculated as follows: Transfer Allowable Fee = (MS-DRG Allowable Fee/Mean Length of Stay) X (Length of Stay + 1 day).

3. The receiving hospital which ultimately discharges the patient will receive the full DRG payment amount, and if applicable, any outlier payments associated with the care. All other hospitals which admitted and subsequently transferred the patient to another hospital during a single spell of illness shall be considered transferring hospitals.

b. If the transferring or discharge hospital or unit is exempt from the PPS, that hospital or unit will be reimbursed according to the method of payment applicable to the particular facility or unit.

State: Oklahoma
Date Received: June 16, 2016
Date Approved: AUG 04 2016
Date Effective: April 1, 2016
Transmittal Number: 16-18

Revised 04-01-16

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

VI. PER DISCHARGE PROSPECTIVE PAYMENT METHODOLOGY FOR HOSPITALS (continued)

E. Special Prospective Payment Provisions (continued)

1. Payment for Readmissions

Readmissions occurring within 30 days of prior acute care admission for a related condition will be reviewed under a retrospective utilization review policy to determine medical necessity and appropriateness of care. If it is determined that either or both admissions were unnecessary or inappropriate, payment for either or both admissions may be denied. Such review may be focused to exempt certain cases at the sole discretion of the OHCA.

OHCA does not have any prior authorization requirement for inpatient services. Utilization reviews of inpatient stays occur after members have been served and the hospitals file claims; an analysis by the QIO is based on a review of the claims.

Effective April 1, 2016 the OHCA implemented a hospital readmissions initiative designed to reduce the rate of potentially preventable readmissions (PPR). The OHCA approach to achieving this goal is payment reduction for those facilities that have higher than expected PPR rates after adjusting for the types of diagnoses, severity of illness, age groups, and mental health comorbidities seen at individual facilities.

The methodology is as follows:
PPR Assignment
OHCA collects data from all inpatient admissions, but some admissions are excluded from the analysis by third party software. Global exclusions currently include Medicare crossover claims for dual eligible members, admissions related to HIV or eye care, admissions where the patient left against medical advice, most malignancy and neonatal admissions, and non-events such as transfers between acute care facilities or admission to non-acute care facilities. A maximum of 30 days can elapse between the discharge date of an admission and the admitting date of a readmission. If the third party software algorithm determines that a readmission is clinically related to a prior admission, it is considered a PPR. The prior hospitalization that is clinically related to the PPR is called an Initial Admission (IA). An initial admission is the start of a PPR chain that includes at least one PPR; more than one PPR can be attributed to a single initial admission. A hospitalization that is not clinically related to a prior or subsequent admission within a 30-day period is considered an Only Admission (OA). Initial Admissions and Only Admissions combined are Qualifying Admissions (QA), which are used in calculating PPR rates.

State: Oklahoma
Date Received: June 15, 2016
Date Approved: NOV 22 2016
Date Effective: April 1, 2016
Transmittal Number: 16-17

Revised 04-01-16

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

VI. PER DISCHARGE PROSPECTIVE PAYMENT METHODOLOGY FOR HOSPITALS (continued)

Clinically Related Admissions

The key component of the third party software assignment is the proprietary algorithm that determines whether admissions are clinically related. Readmissions are considered to be potentially preventable in the following cases:

- Medical readmission for a continuation or recurrence of the reason for the IA, or for a condition closely related to the reason for the IA
- Ambulatory care sensitive conditions as designated by the Agency for Healthcare Research and Quality (AHRQ)
- All other readmissions for a chronic problem that may be related to care either during or after the IA
- Medical readmission for an acute medical condition or complication that may be related to or may have resulted from care during the IA or in the post-discharge period after the IA
- Readmission for a surgical procedure to address a continuation or a recurrence of the problem causing the IA
- Readmission for a surgical procedure to address a complication that may be related to or may have resulted from care during the IA
- Readmission for mental health or substance abuse reasons

Statewide PPR Calculations

Each admission is assigned to an All Patient Refined Diagnosis Related Groups (APR DRGs) according to the reason for admission. Each admission is also assigned to one of four severity of illness (SOI) levels based on both comorbidities and severity of the underlying illness. A statewide average PPR rate for each APR DRG-SOI combination is defined by the ratio of IA/QA for that APR DRG-SOI. APR DRG-SOI combinations with less than 5 QA across the state are excluded from the analysis.

The third party software also identifies admissions with secondary diagnoses of major mental health conditions. It is well-established that individuals with mental health comorbidities are more likely to be readmitted. Therefore, the third party software output can be used to calculate a PPR adjustment factor to account for the presence or absence of mental health comorbidities when determining the number of expected PPRs for a facility. Likewise, an age group adjustment factor is applied to account for the fact that pediatric patients are less likely to be readmitted than adults.

State: Oklahoma
Date Received: June 15, 2016
Date Approved NOV 22 2016
Date Effective: April 1, 2016
Transmittal Number: 16-17

New Page 04-01-16

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

VI. PER DISCHARGE PROSPECTIVE PAYMENT METHODOLOGY FOR HOSPITALS
(continued)

Facility-Specific PPR Calculations

The third party software classifies each admission within a specific facility as an IA, OA, readmission, or excluded admission. Each admission is also assigned to an APR DRG-SOI. For each APR DRG-SOI observed within each hospital's data set, the expected number of PPR chains is calculated by multiplying the statewide average PPR rate for that APR DRG-SOI by the number of QA for that APR DRG-SOI. That expected value is also multiplied by the adjustment factor for the appropriate age group and mental health status. Some states set a "target" PPR rate that is different from the statewide average PPR rate. At this time, OHCA has chosen a target rate of 102% decreasing annually by one percent until the target rate reaches 100%. The expected number of PPR chains for the hospital is the sum of the expected number of PPR chains across all APR DRG-SOI. If a hospital has a higher number of actual PPR chains than would be expected based on the statewide average, then the number exceeding the expectation are considered excess PPR chains and are subject to payment reduction. The payment reduction is equal to the number of excess PPR chains multiplied by the average reimbursement for PPRs clinically related to initial admissions originating at that facility. Currently, to be included in the reporting process, a hospital must have at least 40 qualifying admissions, 5 actual PPR chains, and 5 expected PPR chains. The minimum number or qualifying admissions, actual PPR chains, and expected PPR chains may be reconsidered as the program evolves. At this time, only facilities that are paid on a DRG basis are subject to payment reduction. Included and excluded facilities may be reconsidered as the program evolves.

Penalty Recoupment Process

OHCA will process the payment reduction through a lump sum recoupment process. After the penalty calculations are completed in the final quarter of the state fiscal year, OHCA will distribute PPR data and notify all hospitals of total penalty amount owed. OHCA will then create accounts receivable for each facility in the MMIS for the total amount of the facility specific penalty. OHCA may set up the accounts receivable to recoup the penalty amount over more than one week. The PPR penalty shall not be included in uncompensated care claims submitted by the hospitals. If the State determines that a participating provider has erroneously filed an uncompensated care claim that incorporates denials for preventable readmissions, the State will notify pertinent auditors of the need to take appropriate steps to disallow these amounts and educate the providers accordingly.

2. Payment for Inappropriate Brief Admissions

Hospital stays less than three days in length will be reviewed under a retrospective utilization review policy for medical necessity and appropriateness of care. (Discharges involving healthy mother and healthy newborns may be excluded from this review requirement.) If it is determined that the inpatient stay was unnecessary or inappropriate, the prospective payment for the inpatient stay will be denied.

Provisions Relating to Organ Transplants

In order for a hospital to receive payment for medically necessary organ transplant services, the following criteria must apply:

The transplant must be prior authorized by the OHCA. Prior authorization request must be submitted jointly by the hospital and the transplant surgeon, and must include written documentation attesting to the appropriateness of the proposed transplant. Payment will not be made without prior authorization approval.

New Page 04-01-16

State:
Oklahoma
Date Received:
June 15, 2016
Date Approved:
NOV 22 2016
Date Effective:
April 1, 2016
Transmittal
Number: 16-17

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

VI. PER DISCHARGE PROSPECTIVE PAYMENT METHODOLOGY FOR HOSPITALS (continued)

E. Special Prospective Payment Provisions (continued)

6. Provisions Relating to Organ Transplants (continued)

In addition to the DRG rate, payment will be made to certified transplant centers for the reasonable costs associated with the acquisition of organs for transplant. This payment will be the additional amount for the organ equal to the Standard Organ Acquisition Charge established by the facility as noted in CMS regulations.

7. Provisions Relating to Hospitals Experiencing a Significant Volume Decrease

In addition to the DRG payment, effective on or after April 1, 2012, Oklahoma State University Medical Center will be paid a payment adjustment of $9,000,000. This payment is for the higher incremental operating costs associated with a lower volume number of discharges due to change of ownership and to sustain the viability of this hospital and maintain access to care. This payment will be made in one (1) installment on or before June 30, 2012 for SFY 2012. For state fiscal year 2013, this payment will be made in four quarterly installments at the beginning of each quarter. These payments are for state fiscal years 2012 and 2013 only.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

VI. PER DISCHARGE PROSPECTIVE PAYMENT METHODOLOGY FOR HOSPITALS (continued)

F. Appeals

The OHCA provides an administrative adjustment procedure that allows individual hospitals an opportunity to receive administrative review of payment rates for those special circumstances and occurrences which meet the criteria described below.

1. Items subject to appeal:

   a. Adjustment to peer group classification variable assignment: Any hospital seeking an exception to its peer group rate designation shall submit a written request to the OHCA within 30 days after receipt of the letter notifying the hospital of its peer group rate. This time period may be extended (i) upon agreement between the OHCA and the hospital or (ii) by the OHCA upon the hospital's submission of a request for an extension of time, within the thirty-day period, showing good cause for the extension.

   The provider's request should specify that any or all of the following information from cost reports is incorrect: bed size, urban status, teaching status, sole-provider status, critical access status and this factor(s) has resulted in the wrong base-rate peer group assignment. The provider must provide documentation of the facility's CMS ID number and the CMS cost report(s) that supports the claim.

   If fact checking shows that the OHCA used the wrong cost reports for that facility, then the facility's information will be corrected in the hospital/ccr/base-rate table.

   b. Adjustment to cost-to-charge (CCR) ratio: The CCRs are an average of reports on file to produce more stable estimates for the 3-year period covered by the claim database used to compute DRG weights. A provider may appeal the calculation of the determination of the cost-to-charge ratio calculated from Medicare cost reports. The provider must provide documentation of the facility's CMS ID number and the CMS cost report(s) that supports the claim.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

VI. PER DISCHARGE PROSPECTIVE PAYMENT METHODOLOGY FOR HOSPITALS (continued)

F. Appeals (continued)

2. The following items are not subject to appeal:

a. Use and computation of DRG relative weights;
b. Use and computation of peer group classification variables;
c. Use and computation of hospital base rates;
d. Use and computation of outlier adjustment factor;
e. Use and computation of direct medical education supplemental pool;
f. Use and computation of supplemental payment adjustment pool.

~~VII.~~ **VI. GRADUATE MEDICAL EDUCATION ACTIVITIES**

The OHCA will make payment adjustments for Direct and Indirect Medical Education Costs.

A. Direct Medical Education (DME)

Effective June 1, 1999, in-state qualified teaching hospitals will receive a payment adjustment for direct medical education (DME) expenses. These payments will be made in order to encourage training in rural hospital and primary care settings.

1. Definitions

For purposes of this amendment, the following definitions apply:

a. Affiliation - means a written agreement to support the costs of medical residency education in an approved medical residency education program.

b. Approved Medical Residency Program - means a program approved by the Accreditation Council for Graduate Medical Education (ACGME) of the American Medical Association, by the Bureau of Professional Education of the American Osteopathic Association, or other professional accrediting associations. The Medical residency programs are those required for certification by the appropriate specialty board.

STATE Oklahoma
DATE RECD 7-12-05
DATE APPVD 9-27-05
DATE EFF 10-1-05
HCFA ID 05-06

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

VI. GRADUATE MEDICAL EDUCATION ACTIVITIES(continued)

A. Direct Medical Education (DME)(continued)

1. Definitions (continued)

c. FTE - stands for full-time equivalent. A FTE is defined as a resident assigned by the residency program to a rotation that is in a hospital or hospital-based facility for 173 hours or more for the month.

d. Resident - defined as a Post-Graduate Year I (PGYI) and above resident who participates through hospital-based rotations in approved medical residency/internship programs in family medicine, internal medicine, pediatrics, surgery, ophthalmology, psychiatry, obstetrics/gynecology, anesthesiology, osteopathic medicine or other residency program, including specialties and sub-specialties. The medical residency programs are those required for certification by the appropriate specialty board.

e. Resident Month - defined as a resident/intern FTE for a given month.

f. Major Teaching Hospital - defined as a teaching hospital with 150 or more FTE residents enrolled in teaching programs.

g. Public/Private Hospital - defined as a hospital owned by the State of Oklahoma that has entered into a joint operating agreement with a private hospital system.

2. Eligibility

a. In order to qualify as a teaching hospital and be deemed eligible for DME payment adjustments, the hospital must:

i. be licensed by the State of Oklahoma; and

ii. have costs associated with approved or certified Oklahoma medical residency programs in medicine, osteopathic medicine and/or associated specialties and sub-specialties; and

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

VI. GRADUATE MEDICAL EDUCATION ACTIVITIES(continued)

A. Direct Medical Education (DME) (continued)

2. Eligibility (continued)

iii. apply for certification to the OHCA prior to receiving payments for any quarter during a State Fiscal Year. To qualify, a hospital must have a contract with the OHCA to provide Medicaid services and belong to The Council on Teaching Hospitals or otherwise show proof of affiliation with an approved Medical Education Program.

b. Federal and State Hospitals, including Veteran's Administration, Indian Health Service/Tribal Facilities, and Oklahoma Department of Mental Health and Substance Abuse Services facilities are not eligible for DME payments under this section.

3. Determination of the Count of Eligible Resident FTE

The resident must be assigned to a specific hospital for a supervised hospital-based experience. Required residency, clinical or educational experience will be allowed. Rotations that are primarily clinical, even though involving some hospital training are not counted as resident-months. Training outside the formal residency program (moonlighting and overtime) is not eligible for this payment.

4. Reporting Requirements

Determination of a hospital's eligibility for a DME payment adjustment will be done quarterly by the OHCA based on reports designed by the OHCA. The reports will detail the resident-months of support provided by the hospital and be attested to by the hospital's administrator or designated personnel and by the residency program director. The hospitals, at a minimum, will report the resident's name, Social Security Number, hours worked, total assigned resident-months for the quarter and department of assignment. The reportswill be subject to audit and payments will be recouped for inaccurate or false data. The reported resident-months will also be periodically compared to the annual budgets of three schools, the Annual CMS form 2552 (Cost Report) and the monthly assignment schedules prepared by the schools.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

VII. GRADUATE MEDICAL EDUCATION ACTIVITIES(continued)

A. Direct Medical Education (continued)

5. Determination of Amount of Payment and Allocation of Funds

a. An annual fixed DME pool will be established not to exceed the base amount of $16,268,148 trended forward for inflation. The amount of the funding pool shall be determined based on the estimated cost of Title XIX direct graduate medical education from CMS-2552 cost report data.

b. The payments will be distributed quarterly based on the relative value of the eligible hospitals' resident-months weighted for Medicaid Services rendered. The relative value is determined as follows:
   1) Annually (prior to each state fiscal year) the OHCA will determine each hospital's individual acuity factor from paid claims data and current median rates taken from the Oklahoma MMIS system. The acuity factor will be determined as follows:
      a) The current median rates for the levels of care (described in 4.19A, page 3) will be weighted by setting the value of the median rate for the routine level of care at 1:(i.e., the individual median rates will be weighted b dividing each by the value of the median rate for routine care.)
      b) The previous calendar year days of service rendered by each hospital by the levels of care will be determined from the Oklahoma MMIS system.
      c) For each hospital the number of days in each level of care will be multiplied by the weight determined for that level of care in (a) above. The total of these calculations will be added and divided by the total days of service in all levels of care to determine the total acuity factor for each hospital.
   2) Determine the total resident months from the quarterly reports in 4 above for each hospital.
   3) Determine the total Medicaid eligible patient days for the quarter from the reports in 4 above for each hospital.
   4) The relative value for each hospital is the product of the total resident-months (determined in step 2) times the total patient days (determined in step 3 above) times the hospital's acuity factor (determined in step 1 above.

STATE Oklahoma
DATE RECD 7-12-05
DATE APPVD 9-27-05
DATE EFF 10-1-05
HCFA 179 05-06

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

VII. **GRADUATE MEDICAL EDUCATION ACTIVITIES** (continued)

A. Direct Medical Education (continued)

c. The payment per resident per month (PRPM) will be limited to $11,000 and the total payments will be limited to and not exceed the upper payment limits described in 6 below.

6. Upper Payment Limit

If payment in section VII.A.5 causes total payments to exceed Medicare upper limits as required by CFR 447.272, the amount of payments over the limit will be recouped based on the total resident-months for that fiscal year. The upper payment limits will be determined in advance of the fiscal year from a compilation of the total allowable costs for all hospitals reported on the latest available CMS 2552 cost reports compared to the reimbursement (including spend-down, TPL, and co-payments) for the same periods as reported through the State MMIS.

B. Indirect Medical Education (IME) Adjustment

Effective February 11, 1999, acute care hospitals that qualify as major teaching hospitals will receive an indirect medical education (IME) payment adjustment which covers the increased operating or patient care costs that are associated with approved intern and resident programs.

1. Eligibility

In order to qualify as a major teaching hospital and be deemed eligible for an IME adjustment, the hospital or hospitals of common ownership or management must:

a. belong to the Council on Teaching Hospitals or have a medical school affiliation; and

b. be licensed by the State of Oklahoma; and

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

VII. **GRADUATE MEDICAL EDUCATION ACTIVITIES** (continued)

B. Indirect Medical Education (IME) Adjustment (continued)

1. Eligibility (continued)

c. Have 150 or more full-time equivalent (FTE) residents enrolled in approved teaching programs.

Eligibility for an IME adjustment will be determined by the OHCA using the provider's most recently received cost report or the application described in paragraph VII.B.2 for the quarterly Direct Medical Education Payment.

2. Calculation of Payment Amounts

a. An annual fixed IME payment pool with be established and is not to exceed the base 2002 amount of $22,023,994 trended forward for inflation. The base year amount will be updated annually each July 1 using the first quarter publication of the DRI PPS-type hospital market basket forecast for the midpoint of the upcoming fiscal year. The pool of funds will be distributed annually each state fiscal year and in equal amounts to the qualifying groups. For the Oklahoma City area, the qualifying group consists of the single hospital, the OU Medical Center. Payment will be made to the University Hospital Trust, the owner/operator of the OU Medical Center. In the Tulsa area, the hospitals under common management, the OSU Medical Center and St. John's, are the members of the qualifying group. The payment will be made equally to the two qualifying hospitals in the Tulsa Group.

b. If payment in paragraph VII.B.2 causes total payments to exceed Medicare upper limits as required by 42 CFR 447.272, the payment in paragraph VII.B.2 will be reduced to not exceed the Medicare upper limit.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

VIII. SUPPLEMENTAL PAYMENTS FOR HOSPITALS WITH LEVEL 1 TRAUMA CENTERS

Hospitals that have Level 1 Trauma Centers will be eligible for a supplemental payment, using the Medicare PPS methodology. The methodology for calculating the payment is as follows:

The components of the Medicare Inpatient Prospective Payment System (PPS) were used to reasonably estimate what Medicare would pay for Medicaid DRG reimbursed inpatient hospital services. The DRG UPL methodology consists of determining a Case Mix Adjusted Medicare DRG base rate, computing a Medicare pass-through payment per discharge, and then calculating the overall aggregate UPL for each of the three categories of hospitals.

1. Case Mix Adjusted Medicare DRG Base Rate

   The Case Mix Adjusted Medicare DRG base rate is computed using Medicare hospital base rate amounts and relative weights to determine a Medicare base payment per Medicaid claim. Oklahoma Medicaid inpatient hospital claims with admission dates in SFY 2005 were extracted from the OHCA MMIS claims processing system. The Oklahoma Medicaid DRG relative weights from the extracted claims were replaced with Medicare Hospital PPS Final Relative Weights for federal fiscal year 2007. DRG codes on newborn claims (Oklahoma Medicaid Newborn DRG codes 601 thru 680) were manually mapped to the Medicare Newborn DRG codes (DRG code 385 thru 391) based on the OHCA Newborn Logic flowchart. After replacing the Medicaid relative weights with the Medicare weights, a hospital specific case mix index (CMI) is computed by summing the Medicare weights for each hospital then dividing the sum of the weights by the number of claims for each hospital. The CMI for each hospital is then multiplied by the hospital's Medicare base rate from the Medicare Hospital PPS Final Rates and Weights for federal fiscal year 2007 to derive a Case Mix Adjusted Medicare DRG Base Rate.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

VIII. SUPPLEMENTAL PAYMENTS FOR HOSPITALS WITH LEVEL 1 TRAUMA CENTERS (continued)

2. Medicare Pass-Through Payments

In addition to the base DRG payment, the Medicare inpatient PPS includes pass-through payments. Medicare pass-through payments include outliers, capital adjustments, GME, IME, routine and ancillary service pass-through, reimbursable bad debt and organ acquisition cost. The Medicare pass-through payments are identified on the Medicare hospital cost report form 2552, worksheet E, Part A. In order to calculate the hospital specific pass-through payment per discharge, all pass-through payments are summed and divided by the Medicare discharges from Worksheet S-3, Part I, line 12.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

IX. HOSPITALS DEEMED DISPROPORTIONATE SHARE

A. DEFINITIONS

State Plan – The approved Oklahoma state plan for medical assistance payments as required by Section 1902 [42 U.S.C. 1396a] of the Social Security Act.

Medical Assistance Payments – Medicaid payments.

Private and Community Hospital – A licensed facility located within the boundaries of the State of Oklahoma that provides medical and / or surgical treatment and care for the sick or the injured.

Public Hospital - A public hospital is one that is located within the boundaries of the State of Oklahoma and is owned or operated by the State or by an instrumentality or a unit of government within the state.

High Disproportionate Share Public Hospital – A public hospital that is located within the boundaries of the State of Oklahoma that meets at least two of the following criteria: (a) a Medicaid utilization rate at least one standard deviation above the mean Medicaid utilization rate in the state; (b) a low income utilization rate at least twice the federal minimum required; or (c) the hospital with the greatest number of Medicaid inpatient days of any hospital in the state in the previous year.

Teaching Hospital – A licensed acute care hospital located within the boundaries of the State of Oklahoma that has a medical school affiliation or belongs to the Council on Teaching Hospitals. A major teaching hospital has 150 or more full-time equivalent (FTE) residents enrolled in approved teaching programs.

Public - Private Major Teaching Hospital – A major teaching hospital owned by the State of Oklahoma that entered into a joint operating agreement with a private hospital system.

Institution(s) for Mental Disease (IMD) – An institution located within the boundaries of the State of Oklahoma that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, meets the federal definition established in 42 CFR 435.1009 and whose facility is licensed by the Oklahoma Department of Health as a Specialized Hospital: Psychiatric.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

IX. **HOSPITALS DEEMED DISPROPORTIONATE SHARE** (continued)

Hospital Specific Cost to Charge Ratio – Cost to Charge Ratio (CCR) data is extracted from CMS' Healthcare Cost Report Information System (HCRIS). CCRs are computed using the following method:

1) Select data from worksheet B-1 column 27 (total cost) and worksheet C-1, columns 6 (inpatient charges) and 7 (outpatient charges).
2) Compute the CCR for each cost report according to the formula:
    a. Numerator (cost) = B-1, Col. 27, Line 95 minus sum of Lines 63 through 94, including subscripts.
    b. Denominator (charges) = (C-1, Col. 6, Line 101) plus (C-1, Col. 7, Line 101) minus (the sum of Col. 6 Lines 63 through 100, including subscripts), minus (the sum of Col. 7 Lines 63 through 100, including subscripts).
    c. Ratio (CCR) = Numerator / Denominator.
3) Compute the average CCR for each CMS ID over all their cost reports in the most recent three years.
4) Join the CCRs to OHCA providers using the CMS ID cross-walk, which results in three kinds of matches:
    a. OHCA providers with one CCR get the computed CCR.
    b. OHCA providers with more than one CCR get the average of all the CCRs for matching CMS ID numbers.
    c. OHCA providers with no CCR get the overall average of all similar providers (i.e. the default CCR) – Critical Access Hospitals (CAH) get the average of all CAH, and non-CAH get the average of all non-CAH hospitals.

OHCA sends a letter to each hospital administrator to verify their assigned CMS ID number and validate the calculated CCR

Disproportionate Share Hospital Survey (DSH) – The annual survey of hospitals conducted by the Oklahoma Health Care Authority. Surveys are to be completed in full, electronically submitted when possible and signed and mailed pursuant to the instructions contained on the survey document.

Uninsured Charges – Uninsured charges are the total amount of inpatient and outpatient charges where no third party insurance exists, are a subset of bad debt and charity care charges, and only include outpatient hospital charges that are under the hospital benefit. The uninsured include all people documented as self pay by the hospital who have no creditable health insurance coverage of any kind. Uninsured charges are defined by Federal Law (Section 1923. [42 U.S.C. 1396r–4] of the Social Security Act and 42 CFR Parts 447 & 455).

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

IX. **HOSPITALS DEEMED DISPROPORTIONATE SHARE** (continued)

Medicaid Gross Charges – Medicaid gross charges represent a provider's usual and customary charges billed on claims submitted which reach a paid status in the Oklahoma Medicaid Management Information System (MMIS).

Dual Eligibles – Dual eligibles are people that qualify for both Medicaid and Medicare. The definition of dual eligible costs and charges for the purposes of this plan are consistent with the federal definitions as stated in the Federal Register / Vol. 73, No. 245 / Friday, December 19, 2008 / Rules and Regulations. Consistent with the federal definition, in calculating the Medicare payment for service, the hospital has to include the Medicare DSH adjustment and any other Medicare payment adjustment (Medicare IME and GME) with respect to that service.

Bad Debt Allowance – Bad debt allowance represents non-payment on behalf of an individual who has third party coverage. Bad debt allowance is only factored into the state allocation formula portion of this plan (Section E) and consistent with 42 CFR Parts 447 & 455 will not be a part of the hospital specific DSH Limit calculation.

Charity Care Gross Charges – "Charity care" is a term used by hospitals to describe an individual hospital's program of providing free or reduced charge care to those that qualify for the particular hospital's charity care program. Gross charges are those charges attributable to people under the hospital's charity care policy. Charity care gross charges are only factored into the state allocation formula portion of this plan (Section E) and consistent with 42 CFR Parts 447 & 455 will not be a part of the hospital specific DSH Limit calculation.

For the purposes of meeting the mandatory federal requirements in Section IX C. of this State Plan to qualify as a disproportionate share hospital, the term "Rural Hospital" means a hospital located in any county not included in a Metropolitan Statistical Area, or beginning in 2003 Core-Based Statistical Area (CBSA). The CBSAs are reported each year in the Final Rule for the Medicare Inpatient Prospective Payment System.

B. MINIMUM FEDERAL CRITERIA

Pursuant to Section 1923(b) of the Social Security Act and 42 CFR Parts 447 & 455:

A hospital as defined in this section of the Oklahoma State Plan which meets the following requirements is deemed to be a disproportionate share hospital if:

(1) The hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

IX. **HOSPITALS DEEMED DISPROPORTIONATE SHARE** (continued)

The term "Medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage)

The numerator of which is the hospital's total number of Oklahoma inpatient days attributable to patients who (for such days) were eligible for medical assistance in a period (regardless of whether such patients receive medical assistance on a fee-for-service basis or through a managed care program) and Oklahoma dual eligible days.

The denominator of which is the total number of the hospital's days in that same period. In this paragraph, the term "inpatient days" includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere. Inpatient days include psychiatric days and days attributable to Medicaid patients between 21 and 65 years of age in Institutions for Mental Disease (IMD). They also include days attributable to individuals eligible for Medicaid in another state. They do not include days which are attributable to services rendered in a separately licensed/certified off-site entity, swing bed and skilled nursing days;

Or

(2) the hospital's low-income utilization rate exceeds 25 percent.

The term "low-income utilization rate" means, for a hospital, the sum of (a) and (b) below:

(a) the fraction (expressed as a percentage):

(i) the numerator of which is the sum (for a period) of the total revenues paid the hospital for patient services under the Oklahoma State plan under this title (regardless of whether the services were furnished on a fee-for-service basis or through a managed care program) and the amount of the cash subsidies for patient services received directly from State and local governments, and

(ii) the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and

TN# 15-03
Supersedes
TN# 10-10

Approval Date NOV 03 2015 Effective Date 7-1-2015

State: Oklahoma
Date Received: September 26, 2015
Date Approved: NOV 03 2015
Date Effective: July 1, 2015
Transmittal Number: 15-03

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

IX. **HOSPITALS DEEMED DISPROPORTIONATE SHARE** (continued)

(b) the fraction (expressed as a percentage):

(i) the numerator of which is the total amount of the hospital's charges for inpatient hospital services which are attributable to charity care in a period, less the portion of any cash subsidies for patient services received directly from State and local governments in the period reasonably attributable to inpatient hospital services, (the numerator shall not include contractual allowances and discounts other than for indigent patients not eligible for medical assistance under the State plan), and

(ii) the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

C. MANDATORY FEDERAL REQUIREMENTS TO QUALIFY AS DISPROPORTIONATE SHARE HOSPITAL

(1) Except as provided in paragraph (2) below, no hospital may be defined or deemed as a disproportionate share hospital unless the hospital has at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under such State plan.

(2) (a) The preceding requirement shall not apply to a hospital which:

(i) the inpatient days are attributed predominantly to individuals under 18 years of age; or

(ii) did not offer non-emergency obstetric services to the general population prior to December 21, 1987.

(b) In the case of a hospital located in a rural area (as defined by section 1886 of the Social Security Act), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

(3) No hospital may be defined or deemed as a disproportionate share hospital unless the hospital has a Medicaid inpatient utilization rate (as defined in Section (B) (1)) of no less than 1 percent.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

IX. **HOSPITALS DEEMED DISPROPORTIONATE SHARE** (continued)

D. REQUIREMENTS TO QUALIFY AS AN OKLAHOMA DISPROPORTIONATE SHARE HOSPITAL

(1) Hospitals as defined in Section A which meet the requirements in Section C will automatically be qualified as an Oklahoma disproportionate share hospital and, for the purpose of payment, will be treated in the same manner as all other hospitals within their group as defined below.

(2) IMD hospitals as defined in Section A must meet the requirements in Section B and the requirements in Section C in order to be qualified as an Oklahoma disproportionate share hospital.

E. STATE ALLOCATION METHODOLOGY AND FORMULAS

The aggregate total amount of DSH payments to all hospitals and IMDs deemed Oklahoma Disproportionate Share Hospitals will equal the annual CMS disproportionate share hospital amount allocated to the State.

Eligibility for disproportionate share payments will be determined annually. All information used for all allocation calculations will be derived from the Annual Disproportionate Share Hospital Survey conducted by OHCA, the OHCA MMIS system and the most currently available United States Bureau of Economic Analysis reports.

Only hospitals that return disproportionate share surveys in accordance with the date specified in the instructions of the survey will be considered for DSH payments. The information used to complete the survey must be extracted from the hospital's financial records and fiscal year cost report ending in the most recently completed calendar year.

Any hospital providing incomplete surveys to OHCA may be deemed ineligible to receive funds allocated pursuant to this Section of the State Plan.

(1) Effective January 1, 2007, Oklahoma disproportionate share hospital payments may be allocated from the following funding pools:

(a) Hospitals meeting the definitions of a High Disproportionate Share Public Hospital / Public - Private Major Teaching Hospital will receive an amount equal to the federal fiscal year 2006 allocation, $25,546,749, plus an inflationary increase each year equal to the amount published by the U.S. Department of Labor Bureau of Labor Statistics for the first six months of the most current calendar year (Consumer Price Index - 12 Months Percent Change for All Urban Consumers).

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

IX. **HOSPITALS DEEMED DISPROPORTIONATE SHARE** (continued)

(b) Private and Community or Public Hospitals will receive an amount equal to the state disproportionate share hospital allocation published by the Centers for Medicare & Medicaid Services in the Federal Register less the amount reserved for IMD hospitals and less the amount reserved for hospitals allocated funds in subsection (a) of this section.

(c) IMD hospitals will receive an amount equal to the amount allocated and published in the federal register by the Centers for Medicare & Medicaid Services.

(2) The funds allocated to the pool described in subsection (1) (b) above for Private and Community or Public Hospitals will be distributed in the following manner:

(a) Hospitals will be grouped as follows by licensed bed size based on the Oklahoma State Department of Health Medical Facilities Division health care facility directory:

- Group 1 will include hospitals with 300 or more licensed beds.
- Group 2 will include hospitals with more than 100 but less than 300 licensed beds.
- Group 3 will include hospitals with less than 100 licensed beds.

(b) The DSH Allocation reserved for this pool will be divided between the three groups based on each group's total Medicaid inpatient days divided by the aggregate total number of all Medicaid inpatient days provided by all three groups combined. If the total percentage calculated for hospitals in Group 1 exceeds 65% of the total to be distributed in any given year the distribution will be reduced to 65% for that Group and the balance will be distributed accordingly to the remaining two groups.

(c) Hospitals in each group will receive funds based on their relationship to the total amount of Indigent Care Costs provided by the group. Indigent Care Costs are reported to OHCA by each hospital using the annual DSH Survey.

Indigent Care Costs are calculated based on the following hospital specific formula:

Indigent Care Costs =

(Medicaid Gross Charges + Uninsured Charges + Dual Eligibles + Bad Debt Allowance + Charity Care Gross Charges) x (Hospital Specific Cost to Charge Ratio)

Once allocations are made to each hospital they are compared to the hospital specific DSH upper payment limit and then adjusted down, if necessary, so as to not exceed the limit as calculated below.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

IX. **HOSPITALS DEEMED DISPROPORTIONATE SHARE** (continued)

In the event it is necessary to reduce the amount of DSH payments to remain within the DSH Upper Payment limit(s), the OHCA shall calculate a pro rata increase to all other qualifying hospitals by recycling the remaining amounts through the allocation formula.

Factors in this formula are used only to determine the allocation of the payments under this section. All payments are made in recognition of allowable uncompensated costs incurred in providing inpatient and outpatient hospital services to Medicaid individuals and individuals who have no health insurance or other source of third party coverage.

(3) The funds allocated to the pool described in subsection (1) (c) above for IMDs will be distributed in the following manner:

IMDs will receive funds based on their relationship to the total amount of Indigent Care Costs provided by all IMDs. Indigent Care Costs are reported to OHCA by each hospital using the annual DSH Survey.

Indigent Care Costs are calculated based on the following hospital specific formula:

Indigent Care Costs =

(Medicaid Gross Charges + Uninsured Charges + Dual Eligibles + Bad Debt Allowance + Charity Care Gross Charges) x (Hospital Specific Cost to Charge Ratio)

Once allocations are made to each IMD they are compared to the hospital specific DSH upper payment limit and then adjusted down, if necessary, so as to not exceed the limit as calculated below.

In the event it is necessary to reduce the amount of DSH payments to remain within the DSH Upper Payment limit(s), the OHCA shall calculate a pro rata increase to all other qualifying hospitals by recycling the remaining amounts through the allocation formula.

Factors in this formula are used only to determine the allocation of the payments under this section. All payments are made in recognition of allowable uncompensated costs incurred in providing inpatient and outpatient hospital services to Medicaid individuals and individuals who have no health insurance or other source of third party coverage.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

IX. **HOSPITALS DEEMED DISPROPORTIONATE SHARE** (continued)

F. HOSPITAL SPECIFIC DSH UPPER PAYMENT LIMIT (UPL)

Pursuant to Section 1923(g) of the Social Security Act, hospitals will be subject to hospital specific DSH limits.

Any hospital found to have been paid more than their hospital specific DSH UPL or was inappropriately paid DSH at any time or in any year subject to audit will be required to pay the funds back to the state in full. The state will reallocate any funds recovered due to overpayment to other DSH hospitals that were not paid up to their hospital specific DSH UPL. Recovered funds will be reallocated based on the most current allocation and distribution method used by the state.

After the final payment during the federal fiscal year has been issued, no adjustment will be given on DSH payments, even if subsequently submitted documentation demonstrates an increase in uncompensated care costs for the qualifying hospital.

Hospitals and / or units which close or withdraw from the Medicaid Program shall become ineligible for further DSH pool payments for the remainder of the current DSH pool payment cycle.

G. REPORTS AND AUDITS

Each hospital will be responsible for maintaining its own supporting documents and records related to information reported to OHCA on the annual DSH survey.

Pursuant to Section 1923(j) of the Social Security Act, hospitals will be subject to annual audits. Hospitals found to be out of compliance as a result of the audits will be responsible for reimbursing the state for any DSH payments incorrectly made during the period reviewed.

Pursuant to 42 CFR 433.32, which relates to Fiscal policies and accountability, hospitals receiving DSH funds are required to:

(a) Maintain an accounting system and supporting fiscal records used by the hospital to complete the annual DSH survey;
(b) Retain records for 3 years from date of submission of a final expenditure report; and
(c) Retain records beyond the 3-year period if audit findings have not been resolved.

The State reserves the right to request any other information from hospitals receiving DSH funds as may be necessary to meet the audit and reporting requirements of federal law.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

IX. **HOSPITALS DEEMED DISPROPORTIONATE SHARE** (continued)

H. APPEALS

Any hospital required to pay back any or all portions of DSH funds allocated pursuant to this Section will have the right to an appeal pursuant to the appeal provisions included in this State Plan.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

X. SUPPLEMENTAL PAYMENTS FOR HOSPITALS PARTICIPATING IN THE SUPPLEMENTAL HOSPITAL OFFSET PAYMENT PROGRAM (SHOPP)

1. Supplemental Payment Pools

The components of the Medicare Inpatient Prospective Payment System (PPS) were used to reasonably estimate what Medicare would pay for Medicaid DRG reimbursed inpatient hospital services. The DRG upper payment limit (UPL) methodology consists of determining a Case Mix Adjusted Medicare DRG base rate, computing a Medicare pass-through payment per discharge, calculating Medicaid costs for hospitals not paid on a DRG basis, and then calculating the overall aggregate UPL for each of the three classes of hospitals.

a. Case Mix Adjusted Medicare DRG Base Rate

The Case Mix Adjusted Medicare DRG base rate is computed using Medicare hospital base rate amounts and relative weights to determine a Medicare base payment per Medicaid claim. Oklahoma Medicaid inpatient hospital claims paid in the previous state fiscal year were extracted from the OHCA MMIS claims processing system. The Oklahoma Medicaid DRG relative weights from the extracted claims were replaced with Medicare Hospital PPS Final Relative Weights for the applicable dates of service. DRG codes newborn claims (Oklahoma Medicaid Newborn DRG codes N01 thru N80) were manually mapped to the Medicare newborn DRG codes (MS-DRG codes 789 thru 795) based on the OHCA Newborn Logic flowchart. After replacing the Medicaid relative weights with the Medicare weights, a hospital specific case mix index (CMI) is computed by summing the Medicare weights for each hospital then dividing the sum of the weights by the number of claims for each hospital. The CMI for each hospital is then multiplied by the hospital's Medicare base rate from the Medicare Hospital PPS Final Rates and Weights for the applicable federal fiscal year to derive a Case Mix Adjusted Medicare DRG Base Rate.

b. Medicare Pass-Through Payments

In addition to the base DRG payment, the Medicare inpatient PPS includes pass-through payments. Medicare pass-through payments include outliers, capital adjustments, GME, IME, DSH (including uncompensated care DSH), routine and ancillary services pass-through, reimbursable bad debt and organ acquisition cost. The Medicare pass-through payments are identified on the Medicare hospital cost report form 2552, Worksheet E, Part A. Payments are trended a single year using the CMS published Inpatient Hospital PPS Market Basket Update for the applicable year. In order to calculate the hospital specific pass-through payment per discharge, all pass-through payments are summed and divided by the Medicare discharges from Worksheet S-3.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

X. SUPPLEMENTAL PAYMENTS FOR HOSPITALS PARTICIPATING IN THE SUPPLEMENTAL HOSPITAL OFFSET PAYMENT PROGRAM (SHOPP) *(continued)*

c. Non-DRG hospitals

The UPL for Non-DRG reimbursed hospitals are calculated using inpatient hospital specific cost to charge ratios. To determine the ratios, inpatient hospital costs and charges are extracted from the most recently available Medicare hospital cost report form 2552. This cost to charge ratio is multiplied by allowable charges for Medicaid inpatient hospital claims to determine the cost of these services. Costs for these services are trended to the mid-point of the applicable year using the CMS published Inpatient Hospital PPS Market Basket Update for each year.

An annual demonstration of the prior state fiscal year billed charges and payments will be completed to insure that payments are in compliance with 42 CFR § 447.272. The payments cannot exceed the provider's usual and customary charge. Due to the prospective nature of SHOPP payments, this demonstration will compare the prior year billed charges and payments.

d. Upper Payment Limit Gaps

Payments calculated in paragraphs a, b and c shall be summed across the three classes of hospitals: privately owned, non-state government owned, and state government owned. These sums will equal the upper payment limits for each class of hospital. Total Medicaid payments for each class of hospital will be subtracted from its respective upper payment limit to determine the upper payment limit gaps.

2. Disbursement of payments to hospitals:

a. All hospitals shall be eligible for inpatient hospital access payments each year as set forth in this subsection except the following:

i. A hospital that is owned or operated by the state or a state agency, the federal governments, a federally recognized Indian tribe, or the Indian Health Service;
ii. a hospital that provides more than fifty percent (50%) of its inpatient days under a contract with a state agency other than the OHCA;
iii. a hospital that specializes in any one of the following: (i) treatment of a neurological injury (ii) treatment of cancer, (iii) treatment of cardiovascular disease, (iv) obstetrical or childbirth services, (v) surgical care, except that this exemption shall not apply to any hospital located in a city of less than five hundred thousand (500,000) population and for which the majority of inpatient days are for back, neck, or spine surgery; and
iv. a hospital that is certified by the federal Centers for Medicaid and Medicare Services as a long-term acute care hospital or as a children's hospital;

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

X. SUPPLEMENTAL PAYMENTS FOR HOSPITALS PARTICIPATING IN THE SUPPLEMENTAL HOSPITAL OFFSET PAYMENT PROGRAM (SHOPP) (continued)

b. In addition to any other funds paid to critical access hospitals for inpatient hospital services to Medicaid patients, each critical access hospital (CAH) shall receive hospital access payments equal to the amount by which the payment for these services was less than one hundred one percent (101%) of the hospital's cost of providing these services, as determined by using a CCR as described in paragraph 1(c) This cost to charge ratio is multiplied by allowable charges to determine the cost of these services. Costs for these services are trended to the mid-point of the applicable year using the CMS published Inpatient Hospital PPS Market Basket Update for each year.

c. In addition to any other funds paid to hospitals for inpatient hospital services to Medicaid patients, each eligible hospital shall receive inpatient hospital access payments each year equal to the hospitals pro rata share of the inpatient supplemental payment pool available to the hospital's class of hospitals, as reduced by the payments distributed in paragraph 2(b). The pro rata share will be based upon the hospital's Medicaid payments for inpatient services divided by the total Medicaid payments for inpatient services of all eligible hospitals within each class of hospital.

d. The inpatient supplemental payment pool available to each class of hospitals will be determined by multiplying the class's upper payment limit gap, as determined under X.1.d. above, by the available funds ratio. The available funds ratio is determined by dividing the total of all funds available under the Supplemental Hospital Offset Payment Program, less the CAH supplemental payments described in Attachment 4.19-A Page 32.5, X 2(b) and Attachment 4.19-B Page 1d, H 2(b), by the total of the inpatient and outpatient upper payment limit gaps for all classes of hospital eligible for supplemental payments under this paragraph.

3. Frequency of Payments

The OHCA will pay from the Supplemental Hospital Offset Payment Program Fund quarterly installment payments to hospitals, not to exceed the UPL, of amounts available for supplemental payments for Critical Access Hospitals and supplemental inpatient payments.

State: Oklahoma
Date Received: November 30, 2016
Date Approved: FEB 14 2017
Date Effective: January 1, 2017
Transmittal Number: 16-29

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

16. Inpatient Psychiatric Services for Individuals under Age 21 (42 CFR 440.160)

The Medicaid Agency may pay the customary charges of the provider but must not pay more than the prevailing charges in the locality for comparable services under comparable circumstances in accordance with 42 CFR 447.325.

16.a. Inpatient Psychiatric Services for Individuals under Age 21

(A) General

Except as otherwise noted in the plan, all Medicaid services furnished to individuals receiving acute level 2 services in private psychiatric hospitals and general hospitals with a psychiatric unit are considered all-inclusive of the service, i.e., all medical services provided to residents of psychiatric hospital and general hospitals with psychiatric units with 17 beds or more should be billed to the psychiatric hospital and general hospitals with psychiatric units.

(B) Payment to State-owned Government Providers

State-owned psychiatric hospitals will be paid an interim rate based on the previous year's cost report (HCFA 2552) data and settled to total allowable costs based on the current year's cost report. Total allowable cost will be determined in accordance with Medicare principles of reimbursement.

(C) Payment to State–licensed, Private Psychiatric Hospitals and General Hospitals with Psychiatric Units

i. Base Rate

A prospective per diem payment is made for covered services based on facility peer group. State licensure requires RN staffing 24 hours per day for hospitals at a ratio of one RN for up to 15 patients. An additional RN must be added for more than 15 patients; however, an LPN may be substituted for 16-20 patients. A second RN is needed for 21 patients and above.

The rates listed below are effective as of 05-01-2016 and are equivalent to a 15 percent rate reduction from the rates in effect on 04-30-2016 for private psychiatric hospitals and general hospitals with psychiatric units.

Peer Group	Psychiatric Hospital	Hospital Psychiatric Unit
Standard	$293.29	$293.29
Specialty 1 – Sexual Offender	$293.29	$293.29
Specialty 2 – Eating Disorder, TBI	$367.42	$367.42

ii. The following services will not be reimbursed outside of the per diem:

- Dental (excluding orthodontia);
- Vision;
- Prescription Drugs;
- Practitioner Services; and
- Other medically necessary services not otherwise specified.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

16. Inpatient Psychiatric Services for Individuals under Age 21 (42 CFR 440.160) *(continued)*

16.a. Inpatient Psychiatric Services for Individuals under Age 21 *(continued)*

(C) Payment to State–licensed, Private Psychiatric Hospitals and General Hospitals with Psychiatric Units *(continued)*

iii. Add-on Payments

(a) Intensive Treatment Services (ITS) Add-on Per Diem

An ITS per diem of **$110.99** will be allowed for children requiring intensive staffing supports in an acute level 2 setting when it is determined that there is medical necessity for non-acute care, the services are documented in the facilities' records, and are prior authorized.

(b) Prospective Complexity Add-on Per diem for Non-verbal Children

A per diem of **$77.51** will be allowed to recognize the increased cost of serving children with a mental health diagnosis complicated with non-verbal communication in an acute level 2 setting. These services must be medically necessary, documented in the facilities' record, and prior authorized.

(c) Specialty Add-on Per Diem

A per diem of **$210.00** will be allowed to recognize the increased cost of serving children with specialized needs in an acute level 2 setting. These services must be medically necessary, documented in the facility's record, and prior authorized.

iv. Outlier Intensity Adjustment

(a) An outlier payment adjustment may be made on a case by case basis for complex cases. The intent of the outlier payment is to promote access to inpatient psychiatric services for individuals under 21 for those patients who require services beyond the cost of services provided by ITS, Prospective Complexity, and Specialty add-on payments.

(b) The outlier adjustment may be a short stay outlier adjustment or a high cost outlier adjustment.

(c) In order to be eligible for the short stay outlier adjustment:

1. The private psychiatric hospital and general hospital with a psychiatric unit must submit an annual cost report in a format prescribed by the agency and request the outlier adjustment only upon the member's discharge; and
2. The total length of stay must be less than 6 days.
3. The outlier adjustment will be the lessor of the following:
   a. 100% of the private psychiatric hospital's and general hospital's with a psychiatric unit cost; or
   b. 120% of the peer group per diem multiplied by the LOS.

(d) In order to be eligible for the high cost outlier adjustment:

1. The private psychiatric hospital or general hospital with a psychiatric unit must submit an annual cost report in a format prescribed by the agency and request the outlier adjustment only upon the member's discharge; and
2. The outlier payment will be made if the psychiatric hospital's or general hospital's with a psychiatric unit total cost of care exceeds 115% of the Medicaid payment.
3. The appropriate outlier amount will be determined by comparing the total cost and 115% of the Medicaid payment for the entire stay, and multiplying the difference by a loss sharing ratio of .20 to the psychiatric hospital or general hospital with a psychiatric unit and .80 to the state, if the stay is less than or equal to 90 days, and .40 to the Medicare certified hospital and .60 to the state for a stay > 90 days.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

16. Inpatient Psychiatric Services for individuals under age 21 (42 CFR 440.160) *(continued)*
16.a. Inpatient Psychiatric Services for Individuals under Age 21 *(continued)*

(C) Payment to State–licensed, Private Psychiatric Hospitals and General Hospitals with Psychiatric Units *(continued)*

v. Services Provided under Arrangement

Separate payment may be made directly to individual practitioners or suppliers for services provided under arrangement using existing State plan methodologies and fees. The State assures there is no duplication of payment between the psychiatric hospitals' or general hospitals with psychiatric units' base rate and the items paid for separately. The State also assures that no duplication of payment will be made for transitioning services to both a community Case Manager provider and a Health Home provider for the same person.

(a) **Case Management Transitioning Services** – Transitional case management services are considered to be psychiatric hospital or general hospital with a psychiatric unit services, when services exceed and do not duplicate inpatient discharge planning during the last 30 days of a covered stay. Case management transitioning services to assist children transitioning from a psychiatric hospital or general hospital with a psychiatric unit to a community setting will not duplicate inpatient discharge planning services. Case management transitioning services will be billed by the psychiatric hospital or general hospital with a psychiatric unit as inpatient psychiatric services for individuals under age 21 services and claimed as inpatient psychiatric services for individuals under age 21 services. Payment for Case Management transition services provided under arrangement with the psychiatric hospital or general hospital with a psychiatric unit will be directly reimbursed to a qualified community-based Case Management provider. Payment is made to Outpatient Behavioral Health Agencies with qualified case managers in accordance with the methodology in Attachment 4.19-B, Page 22.

Transitional services are exempt from the payment methodology at 16.a.C.ii on Attachment 4.19-A, Page 33.

(b) **Evaluation and psychological testing by a licensed Psychologist** - Payment is made in accordance with the methodology in Attachment 4.19-B, Page 8.

(D) Payment for Out–of–State Services

Reimbursement for out-of-state placements for individuals under the age of 21 shall be made in the same manner as in-state providers. In the event that comparable services cannot be purchased from an out-of-state provider using Medicaid established rates, a rate may be negotiated that is acceptable to both parties. The rate will generally be the lesser of usual and customary charges or the Medicaid rate in the state in which services are provided. Reimbursement shall not be made for inpatient psychiatric services for individuals under age 21 provided out of state unless the services are medically necessary and are not available within the State and prior authorization has been granted.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of inpatient psychiatric services for individuals under 21. The agency's fee schedule rate was set as of May 1, 2016 and is effective for services provided on or after that date. All rates are published on the Agency's website oklahoma.gov/ohca/providers/claim-tools/fee-schedule.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

16. Inpatient Psychiatric Services for individuals under age 21 (42 CFR 440.160) *(continued)*

16.b. Residential Level of Care in a Psychiatric Residential Treatment Facility (PRTF)

(A) Payment to State-owned Government Providers

State-owned PRTFs will be paid an interim rate based on the previous year's cost report (HCFA 2552) data and settled to total allowable costs determined by usual and customary charges. The agency may pay the customary charges of the provider but must not pay more than the prevailing charges in the locality for comparable services under comparable circumstances in accordance with 42 CFR 447.325.

(B) Payment to Private, In-State PRTFs with 17 Beds or More

i. Base Rate

A prospective per diem payment is made based on the facility peer group for a comprehensive package of services and room and board which requires 24-hour nursing care supervised by an RN.

ii. The following services will not be reimbursed outside of the base rate:

- Dental (excluding orthodontia);
- Vision;
- Prescription drugs;
- Practitioner services; and
- Other medically necessary services not otherwise specified.

Facility Peer Group	Base Rate
Special Populations	$550.00
Standard	$336.57

(C) Payment to Private, In-State PRTFs with 16 Beds or Less

i. Base Rate

The rate listed below is effective as of 05-01-2016 and is equivalent to a 15 percent rate reduction from the rate in effect on 04-30-2016 for private, in-state PRTFs with 16 beds or less.

A prospective per diem payment of $187.42 is made for a comprehensive package of services provided under the direction of a physician, as well as and room and board.

ii. Physician and Other Ancillary Services

All other medically necessary services, i.e., EPSDT services, are arranged by the PRTF with 16 beds or less and billed separately. The reimbursement for the EPSDT service does not duplicate billing for inpatient psychiatric services under section 1905(a)(16)(A) of the Act by the PRTF with 16 beds or less or a provider furnishing inpatient psychiatric services under arrangement with the PRTF with 16 beds or less. Payment for the EPSDT service is made in accordance with the applicable State Plan payment methodologies and fees. Claiming of such expenditures for federal financial participation (FFP) are in accordance with the CMS-64 form claiming guidance for EPSDT services.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

16. Inpatient Psychiatric Services for individuals under age 21 (42 CFR 440.160) *(continued)*

16.b. Residential Level of Care in a PRTF *(continued)*

(D) PRTF Add-on Payments

(a) Intensive Treatment Services (ITS) Add-on Per Diem

An ITS per diem of **$110.99** will be allowed for children requiring intensive staffing supports in a PRTF setting when it is determined that there is medical necessity for non-acute care, the services are documented in the facilities' records, and are prior authorized.

(b) Prospective Complexity Add-on Per diem for Non-verbal Children

A per diem of **$77.51** will be allowed to recognize the increased cost of serving children with a mental health diagnosis complicated with non-verbal communication in a PRTF setting. These services must be medically necessary, documented in the facilities' record, and prior authorized.

(c) Specialty Add-on Per Diem

A per diem of **$210.00** will be allowed to recognize the increased cost of serving children with specialized needs in a PRTF setting. These services must be medically necessary, documented in the facility's record, and prior authorized.

(E) Outlier Intensity Adjustment

(A) An outlier payment adjustment may be made on a case by case basis for complex cases. The intent of the outlier payment is to promote access to inpatient psychiatric services for individuals under 21 for those patients who require services beyond the cost of services provided by ITS, Prospective Complexity, and Specialty add-on payments.

(B) The outlier adjustment may be a short stay outlier adjustment or a high cost outlier adjustment.

(C) In order to be eligible for the short stay outlier adjustment:

1. The facility must submit an annual cost report in a format prescribed by the agency and request the outlier adjustment only upon the member's discharge; and
2. The total length of stay must be less than 6 days.
3. The outlier adjustment will be the lessor of the following:
   a. 100% of the facility's cost; or
   b. 120% of the peer group per diem multiplied by the LOS.

(D) In order to be eligible for the high cost outlier adjustment:

1. The facility must submit an annual cost report in a format prescribed by the agency and request the outlier adjustment only upon the member's discharge; and
2. The outlier payment will be made if the facility's total cost of care exceeds 115% of the Medicaid payment.
3. The appropriate outlier amount will be determined by comparing the total cost and 115% of the Medicaid payment for the entire stay, and multiplying the difference by a loss sharing ratio of .20 to the facility and .80 to the state, if the stay is less than or equal to 90 days, and .40 to the facility and .60 to the state for a stay > 90 days.

(F) PRTF Services Provided under Arrangement

Separate payment may be made directly to individual practitioners or suppliers for services provided under arrangement using existing State plan methodologies and fees. The State assures there is no duplication of payment between the psychiatric hospitals' or general hospitals with psychiatric units' base rate and the items paid for separately.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

16. Inpatient Psychiatric Services for individuals under age 21 (42 CFR 440.160) *(continued)*

16.b. Residential Level of Care in a PRTF *(continued)*

(F) PRTF Services Provided under Arrangement *(continued)*

(a) Case Management Transitioning Services – Transitional case management services are considered to be psychiatric hospital or general hospital with a psychiatric unit services, when services exceed and do not duplicate inpatient discharge planning during the last 30 days of a covered stay. Case management transitioning services to assist children transitioning from a psychiatric hospital or general hospital with a psychiatric unit to a community setting will not duplicate inpatient discharge planning services. Case management transitioning services will be billed by the psychiatric hospital or general hospital with a psychiatric unit as inpatient psychiatric services for individuals under age 21 services and claimed as inpatient psychiatric services for individuals under age 21 services. Payment for Case Management transition services provided under arrangement with the psychiatric hospital or general hospital with a psychiatric unit will be directly reimbursed to a qualified community-based Case Management provider. Payment is made to Outpatient Behavioral Health Agencies with qualified case managers in accordance with the methodology in Attachment 4.19-B, Page 22.

Transitional services are exempt from the payment methodology at 16.b.B.ii on Attachment 4.19-A, Page 35 and 16.b.C.ii on Attachment 4.19-A, Page 36.

(b) Evaluation and psychological testing by a licensed Psychologist - Payment is made in accordance with the methodology in Attachment 4.19-B, Page 8.

(G) PRTF Payment for Out–of–State Services

Reimbursement for out-of-state placements for individuals under the age of 21 shall be made in the same manner as instate providers. In the event that comparable services cannot be purchased from an out-of-state provider using Medicaid established rates, a rate may be negotiated that is acceptable to both parties. The rate will generally be the lesser of usual and customary charges or the Medicaid rate in the state in which services are provided. Reimbursement shall not be made for private PRTF services provided in out of state unless the services are medically necessary and are not available within the State and prior authorization has been granted.

State of Oklahoma
Department of Human Services

Sequoyah Memorial Office Building
P.O. Box 25352
Oklahoma City, Oklahoma 73125

COMMISSION
FOR HUMAN SERVICES

ROBERT FULTON
Director of Human Services

December 20, 1984

Jerry Sconce
Regional Administrator
Department of Health and Human Services
Health Care Financing Administration
1200 Main Tower Building
Dallas, Texas 75202

Dear Mr. Sconce:

This letter is in regard to the enclosed Title XIX State Pre-Print Plan amendment. The amendment clarifies the existing reimbursement methodology for Skilled Nursing and Intermediate Care Facilities located in Attachment 4.19-D, page 1. This amendment is not a significant change in reimbursement methodology, but merely reflects an additional level of ICF care, ICF - Type III. 84-17

In addition, the State of Oklahoma assures that it meets the requirements of Section 2314 of the Deficit Reduction Act, P. L. 98-369, regarding reimbursement under Medicaid and Medicare for capital related costs. The payment methodology utilized by the State for payments to hospitals, skilled nursing facilities and intermediate care facilities can reasonably be expected not to increase such payments solely as a result of a change of ownership, in excess of the increase which would result from the application of the Medicare requirements of Section 1861 (v)(1)(O) of the Act. (A-1)

Please contact this office if you have any questions.

Sincerely,

Robert Fulton

Robert Fulton
Director of Human Services

Enclosure

DEC 1984
DHHS/HCFA/DPO

APPROVED BY DHHS/HCFA/DPO
DATE: Feb. 5, 1985
TRANSMITTAL NO: (A-1)

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Effective Dates for Reimbursement Rates for Specified Services:

Reimbursement rates for the services listed on this introduction page are effective for services provided on or after that date with two exceptions:

1. Medicaid reimbursement using Medicare rates are updated annually based on the methodology specified in Attachment 4.19-B, Methods and Standards for Establishing Payment Rates.
2. Medicaid reimbursement using Medicare codes are updated and effective on the first of each quarter based on the methodology specified in Attachment 4.19-B, Methods and Standards for Establishing Payment Rates.

Payment methods for each service are defined in Attachment 4.19-B, Methods and Standards for Establishing Payment Rates, as referenced. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of outpatient services. The fee schedule is published on the agency's website at www.okhca.org/feeschedules.

In the event an out-of-state provider will not accept the payment rate established in Attachment 4.19-B, Methods and Standards for Establishing Rates, the state will either: a) negotiate a reimbursement rate equal to the rate paid by Medicare, unless otherwise specified in the plan; or b) services that are not covered by Medicare, but are covered by the plan, will be reimbursed as determined by the State.

Service	State Plan Page	Effective Date
Outpatient Hospital Services	Attachment 4.19-B, Page 1	October 1, 2019
A. Emergency Room Services		October 1, 2019
B. Outpatient Surgery	Attachment 4.19-B, Page 1a	October 1, 2019
C. Dialysis Services		October 1, 2019
D. Ancillary Services, Imaging and Other Diagnostic Services		February 1, 2021
E. Therapeutic Services	Attachment 4.19-B, Page 1b	October 1, 2019
F. Clinic Services and Observation/Treatment Room		October 1, 2019
H. Partial Hospitalization Program Services		April 1, 2019
Clinical Laboratory Services	Attachment 4.19-B, Page 2b	October 1, 2019
Physician Services	Attachment 4.19-B, Page 3	October 1, 2019
Home Health Services	Attachment 4.19-B, Page 4	October 1, 2019
Free-Standing Ambulatory Surgery Center-Clinic Services	Attachment 4.19-B, Page 4b	October 1, 2019
Dental Services	Attachment 4.19-B, Page 5	October 1, 2022
Transportation Services	Attachment 4.19-B, Page 6	October 1, 2019
Psychological Services	Attachment 4.19-B, Page 8	July 1, 2022
Eyeglasses	Attachment 4.19-B, Page 10.1	October 1, 2019
Nurse Midwife Services	Attachment 4.19-B, Page 12	October 1, 2019
Family Planning Services	Attachment 4.19-B, Page 15	October 1, 2019
Renal Dialysis Facilities	Attachment 4.19-B, Page 19	October 1, 2019
Other Practitioners' Services		
• Anesthesiologists	Attachment 4.19-B, Page 20	October 1, 2019
• Certified Registered Nurse Anesthetists (CRNAs) and Anesthesiologist Assistants	Attachment 4.19-B, Page 20a	October 1, 2019
• Physician Assistants	Attachment 4.19-B, Page 21	October 1, 2019
Nutritional Services	Attachment 4.19-B, Page 21-1	October 1, 2019
4.b. EPSDT		
• Partial Hospitalization Program Services	Attachment 4.19-B, Page 17	April 1, 2019
• Emergency Hospital Services	Attachment 4.19-B, Page 28.1	October 1, 2019
• Speech and Audiologist Therapy Services, Physical Therapy Services, and Occupational Therapy Services	Attachment 4.19-B, Page 28.2	February 1, 2021 October 1, 2019
• Hospice Services	Attachment 4.19-B, Page 28.4	

DATES FOR ESTABLISHING PAYMENT RATES FOR ATTACHMENT 4.19-B SERVICES

Effective Dates for Reimbursement Rates for Specified Services: *(continued)*

Service	State Plan Page	Effective Date
4.b. EPSDT (continued) • Other Practitioner – Applied Behavior Analysis (ABA) Services	Attachment 4.19-B, Page 28.13	July 1, 2019
Christian Science Nurses	Attachment 4.19-B, Page 28.5	October 1, 2019
Dentures	Attachment 4.19-B, Page 28.6	October 1, 2019
Respiratory Care	Attachment 4.19-B, Page 28.7	October 1, 2019
Private Duty Nursing Services	Attachment 4.19-B, Page 28.8	October 1, 2019
Physical Therapist	Attachment 4.19-B, Page 28.9	February 1, 2021
Occupational Therapist	Attachment 4.19-B, Page 28.10	February 1, 2021
Speech Language Pathologist	Attachment 4.19-B, Page 28.10.1	February 1, 2021
Christian Science Sanatoria	Attachment 4.19-B, Page 28.11	October 1, 2018
Other Practitioner – Licensed Clinical Social Worker	Attachment 4.19-B, Page 28.12	October 1, 2019
Residential Substance Use Disorder (SUD) Services	Attachment 4.19-B, Page 30b	July 1, 2022
Outpatient Behavioral Health and Substance Use Disorder Treatment Services A. Outpatient Behavioral Health Services in Agency Setting B. Partial Hospitalization Program (PHP)	Attachment 4.19-B, Page 29	 July 1, 2022 September 1, 2022
Program of Assertive Community Treatment (PACT) Services	Attachment 4.19-B, Page 29a	July 1, 2022
Alternative Treatments for Pain Management	Attachment 4.19-B, Page 31	January 1, 2022
Pediatric or Family Nurse Practitioner (Advanced Practice Nurse) Services	Attachment 4.19-B, Page 32	October 1, 2019
Diabetes Self-management Training (DSMT) Services	Attachment 4.19-B, Page 43	January 1, 2020
Medication Assisted Treatment (MAT)	Attachment 4.19-B, Page 44	October 1, 2020
Qualifying Clinical Trials	Attachment 4.19-B, Page 45	January 1, 2022
ACIP-Recommended Vaccine Administration	Attachment 4.19-B, Page 47	August 24, 2020

DATES FOR ESTABLISHING PAYMENT RATES FOR ATTACHMENT 4.19-B SERVICES

Reserved Page

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Outpatient Hospital Reimbursement

General

These provisions apply to all hospitals approved for participation in the Oklahoma SoonerCare program. In no case can reimbursement for outpatient hospital services exceed the upper payment limits as defined under 42 CFR 447.321. Laboratory services will not exceed maximum levels established by Medicare. Clinical diagnostic lab services (not laboratory services) do not exceed the maximum levels.

Effective February 1, 2010, payment for outpatient services will not be made for three national coverage determinations which relate to serious, preventable errors in medical care. These errors include surgery performed on wrong body part, surgery performed on wrong patient, and wrong surgery performed on patient.

A. Emergency Room Services

Payment will be made based on Medicare APC groups for Type A and Type B Emergency Departments.

B. Outpatient Surgery

1. Payment will be made for certain outpatient surgical procedures provided in hospitals based on the Medicare Ambulatory Surgery Center (ASC) facility services payment system unless otherwise denoted in this section. The surgical procedures are classified into payment groups based on Current Procedural Terminology (CPT). All procedures within the same payment group are paid at a single payment rate. For purposes of specifying the services covered by the facility rate, the OHCA hereby adopts and incorporates herein by reference the Medicare ASC procedures.

1a. Effective on or after January 1, 2018, certain outpatient surgical services provided in an outpatient hospital are reimbursed on a cost basis. Dental and Level 4 ear, nose, and throat (ENT) surgical procedures are classified into a payment group based on CPT codes. A facility specific outpatient cost to charge ratio (CCR) from the hospital Medicare cost report is used to determine average cost per unit by facility, then in total. Each individual procedure code for the dental (D9999) and Level 4 ENT (various codes) will be paid the same cost based single rate set based on statewide hospital costs. These rates will be recalculated annually using the most recent available cost report data from HCRIS.

State: Oklahoma
Date Received: 14 September, 2018
Date Approved: 26 November, 2018
Effective Date: 1 October, 2018
Transmittal Number: 18-026

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Outpatient Hospital Reimbursement *(continued)*

B. Outpatient Surgery *(continued)*

2. Facility fees for surgical procedures not covered as ASC procedures and otherwise covered under Medicaid will be reimbursed according to a state-specific fee schedule based on APC pricing. Bilateral or multiple procedures performed in one day will be subject to discounting.

3. Separate fees for outpatient surgery services are not payable to the hospital if the patient is admitted to the same hospital within 72 hours.

C. Dialysis Services

1. Dialysis visits will be reimbursed at the provider's Medicare composite rate for dialysis services determined by Medicare under 42 CFR 413 subpart H. The facility's composite rate is a comprehensive prospective payment for all modes of facility and home dialysis and constitutes payment for the complete dialysis treatment, except for a physician's professional services, separately billable laboratory services and separately billable drugs.

2. The provider must furnish all of the necessary dialysis services, equipment and supplies. Reimbursement for dialysis services and supplies is further defined in the Medicare Provider Reimbursement Manual, HCFA Pub. 15 (referred to as "Pub. 15"). For purposes of specifying the services covered by the composite rate and the services that are separately billable, the agency hereby adopts and incorporates herein by reference Pub. 15.

D. Ancillary Services, Imaging and Other Diagnostic Services

Ancillary services, imaging services, and other diagnostic services will be reimbursed on a prospective basis by paying the lower of usual and customary charges or a fee basis.

1. Services such as physical, occupational, and speech therapy services are reimbursable at a flat statewide fee schedule rate. The rate is based on APC group 0600.
    a. Reimbursement for licensed OT/PT/ST assistants will equal 85 percent of the payment made to a fully licensed therapist. Licensed speech language pathologist clinical fellows will be paid at the same rate of fully licensed speech language pathologists.

2. For each imaging service or procedure, the fee will be the technical component of the Medicare resource-based relative value scale (RBRVS).

3. For each diagnostic service or procedure, the fee will be the technical component of the RBRVS. For those services where there is no technical component under RBRVS, the fee will be 100 percent of the global value.

4. A facility fee will be reimbursed to the hospital for the services listed in D.2-3 in accordance with the

State: Oklahoma
Date Received: 14 September, 2018
Date Approved: 26 November, 2018
Effective Date: 1 October, 2018
Transmittal Number: 18-026

Pen and Ink Correction:
Red Text changed to black
12/20/18 sss

Revised 02-01-21

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Outpatient Hospital Reimbursement *(continued)*

E. Therapeutic Services

1. Payment is made for drugs and supplies for outpatient chemotherapy. A separately billable facility fee payment is made for administration based on Medicare APC group 0117. Claims cannot be filed for an observation room, clinic, or ER visits on the same day.

2. For each therapeutic radiology service or procedure, payment will be the technical component of the Medicare RBRVS.

F. Clinic Services and Observation/Treatment Room

A fee will be established for clinic visits and certain observation room visits. Reimbursement is limited to one unit per day per patient, per provider. The payment rates are based on APC groups 601 and 0339, respectively. Separate payment will not be made for observation room following outpatient surgery.

G. Hospital-based Community Mental Health Centers (CMHCs) Operated by Units of Government

1. CMHCs will be paid on the basis of cost in accordance with the following methodology: An overall outpatient cost-to-charge ratio (CCR) for each hospital will be calculated using the most recently available cost reports, with data taken from Worksheet C, Part 1. The overall CCR for each hospital will be applied to the Medicaid charges for the state fiscal year to determine the Medicaid costs for the year.

2. The agency's fee schedule rates are set as of July 1, 2006 and in effect for services provided on or after that date. All rates are published on the agency's website located at www.okhca.org. A uniform rate is paid to governmental and non-governmental providers.

3. Effective for services provided on or after 04-01-10, the rates in effect on 03-31-10 will be decreased by 3.25%

H. *Reserved section.*

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES OTHER TYPES OF CARE OUTPATIENT HOSPITAL SERVICES

I. SUPPLEMENTAL PAYMENTS FOR OUTPATIENT HOSPITALS PARTICIPATING IN THE SUPPLEMENTAL HOSPITAL OFFSET PAYMENT PROGRAM (SHOPP)

1. Hospital Outpatient Supplemental Payment Pools

Components of the Medicare Cost Report form 2552 were used to reasonably estimate what Medicare would pay for Medicaid outpatient hospital services. The upper payment limit (UPL) methodology consists of determining a hospital specific Medicare outpatient cost to charge ratio, applying that to Medicaid charges and then calculating the overall aggregate UPL for each of the three classes of hospitals.

a. Cost to Charge Ratios

The UPL was calculated using outpatient hospital specific cost to charge ratios. To determine the ratios, ancillary outpatient hospital costs were extracted from the most recently available Medicare hospital cost report form 2552 Worksheet Cless applicable RHC charges.

b. Upper Payment Limit Gaps

The hospital specific cost to charge ratio in 1(a) shall be applied to hospital specific total outpatient hospital Medicaid charges. Costs for these services are trended to the mid-point of the applicable year using the CMS published Outpatient Hospital PPS Market Basket Update for each year. That amount calculated shall be separately summed across the three classes of hospitals: privately owned, non-state government owned, and state government owned. These sums will equal the upper payment limits for each class of hospitals. Total Medicaid payments for each class of hospitals will be subtracted from its respective upper payment limit to determine the upper payment limit gaps.

2. Disbursement of payments to hospitals:

a. All hospitals shall be eligible for outpatient hospital access payments each year as set forth in this subsection except the following:
   i. A hospital that is owned or operated by the state or a state agency, the federal governments, a federally recognized Indian tribe, or the Indian Health Service;
   ii. a hospital that provides more than fifty percent (50%) of its inpatient days under a contract with a state agency other than the OHCA;

State: Oklahoma
Date Received: November 30, 2016
Date Approved: FEB 14 2017
Date Effective: January 1, 2017
Transmittal Number: 16-29

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE OUTPATIENT HOSPITAL SERVICES

I. SUPPLEMENTAL PAYMENTS FOR OUTPATIENT HOSPITALS PARTICIPATING IN THE SUPPLEMENTAL HOSPITAL OFFSET PAYMENT PROGRAM (SHOPP) (continued)

iii. a hospital that specializes in any one of the following: (i) treatment of a neurological injury (ii) treatment of cancer, (iii) treatment of cardiovascular disease, (iv) obstetrical or childbirth services, (v) surgical care, except that this exemption shall not apply to any hospital located in a city of less than five hundred thousand (500,000) population and for which the majority of inpatient days are for back, neck, or spine surgery; and

iv. a hospital that is certified by the federal Centers for Medicaid and Medicare Services as a long-term acute care hospital or as a children's hospital;

b. In addition to any other funds paid to critical access hospitals for outpatient hospital services to Medicaid patients, each critical access hospital (CAH) shall receive hospital access payments equal to the amount by which the payment for these services was less than one hundred one percent (101%) of the hospital's cost of providing these services, as determined using the CCR as described in paragraph 1(a). This cost to charge ratio is multiplied by allowable charges to determine the cost of these services. Costs for these services are trended to the mid-point of the applicable year using the CMS published Outpatient Hospital PPS Market Basket Update for each year.

c. In addition to any other funds paid to hospitals for outpatient hospital services to Medicaid patients, each eligible hospital shall receive outpatient hospital access payments each year equal to the hospital's pro rata share of the outpatient supplemental payment pool available to the hospital's class of hospitals, less the payments distributed in paragraph 3(b), based upon the hospital's Medicaid payments for outpatient services divided by the total Medicaid payments for outpatient services of all eligible hospitals within each class of hospital.

d. The outpatient supplemental payment pool available to each class of hospitals will be determined by multiplying the class's upper payment limit gap, as determined under H.1.b. above, by the available funds ratio. The available funds ratio is determined by dividing the total of all funds available under the Supplemental Hospital Offset Payment Program, less the CAH supplemental payments described in Attachment 4.19-A Page 32.5, X 2(b) and Attachment 4.19-B Page 1d, H 2(b), by the total of the inpatient and outpatient upper payment limit gaps for all classes of hospital eligible for supplemental payments under this paragraph.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE OUTPATIENT HOSPITAL SERVICES

H. SUPPLEMENTAL PAYMENTS FOR OUTPATIENT HOSPITALS PARTICIPATING IN THE SUPPLEMENTAL HOSPITAL OFFSET PAYMENT PROGRAM (SHOPP) (continued)

a. The total amount of payments shall not exceed the upper payment limit gap calculated in paragraph 1 for any of the three classes of hospitals.

2. Frequency of Payments

The OHCA will pay from the Supplemental Hospital Offset Payment Program Fund quarterly installment payments to hospitals of amounts available, not to exceed the UPL, for supplemental payments for Critical Access Hospitals and supplemental outpatient payments.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES OTHER TYPES OF CARE OUTPATIENT HOSPITAL SERVICES

J. SUPPLEMENTAL PAYMENTS FOR HOSPITALS WITH LEVEL 1 TRAUMA CENTERS

Hospitals that have Level 1 Trauma Centers will be eligible for a supplemental payment. The methodology for calculating the payment is as follows:

1. Hospital Level 1 Trauma Center Outpatient Supplemental Payment

   Components of the Medicare Cost Report form 2552 were used to reasonably estimate what Medicare would pay for Medicaid outpatient hospital services. The upper payment limit (UPL) methodology consists of determining a hospital specific Medicare outpatient cost to charge ratio, applying that to Medicaid charges and then calculating the UPL for all Level 1 Trauma Centers.

   a. Cost to Charge Ratios

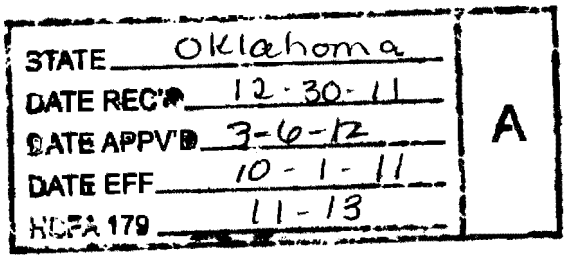
      The UPL was calculated using outpatient hospital specific cost to charge ratio. To determine the ratio, outpatient hospital costs were extracted from the most recently available Medicare hospital cost report form 2552 Worksheet C, Part 1, column 5, lines 37-68 and charges from Worksheet C, Part 1, column 8, lines 37-68 less applicable RHC charges.

   b. Upper Payment Limit Gaps

      The hospital specific cost to charge ratio in 1(a) shall be applied to hospital specific total outpatient hospital Medicaid charges. Total Medicaid payments will be subtracted from its respective upper payment limit to determine the upper payment limit gap.

2. Frequency of Payments

   The OHCA will make quarterly installment payments in an amount not to exceed the UPL for supplemental payments for Level 1 Trauma Center outpatient payments.



New Page 10-01-11

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES OTHER TYPES OF CARE

REIMBURSEMENT FOR INDIAN HEALTH SERVICE, TRIBAL PROGRAMS, AND URBAN CLINICS

For services provided by a qualified facility operated by the Indian Health Service, tribal government(s), or urban Indian health program (I/T/U) the applicable Office of Management and Budget (OMB) rate will be paid as published and specified in the Federal Register.

Alternative Payment Methodology for Reimbursement of Indian Health Services and Tribal 638 Facilities contracted as FQHCs

For qualified facilities operated by I/T/U providers that contract with the Medicaid agency as an FQHC, hereafter referred to as I/T/U-FQHC, an alternate payment method (APM) is allowed. The APM rate for services provided by an I/T/U-FQHC is set at the OMB rate.

The rate for services will be the same for both AI/AN and non-AI/AN.

For purposes of being recognized as an FQHC by Medicaid, Tribal facilities need not meet any requirement other than being operated by a Tribe or Tribal organization under P.L. 93-638.

Encounter reimbursement of I/T/Us & I/T/U/FQHCs

Reimbursement is made for an individual medical, dental, and outpatient behavioral health encounter per member per day. Reimbursement for more than one outpatient visit within a 24-hour period is made when services are provided for a distinctly different diagnosis.

Reimbursement of Residential Substance Use Disorder (SUD) Treatment Services

Reimbursement is made to qualified facilities operated by I/T/U providers for residential SUD treatment services at the outpatient OMB rate. Reimbursement will be provided in the amount of one outpatient encounter rate per member per day of service.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment for Rural Health Clinic Services and Other Ambulatory Services furnished by Rural Health Clinics

Effective January 1, 2001 payments to Rural Health Clinics (RHCs) for Medicaid covered services during RHC fiscal year 2001 will be paid on a per visit basis. The methodology described below is in accordance with the provisions of the Benefits Improvement and Protection Act (BIPA) of 2000.

A per visit rate for each facility will be determined based on 100 percent of the average facility's reasonable costs for providing all Medicaid covered services (including other ambulatory services) during RHC fiscal year 1999 and RHC fiscal year 2000. RHC fiscal year means cost reports ending in 1999 and 2000. The averaging methodology is as follows: total costs for 1999 and 2000 will be added together and divided by the number of visits.

The per-visit rate will be adjusted to account for any increase or decrease in the scope of services furnished during RHC fiscal year 2001. This adjustment will be calculated based on a review of available financial or statistical information, including data submitted on cost reports and special surveys to calculate any base rate adjustment. Each facility will be responsible for supplying the needed documentation to the OHCA

Beginning with RHC fiscal year 2002 and each RHC fiscal year thereafter, each facility's per visit rate will be inflated by the percentage increase in the Medicare Economic Index (MEI) for primary care services. Each facility's per visit rate will also be adjusted to account for any increase or decrease in the scope of services using the methodology described in paragraph 3 above.

Rural Health Clinics that enroll in Medicaid after RHC fiscal year 2000 will have their initial per visit rate established either by reference to payments to other RHCs in the same or adjacent areas.

Effective July 1, 2019, RHCs have the option to be paid using an alternative payment methodology (APM) if the RHC elects. RHC services paid using the APM are reimbursed at the rate indicated on the facilities periodic rate notification letter from the Medicare Fiscal Intermediary. In order to receive this rate, a RHC must agree to the APM and forward a copy of the facilities' periodic rate notification letter for its most recent full cost reporting year received from the fiscal intermediary to the state agency. The APM rate a facility receives will not be less than prospective payment system (PPS). There is no retroactive cost settlement.

Other ambulatory services are defined and furnished in accordance with the approved State Plan and recognized by the state under the FQHC benefit.

State: Oklahoma
Date Received: 12 July, 2019
Date Approved: 8 October, 2019
Effective Date: 1 July, 2019
Transmittal Number: 19-0023

Revised 07-01-19

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES OTHER TYPES OF CARE

Payment for Federally Qualified Health Center Services

Effective January 1, 2001 payments to Federally Qualified Health Centers for Medicaid covered services during State fiscal year 2001 will be paid on a per visit basis. The methodology described below is in accordance with the provisions of the Benefits Improvement and Protection Act (BIPA) of 2000.

A per visit rate for each facility will be determined based on 100 percent of the average facility's reasonable costs for providing all Medicaid covered services (including other ambulatory services) during State fiscal year 1999 and State fiscal year 2000. The averaging methodology is as follows: total costs for 1999 and 2000 will be added together and divided by the number of visits.

The per visit rate will be adjusted to account for any increase or decrease in the scope of services furnished during State fiscal year 2001. This adjustment will be calculated based on a review of available financial or statistical information, including data submitted on cost reports and special surveys to calculate any base rate adjustment. Each facility will be responsible for supplying the needed documentation to the OHCA.

Beginning with State fiscal year 2002 (July 1, 2001) and each State fiscal year thereafter, each facility's per visit rate will be inflated by the percentage increase in the Medicare Economic Index (MEI) for primary care services. Each facility's per visit rate will also be adjusted to account for any increase or decrease in the scope of services using the methodology described in paragraph 3 above.

Federally Qualified Health Centers that enroll in Medicaid after State fiscal year 2000 will have their initial per visit rate established either by reference to payments to other Federally Qualified Health Centers in the same or adjacent areas, or in the absence of such other clinics, through cost reporting methods. After the initial year, the per visit rate shall be established using the facility's reasonable costs inflated by the increase in the MEI.

Supplemental payments will be made to Federally Qualified Health Centers that subcontract directly or indirectly with managed care entities. Payments will represent the difference paid by the plans and the payment to which the Federally Qualified Health Centers would be entitled under a prospective pay per visit rate. Payments will be made quarterly.

TN# 01-03 Approval Date 06-18-01 Effective Date 01-01-01
Supersedes
TN# 90-09

STATE Oklahoma
DATE REC'D 03-20-01
DATE APPV'D 06-18-01
DATE EFF 01-01-01
HCFA 179 OK-01-03

A

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES OTHER TYPES OF CARE

Payment for Federally Qualified Health Center Services (Cont.)

Effective for services provided on or after June 1, 2012, the PPS payment methodology is available for services provided by Licensed Professional Counselors (LPC), Licensed Alcohol and Drug Counselors (LADC), Licensed Marital and Family Therapist (LMFT) and Licensed Behavioral Professionals (LBP) employed by or contracted by FQHCs who provide behavioral health services to children in accordance with the Oklahoma State Plan and HRSA grant award authority or Notice of Look-alike Designation (NLD).

Scope-of-Service Rate Adjustments

An FQHC may apply for an adjustment to the per-visit rate or the State may review and adjust the per visit rate based on a change in the scope-of-services provided by the FQHC. A change in scope-of-service means any of the following:

(a) The addition of a new FQHC service (such as adding medical, dental or behavioral health services or another health professional service), or deletion of SoonerCare covered services that are included in the existing prospective payment system reimbursement rate.

(b) A change in service due to amended regulatory requirements or rules.

(c) A change in service resulting from either remodeling an FQHC or relocating an FQHC if it has not elected to be treated as a newly qualified clinic.

(d) A change in types of services due to a change in applicable technology and medical practice utilized by the center or clinic.

(e) Changes in operating costs attributable to capital expenditures associated with a modification of the scope of any of the services provided, including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the center or clinic.

(f) A change in the scope of a project approved by HRSA where the change impacts a covered service.

New Page 06-01-12

STATE Oklahoma
DATE REC'D 12-30-11
DATE APPV'D 2-25-13
DATE EFF 6-1-12
HCFA 179 11-12
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment for Federally Qualified Health Center Services (Cont.)
Scope-of-Service Rate Adjustments (Cont.)

A change in costs, in and of itself, will not be considered a scope-of-service change unless all of the following apply:

(a) The increase or decrease in cost is attributable to an increase or decrease in the scope of the approved service under the State Plan.

(b) The cost is allowable under Medicare reasonable cost principles set forth in 42 CFR Part 413.

(c) The change in scope-of-services is a change in the type, intensity, duration, or amount of services, or any combination thereof.

(d) The net change in the FQHC's visit rate equals or exceeds 2.5% for the affected FQHC site. For FQHC's that filed consolidated cost reports for multiple sites to establish the initial prospective payment reimbursement rate, the 2.5% threshold will be applied to the average per visit rate of all sites for the purposes of calculating the cost associated with a scope-of-service change. "Net change" means the per-visit rate change attributable to the cumulative effect of all increases and decreases for a particular year.

If there is a change in scope-of-service, it is the responsibility of the FQHC to request OHCA to review services that have had a change to the scope-of-service. Likewise, it is the responsibility of OHCA to notify the FQHC of any reviews and adjustments related to a change in scope-of-service prior to any adjustments. Adjustments will be made to the base rates on a case by case basis where the FQHC can demonstrate that the increases or decreases in the scope-of-services is not reflected in the base rate and is not temporary in nature. If an FQHC requests a change in scope due to an increase in utilization for services included in the PPS, current utilization will be compared to the utilization used in the calculation of the PPS from appropriate rate adjustments. If it is determined that a significant change in the scope-of-service has occurred, the reasonable incremental cost per encounter from this change will be added to the PPS rate and a new rate will be established. A change will not be considered significant unless it impacts the base rate by 2.5% or more. This new rate will be effective on the date the change in scope-of-service was implemented.

New Page 6-01-12

STATE Oklahoma
DATE REC'D 12-30-11
DATE APPV'D 2-25-13
DATE EFF 6-1-12
NOFA 179 11-12
A

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Clinic Laboratory Services

Payment will be made for covered clinical laboratory services at rates not to exceed 100% of the CMS National Laboratory Fee Schedule, or at rates not to exceed 100% of the local Medicare Carrier's allowable charge for procedures not included in the National Laboratory Fee Schedule, or in instances where no national or local fee has been established, an interim fee will be established by the State Plan Amendment Rate Committee of the Oklahoma Health Care Authority.

State: Oklahoma
Date Received: 14 September, 2018
Date Approved: 26 November, 2018
Effective Date: 1 October, 2018
Transmittal Number: 18-026

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment for physicians' services (includes medical and remedial care and services)

Payment for physician's services, radiology services and services rendered by other practitioners under the scope of their practice under State law, are covered under the Agency fee schedule. The payment amount for each service paid for under the fee schedule is the product of a uniform relative value unit (RVU) for each service and the Medicare conversion factor (CF). The Medicare CF converts the relative values into payment amounts. The general formula for calculating the fee schedule can be expressed as:

RVU x CF = Rate

EPSDT screenings and eye exams by optometrists have been incorporated into the fee schedule.

Effective February 1, 2010, payment will not be made to physicians or other practitioners for three national coverage determinations which relate to serious, preventable errors in medical care. These errors include surgery performed on wrong body part, surgery performed on wrong patient, and wrong surgery performed on patient.

Vaccines are paid the equivalent to Medicare Part B, ASP + 6%. When ASP is not available, an equivalent price is calculated using Wholesale Acquisition Cost (WAC). If no Medicare, ASP, or WAC pricing is available, then the price will be calculated based on invoice cost. No payment will be made to physicians or other practitioners for vaccines that were received through the Vaccine for Children's program.

State: Oklahoma
Date Received: 14 September, 2018
Date Approved: 26 November, 2018
Effective Date: 1 October, 2018
Transmittal Number: 18-026

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment for physicians' services (includes medical and remedial care and services) *(continued)*

Services Provided by Oklahoma Universities Affiliated Physicians

REIMBURSEMENT - Eligible providers specified below will be reimbursed for services rendered to Oklahoma Medicaid recipients. This excludes dually eligible Medicare and Medicaid recipients. The supplemental payments, which reflect the alternative fee schedule, will be made as part of service reimbursement based on the calculation of the differential amount between the base Medicaid payment and supplemental payment for allowable Current Procedural Terminology (CPT) codes. Each Oklahoma Medicaid covered medical billable code (excluding vaccines, technical component, laboratory, and radiology services) listed on the applicable Oklahoma Medicaid fee schedule will be reimbursed in accordance with the payment methodology, below.

With regard to the Agency fee schedule on Attachment 4.19-B, Page 3, a different conversion factor (CF) will be used. The established relative value unit (RVU) will be used and the CF amount will result in a payment equal to 175% of the Medicare allowable. The reimbursed percentage will not exceed the following payment methodology:

a. An average of the commercial payment from the top five (5) commercial payors for each CPT code were provided to generate the Average Commercial Rate (ACR).
b. Both the Medicare rate and the ACR were multiplied by the Oklahoma Medicaid fee-for-service (FFS) volume of services reimbursed for eligible CPT codes.
c. The statewide Medicare equivalent of the ACR was calculated by dividing the product of ACR and FFS volume by the product of the Medicare and FFS volume.

ELIGIBLE PROVIDERS — Providers who are enrolled in Oklahoma Medicaid, and employed by or contracted with an Oklahoma public, non-profit, accredited medical school to provide supervision and teaching of medical students, residents, or fellows through application of the parameters of 42 CFR 447.304. Eligible providers include physicians who are eligible Oklahoma Medicaid providers and furnish Oklahoma Medicaid reimbursable services.

State: Oklahoma
Date Received: 12 July, 2019
Date Approved: 7 October, 2019
Effective Date: 1 July, 2019
Transmittal Number: 19-0014

Reimbursement Template -Physician Services

Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415

Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS. The fee schedule was established by the state using the 2009 Medicare conversion factor and the January 2013 release of RVUs. The fee schedule will be updated with the beginning of the state fiscal year on July 1, 2013 using the April 2013 release of Medicare RVUs times the 2009 conversion factor; in January of 2014 using the November 2013 release of RVUs and the 2009 conversion factor and in July of 2014 using the April 2014 release of RVUs and the 2009 conversion factor.

☐ The rates reflect all Medicare site of service and locality adjustments.

☒ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.

☒ The rates reflect all Medicare geographic/locality adjustments.

☐ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code:_____

Method of Payment

☐ The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.

☒ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on the date of service as published in the agency's fee schedule described in Attachment 4.19B, Page 3, Physician Services of the State plan and the minimum payment required at 42 CFR 447.205.

Supplemental payment is made: ☐ monthly ☒ quarterly

Primary Care Services Affected by this Payment Methodology

STATE Oklahoma
DATE REC'D 3/29/2013
DATE APPV'D 6/20/2013
DATE EFF 4/1/2013
HCFA 179 13-06

A

SUPERSEDES: NONE - NEW PAGE

☐ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.

☒ The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes). 99288, 99444, 99455, 99456 and 99499

(Primary Care Services Affected by this Payment Methodology – continued)

☐ The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

_____

_____

_____

Physician Services – Vaccine Administration

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

☒ Medicare Physician Fee Schedule rate (For Non-VFC Providers)

☒ State regional maximum administration fee set by the Vaccines for Children program (For VFC Providers)

☐ Rate using the CY 2009 conversion factor

Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

☐ The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is:_____.

☒ A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: $13.33.

SUPERSEDES: NONE - NEW PAGE

STATE Oklahoma
DATE REC'D 3/29/2013
DATE APPV'D 6/20/2013
DATE EFF 1/1/2013
OMB NO. 0938-179 13-06

A

☐ Alternative methodology to calculate the vaccine administration rate in effect 7/1/09: _____

_____

_____

Note: This section contains a description of the state's methodology and specifies the affected billing codes.

Effective Date of Payment

E & M Services
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on 12/31/14 but not prior to December 31, 2014. All rates are published **at The Agency's Public Website at www.okhca.org.**

Vaccine Administration
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on 12/31/14 but not prior to December 31, 2014. All rates are published at **The Agency's Public Website at www.okhca.org.**

Supercedes Page: None

PRA Disclosure Statement
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 48 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to :CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

SUPERSEDES: NONE - NEW PAGE

STATE Oklahoma
DATE REC'D 3/29/2013
DATE APPV'D 6/20/2013
DATE EFF 4/1/2013
OMB NO. 0938-0179 12-06

A

Payment is made at the fee schedule amount for skilled visits and home health aide visits.

Payment for Durable Medical Equipment, Supplies, and Appliances:

For items of DME provided in Medicare Competitive Bidding Areas (CBAs) where rates for specific items have been competitively bid under the Medicare program, the rate is set at the lower of the following:

1. The percent listed below of the Medicare single payment amount specific to the geographic area where the item is being provided, that are in effect as of Jan. 1 each year, and updated on a quarterly basis (April 1, July 1, October 1) as needed;
2. The provider's charge; or
3. The non-rural and rural DMEPOS fee schedule rate.

If there is no competitively bid payment rate for an item of DME in a CBA, then one of two methodologies will apply:

1. Reimbursement for DME provided in non-rural areas is set at the lower of the following:
    a. The percent listed below of the Medicare DMEPOS fee schedule rate for Oklahoma geographic, non-rural areas, that are in effect as of Jan. 1 each year; or
    b. The provider's charge.

2. For items of DME provided in rural areas, the rate is set at the lower of the following:
    a. The percent listed below of the Medicare DMEPOS fee schedule rate for Oklahoma geographic, rural areas, set as of Jan. 1 each year; or
    b. The provider's charge.

The percentage of Medicare is as follows:

1. Durable medical equipment, oxygen, purchase equipment that Medicare only rents, and Complex Rehab Technology accessories will be reimbursed at 100 percent of the Medicare prices;
2. Complex Rehab Technology power wheelchairs will be reimbursed at 70 percent of Medicare prices;
3. Enteral food will be reimbursed at 125 percent of the Medicare prices;
4. Supplies will be reimbursed at 100 percent of the Medicare prices;
5. Parenteral equipment and food will be reimbursed at 70 percent of Medicare prices;

For items of durable medical equipment, supplies, and appliances not paid at the Medicare fee or when there is no fee schedule available, the provider will be reimbursed either by a fee determined by OHCA or through manual pricing, as follows:

1. The fee determined by OHCA will be determined from cost information from providers or manufacturers, surveys of the Medicaid fees for other states, survey information from national fee analyzers, or other relevant fee-related information;
2. Manual pricing is reasonable when one procedure code covers a broad range of items with a broad range of costs, since a single fee may not be a reasonable fee for all items covered under the procedure code, resulting in access-to-care issues. Examples include:
    a. Procedure codes with a description of "not otherwise covered," "unclassified," or "other miscellaneous"; and
    b. Procedure codes covering customized items.
    c. If manual pricing is used, the provider will be reimbursed the lower of the Manufacturer's Suggested Retail Price (MSRP) less 30 percent (30%), or the provider's documented invoice cost (Average Wholesale Price (AWP)) plus 30 percent (30%).

Revised 08-01-2020

Payment for Durable Medical Equipment, Supplies, and Appliances (continued):

For durable medical equipment, supplies, and appliances purchased at the pharmacy point of sale, providers will be reimbursed the equivalent of Medicare Part B, ASP + 6%. When ASP is not available, an equivalent price is calculated using Wholesale Acquisition Cost (WAC). If no Medicare, ASP, or WAC pricing is available, then the price will be calculated based on invoice cost.

Payment is not made for durable medical equipment, supplies, and appliances that are not deemed as medically necessary or considered over-the-counter.

The Agency does not pay durable medical equipment providers separately for services that are included as part of the payment for another treatment program. For example, all items required at a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities are paid through those corresponding institutional rate methodologies.

For any item subject to the DME FFP demonstration, these items will be priced at or under 100% of Medicare rural/non-rural pricing.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Free-Standing Ambulatory Surgery Center-Clinic

A. Payment for outpatient surgical procedures that are covered under Medicare's ASC payment system will be reimbursed 100 percent of the 2005 Medicare rate for such services. Surgical procedures are classified into payment groups based on Current Procedural Terminology (CPT). All procedures within the same payment group are paid at a single payment rate. For purposes of specifying the services covered by the facility rate, the OHCA hereby adopts and incorporates herein by reference the Medicare ASC procedures.

B. Facility fees for surgical procedures not covered as Medicare ASC procedures and otherwise covered under Medicaid, will be reimbursed according to a State-specific fee schedule taking into consideration rates for Medicare Ambulatory Patient Classification (APC) pricing and reimbursement for similar services provided in the outpatient hospital setting. Bilateral or multiple procedures performed in one day will be subject to discounting.

C. The fee schedule and any annual/periodic adjustments to the fee schedule are published on the agency secure website and/or public website. The fee schedule will not exceed the upper payment limit (UPL) at 42 CFR 447.321 Outpatient hospital and clinic services: Application of upper payment limits. A uniform rate is paid to governmental and non-governmental providers.

State: Oklahoma
Date Received: 14 September, 2018
Date Approved: 26 November, 2018
Effective Date: 1 October, 2018
Transmittal Number: 18-026

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment to Dentists for General Dental and Orthodontic Services

Dentists are reimbursed a fee for service rate for general dental and orthodontic services. The same rate is paid for each service regardless of where the service was provided.

Payment for dental services is covered under the Agency fee schedule. The payment amount for each service paid under the fee schedule is the product of a uniform relative value unit (RVU) for each service and a conversion factor (CF). The CF converts the relative values into payment amounts. The general formula for calculating the fee schedule can be expressed as:

RVU x CF = Rate

Effective October 1, 2022, the State will utilize the Optum Coding Relative Values for Dentists Data File to update the RVUs annually. The State utilizes different conversion factors for adults and children.

Payments to Dentists Working at a Governmental Hospital Based Children's Dental Clinic

The State reimburses these dentists a fee-for-service amount that equals the average commercial fee schedule, which is calculated in the following manner. For each of the dental procedures rendered by dentists in this dental clinic, the State determined the average commercial allowed amount paid per procedure code by the top five commercial payers. The fee schedule amount for each dental procedure code equals an average of the payment by the top payers. The average commercial fee schedule rate provides for payment in-full and is not an add-on payment to the regular Medicaid rate.

In addition, the reimbursement methodology for amalgam or posterior composite resin restorations which is the mean of the 2009 reimbursement rates for each, will be reduced by 3.00% along with all other dental fees effective 07-01-10.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of dental services. All rates are published on the agency's website at: www.okhca.org/feeschedules.

State: Oklahoma
Date Received: 14 September, 2018
Date Approved: 26 November, 2018
Effective Date: 1 October, 2018
Transmittal Number: 18-026

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Transportation

Payment is made for the least expensive means of transportation commensurate with the patient's needs.

Transportation by Ambulance

1. Ground Ambulance Transports – Payment will be made for each level of service based on the geographically adjusted Medicare Ambulance Fee Schedule (AFS).

a. Supplemental Reimbursement for Ground Ambulance Transportation Providers - Effective October 1, 2018, qualified governmental ground ambulance transportation providers will be eligible to receive supplemental Medicaid payments to provide reimbursement for uncompensated costs incurred by providing ambulance transportation services to Medicaid beneficiaries. Eligible providers will certify their uncompensated cost for providing ambulance transportation services for Medicaid recipients through an annual submission of the Centers for Medicare and Medicaid Services (CMS)-approved cost report.

Supplemental payments provided by this program are available only for allowable costs that are in excess of other Medicaid revenue that eligible entities receive for ground ambulance transportation services to Medicaid recipients. Total reimbursements from Medicaid including the supplemental payment must not exceed one hundred percent of actual costs.

The Oklahoma Health Care Authority will recognize, on a voluntary basis, the allowable certified public expenditures of approved governmental ambulance service providers for providing services as set forth below.

The allowable certified public expenditures of a participating provider who meets the required state enrollment criteria are eligible for federal reimbursement up to reconciled cost in accordance with (i.) through (v.) for services provided on or after October 1, 2018:

i. The governmental ambulance services provider will submit a CMS approved cost report annually, on a form approved by the Oklahoma Health Care Authority. The cost report will be completed on a state fiscal year basis and will be due to the Oklahoma Health Care Authority no later than 90 days following the last day of the state fiscal year
ii. Cost reconciliation and cost settlement processes will be completed within 12 months of the end of the cost reporting period.
iii. The provider's reported direct and indirect costs are allocated to the Medicaid program by applying a Medicaid utilization statistic ratio to Medicaid charges associated with paid claims for the dates of service covered by the submitted cost report.
iv. The Oklahoma Health Care Authority will make annual interim supplemental payments to eligible providers. The interim supplement payments for each provider will be based on the provider's completed annual cost report in the form prescribed by the Oklahoma Health Care Authority and approved by CMS for the applicable cost reporting year. Each eligible provider must compute their annual cost in accordance with Cost Determination Protocols (see section d). Interim payments will be equal to 75 percent of the total uncompensated Medicaid fee-for-service ambulance cost as indicated on the as-filed cost report.
v. A reconciliation will be computed by the Oklahoma Health Care Authority based on the difference between the interim payments and total allowable Medicaid costs from the approved cost report. Any excess payments determined in the reconciliation processes are recouped and the federal share is returned to CMS on the quarterly expenditure report in which the recoupment is made.

State: Oklahoma
Date Received: 7 December, 2018
Date Approved: 5 March, 2019
Effective Date: 1 October, 2018
Transmittal Number: 18-0039

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Transportation

A. Transportation by Ambulance *(continued)*
1. Ground Ambulance Transports *(continued)*

b. Ground Ambulance Provider Eligibility Requirements - To be eligible for supplemental payments, providers must meet all of the following requirements:

i. Be enrolled as an Oklahoma Medicaid provider for the period claimed on their annual cost report;
ii. Provide ground ambulance transportation services to Medicaid recipients; and
iii. Be an organization that:
I. Is publicly owned or operated, defined as a unit of government which is a State, a city, a county, a special purpose district or authority, or other government unit in the State that has taxing authority, has direct access to tax revenues, or is an Indian tribe as defined in Section 4 of the Indian Self-Determination and Education Assistance Act; or
II. Contracts with a local government, defined as an interlocal agreement with a city, county, or local service district, including but not limited to, a rural fire protection district, and all administrative subdivisions of such city, county, or local service district, pursuant to a plan for emergency medical services.

State: Oklahoma
Date Received: 7 December, 2018
Date Approved: 5 March, 2019
Effective Date: 1 October, 2018
Transmittal Number: 18-0039

c. Supplemental Reimbursement Methodology – General Provisions

i. Computation of allowable costs and their allocation methodology must be determined in accordance with the CMS Provider Reimbursement Manual (CMS Pub. 15-1), CMS non-institutional reimbursement policies, 2 CFR Part 200 (Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards), and 2 CFR Part 225 (Cost Principles for State, Local, and Indian Tribal Governments), which establish principles and standards for determining allowable costs and the methodology for allocating and apportioning those expenses to the Medicaid program.
ii. Medicaid base payments to the providers for providing ground ambulance transportation services are derived from the ground ambulance FFS fee schedule established for reimbursements payable by the Medicaid program by procedure code. The primary source of paid claims data is derived from reimbursements in the Oklahoma Medicaid Management Information System (MMIS). The number of paid Medicaid FFS transports is derived from and supported by the MMIS reports for services during the applicable service period.
iii. The total uncompensated care costs of each eligible provider available to be reimbursed under this supplemental reimbursement program will equal the shortfall resulting from the allowable costs determined for each eligible provider providing ground ambulance transportation services to Oklahoma Medicaid beneficiaries, net the payments received and payable from the Oklahoma Medicaid program and all other sources of reimbursement for such services provided to Oklahoma Medicaid beneficiaries. If the eligible provider does not have any uncompensated care costs, then the provider will not receive a supplemental payment under the supplemental payment program.

d. Cost Determination Protocols

i. An eligible ground ambulance transportation provider's specific allowable cost per medical transport rate will be calculated based on the provider's audited financial data reported on the CMS-approved cost report. The cost per medical transport rate will be the sum of actual allowable direct and indirect costs of providing medical transport services divided by the actual number of medical transports provided for the applicable service period.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Transportation

A. Transportation by Ambulance *(continued)*

1. Ground Ambulance Transports *(continued)*

d. Cost Determination Protocols *(continued)*

ii. Direct costs for providing ground ambulance transportation services include only the unallocated payroll costs for the shifts in which personnel dedicate one hundred percent (100%) of their time to providing ground ambulance transportation services, medical equipment and supplies, and other costs directly related to the delivery of covered services, such as first-line supervision, materials and supplies, professional and contracted services, capital outlay, travel, and training. These costs must be in compliance with Medicaid non-institutional reimbursement policy and are directly attributable to the provision of the ground ambulance transportation services.

I. All capital related, salaries and benefits expenses that are not directly assigned to MTS and non-MTS will be allocated based on CAD/Trip Statistics. Through the use of CAD/Trip Statistics, the number of responses or amount of time spent providing direct medical transportation services will be calculated and used as an apportioning measure for costs shared between MTS and non-MTS cost centers.

iii. Indirect costs cannot be readily assigned to a particular cost objective and are those that have been incurred for common or joint purpose. Indirect costs are determined in accordance to one of the following options:

I. Eligible providers that receive more than $35 million in direct federal awards must either have a Cost Allocation Plan (CAP) or a cognizant agency approved indirect rate agreement in place with its federal cognizant agency to identify indirect cost. If the eligible provider does not have a CAP or an indirect rate agreement in place with its federal cognizant agency and it would like to claim indirect cost in association with a non-institutional service, it must obtain one or the other before it can claim any indirect cost.

II. Eligible providers that receive less than $35 million of direct federal awards are required to develop and maintain an indirect rate proposal for purposes of an audit. In the absence of an indirect rate proposal, eligible providers may use methods originating from a CAP to identify its indirect cost. If the eligible provider does not have an indirect rate proposal on file or a CAP in place and it would like to claim indirect cost in association with a non-institutional service, it must secure one or the other before it can claim any indirect cost**.**

III. Eligible providers which receive no direct federal funding can use any of the following previously established methodologies to identify indirect cost:

1. A CAP with its local government;
2. An indirect rate negotiated with its local government; or
3. Direct identification through use of a cost report.

IV. If the eligible provider never established any of the above methodologies, it may do so, or it may elect to use the 10% de minimis rate to identify its indirect cost. The provider-specific cost per medical transport rate is calculated by dividing the total net medical transport allowable costs of the specific provider by the total number of medical transports provided by the provider for the applicable service period

State: Oklahoma
Date Received: 7 December, 2018
Date Approved: 5 March, 2019
Effective Date: 1 October, 2018
Transmittal Number: 18-0039

Cost Settlement Process

i. The payments and the number of transport data for eligible Medicaid transports will be sent by the Agency to eligible participating providers no later than 60 days following the close of the state fiscal year. During the cost reconciliation and cost settlement process that occurs, the Agency will make adjustments to the as-filed cost report based on the reconciliation results of the most recently retrieved MMIS report.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Transportation *(continued)*

A. Transportation by Ambulance *(continued)*
1. Ground Ambulance Transports *(continued)*
e. Cost Settlement Process *(continued)*

i. Each eligible provider will receive an annual lump sum payment in the amount equal to the total of the uncompensated care costs as defined in the above Supplemental Reimbursement Methodology – General Provisions.

ii. If, at the end of the final reconciliation, it is determined that the eligible provider was overpaid, the provider will return the overpayment to Agency and the Agency will return the overpayment to the federal government pursuant to 42 CFR 433.316. If underpayment is determined, then the eligible provider will receive an interim supplemental payment in the amount of the underpayment.

2. Air Ambulance Transports – Reimbursement for air ambulance service is made based on the Medicare AFS. Payment will not exceed 100% of the Medicare allowable rates.

a. **Rotary Wing (RW)** - Payment to providers affiliated with Level I Trauma Centers is based on a blend of the urban and rural rates for both the base payment and the mileage rate. The blended ratio is .41/.59 for the point of pick-up (POP). The rate for base and mileage for all other RW providers is based on the urban rate, regardless of the POP.

b. **Fixed wing (FW)** – Payment is calculated using the urban base rate and mileage, regardless of the POP. Effective with claims for dates of service on or after July 1, 2008, reimbursement is made based on the 2008 Medicare AFS.

B. Non-Emergency

1. Ground Transportation – All transportation by public carrier or private vehicle is coordinated statewide through the designated SoonerRide transportation broker. The State assures that the broker itself will not be a provider of transportation as prescribed at 42 CFR 440.170(a)(4)(i)((D)(ii)(A).

2. Airline Travel - Prior Authorization is required for commercial airline transportation. The use of airline accommodations may be authorized or approved when the individual's medical condition is such that transportation out-of-state by commercial airline is required. Officials authorizing travel by commercial airline will require the most economical fare be used to the maximum extent possible.

C. Meals and Lodging - The cost of meals and lodging are provided only when necessary in connection with transportation to and from medical care. Payment is made using a per diem fee schedule.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Transportation *(continued)*

D. Access Payment Program Fee for Emergency Ambulance Service Providers

Effective January 1, 2022, all non-exempt ambulance service providers of emergency services are eligible to participate in the Ambulance Service Providers Access Payment Program. Eligible ambulance service providers licensed in Oklahoma are assessed an ambulance service provider access payment program fee. An ambulance service provider subject to the assessment of the Ambulance Service Provider Access Payment Program that has not been previously licensed as an ambulance service in the State and that commences operations during a year will pay the required assessment and will be eligible for ambulance service provider access payments.

1. **Exempt Ambulance Service Providers –** The following ambulance service providers are exempt from the ambulance service provider access payment fee:

   a. An ambulance service that is owned or operated by the state or a state agency, the federal government, a federally recognized Indian tribe, or the Indian Health Service;
   b. An ambulance service that is eligible for Supplemental Hospital Offset Payment Program (SHOPP);
   c. An ambulance service that provides air ambulance services only; or
   d. An ambulance service that provides non-emergency transports only.

State: Oklahoma
Date Received: 7 December, 2018
Date Approved: 5 March, 2019
Effective Date: 1 October, 2018
Transmittal Number: 18-0039

2. **Ambulance Service Provider Access Payment –** Access payment amounts are based on the identified emergency medical transportation services for which the provider is eligible to be reimbursed as well as the base payment and the average commercial rate (ACR) for such services. Eligible providers must submit the identified data required to calculate the ACR to the Oklahoma Health Care Authority (OHCA) to receive an access payment. For each eligible provider, the annual assessment is calculated on an annual basis and paid out quarterly as follows:

   a. The paid Medicaid claims for each eligible provider are aligned with the Medicare fees (Medicare Fee Schedule – Urban) for each healthcare common procedure coding system (HCPCS) or current procedure terminology (CPT) code and the Medicare payment is calculated for such claims.

   b. A separate Medicare equivalent of the ACR is calculated for each eligible provider that qualifies for the access payment by dividing the total amount of the average commercial payments for the claims by the total Medicare payments for the claims.

   c. The base payment for services eligible for reimbursement is calculated for each eligible provider.

   d. The amount the eligible provider would have been reimbursed at ACR for the eligible services is determined.

   e. The payment enhancement amount for each eligible provider is determined by subtracting the base payment from the ACR of the eligible services provided.

   f. The medical transportation access payment for each eligible provider is calculated by the sum of all payment enhancement amounts (from e. above) for eligible services provided.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Transportation (*continued*)

D. Access Payment Program Fee for Emergency Ambulance Service Providers *(continued)*

2. Ambulance Service Provider Access Payment *(continued)*

The access payment is comprehensive and does not exceed 100% of the difference between Medicaid payments otherwise made to eligible providers for the provision of medical transportation services and the average amount that would have been paid at the equivalent ACR.

The ambulance service provider medical transportation access payments are to supplement, not supplant, appropriations to support ambulance service provider reimbursement. Payments may not be used to offset any other payment by Medicaid for services to Medicaid beneficiaries.

E. Secure Behavioral Health Transports

Providers of secure behavioral health transports will be paid on a fee-for-service basis through encounter payments and a combination of encounter payments and a set rate per mile as follows:

1. Transports 30 miles and under will be reimbursed $160.00 per encounter, equal to 68.83% of the CY 2021 rate for A0429.

2. Transports over 30 miles will be reimbursed $160.00 per encounter, equal to 68.83% of the CY 2021 rate for A0429, and $2.85 per mile, equal to 38.10% of the CY 2021 rate for A0425.

State: Oklahoma
Date Received: 26 September, 2016
Date Approved: 29 November, 2016
Effective Date: 1 September, 2016
Transmittal Number: 16-27

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment for Prescribed Drugs

(a) Reimbursement – Reimbursement for pharmacy claims is based on the sum of the ingredient cost plus a $11.41 professional dispensing fee. If the provider's usual and customary charge to the general public is lower than the calculated allowable ingredient cost, the reimbursement will be equal to the provider's usual and customary charge to the general public.

(b) Ingredient Cost Methodology and Professional Dispensing fee of $11.41 – The ingredient cost is set by one of the following methods:

(1) **Brand Name Drugs** – Ingredient cost based on Actual Acquisition Cost shall be set as the lower of National Average Drug Acquisition Cost (NADAC) or Wholesale Acquisition Cost (WAC), plus professional dispensing fee of $11.41.

(2) **Generic Drugs** – Ingredient cost based on Actual Acquisition Cost shall be set as the lower of the State Maximum Allowable Cost (SMAC), NADAC, or WAC plus professional dispensing fee of $11.41.

(3) **State Maximum Allowable Cost** (SMAC) – is established for certain products which have a Food and Drug Administration (FDA) approved generic equivalent. The SMAC is calculated using prices from pharmaceutical wholesalers who supply these products to pharmacy providers in Oklahoma. Pharmacies may challenge a specific product's SMAC price by providing a current invoice that reflects a net cost higher than the calculated SMAC price and by certifying that there is not another product available to them which is generically equivalent to the higher priced product.

(4) **340B-Purchased Drugs** – For both, covered entity pharmacies and contract pharmacies, the reimbursement to the pharmacy will be the 340B ceiling price plus professional dispensing fee of $11.41.

(5) **Federal Supply Schedule Drugs** – For drugs purchased under the Federal Supply Schedule, other than by Indian Health Service/Tribal/Urban Indian Clinic pharmacies, the provider will submit and be reimbursed their actual acquisition cost plus professional dispensing fee of $11.41.

(6) **Drugs Acquired at Nominal Price (Outside of 340B or Federal Supply Schedule)** – For drugs acquired at nominal price outside of the 340B program or the Federal Supply Schedule, the provider will submit and be reimbursed their actual acquisition cost plus professional dispensing fee of $11.41.

State: Oklahoma
Date Received: 4 October, 2019
Date Approved: 19 December, 2019
Effective Date: 1 October, 2019
Transmittal Number: 19-0037

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment for Prescribed Drugs *(continued)*

(b) Ingredient Cost Methodology *(continued)*:

(7) Indian Health Service/Tribal/Urban Indian Clinic Facilities are reimbursed at the OMB encounter rate. This is limited to one pharmacy encounter fee per member per facility per day.

(8) Specialty drugs are reimbursed at the lower of NADAC, WAC, or Specialty Pharmaceutical Allowable Cost (SPAC). The factors included in the SPAC calculation are Medicare Part B pricing, (Average Sales Price plus 6%), WAC, and NADAC plus professional dispensing fee of $11.41.

(9) Prescriptions for members residing in long-term care facilities are reimbursed as the lower of NADAC, WAC, SPAC, or SMAC plus the Professional Dispensing Fee of $11.41.

(10) Clotting factor from specialty pharmacies, Hemophilia Treatment Centers (HTCs), and Centers of Excellence – Is reimbursed at the SPAC rate plus the professional dispensing fee of $11.41 for hemophilia clotting factors.

When a Hemophilia Treatment Center which is a 340B covered entity provides clotting factor to Medicaid members whether the pharmacy is owned by the covered entity or has a contract pharmacy arrangement, the procedure for 340B pharmacies listed on Attachment 4.19-B, page 7, section (b)(4) will apply.

(11) Investigational drugs are not covered; including FDA approved drugs being used in post-marketing studies.

(12) The Professional Dispensing Fee is $11.41 per prescription.

(c) Physician Administered Drugs – are reimbursed at a price equivalent to Medicare Part B, ASP + 6%. When ASP is not available, an equivalent price is calculated using WAC.

340B covered entities are allowed to submit their usual and customary cost and are paid at the regular Medicaid allowable rate. At the end of the quarter, the URA is recouped from the covered entity to keep the state whole based on net cost after rebate.

(d) Meeting the Federal Upper Limits (FUL) in the aggregate – By using the lower of NADAC, WAC or SMAC, the FUL will always be met since NADAC is the floor for the FUL.

(e) High-investment drugs – Payment to hospitals for high-investment drugs used to treat members during an inpatient admission or outpatient hospital visit will be the lower of: (1) the Hospital's Actual Acquisition Cost; (2) the WAC; (3) if available, the ASP + 6% Medicare Part B; or, (4) billed charges. A list of high-investment drugs is found on www.okhca.org.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment for Psychological Services

Payment is made to clinical psychologists and to Level 2 Behavioral Health Practitioners (BHPs) on behalf of eligible individuals under 21 years of age through EPSDT. Payment is made to Clinical Psychologists on behalf of children and eligible individuals 21 years of age and older.

(a) Clinical Psychologists

Individuals in Independent Practice – Payment is made at 89.68 percent of the CY2013 Medicare Physician Fee Schedule for psychiatric services, which is equivalent to a 3 percent rate increase from the rates in effect on June 30, 2018. Effective July 1, 2022, a rate floor equal to 80 percent of the CY2021 Medicare Physician Fee Schedule for psychiatric services is implemented.

Individuals in Agency Setting – Refer to Attachment 4.19-B, Page 24 for payment of services provided by psychologists employed by public health, a government or private behavioral health agency, or local school settings.

(b) Level 2 BHPs

Individuals in Independent Practice – Payment is made at rates which equal 70 percent of the reimbursement for services provided by Level 2 BHPs in agency settings, which is equivalent to a 30 percent rate reduction from the rates in effect on April 30, 2016. Payment is not made to Licensure Candidates in this setting.

Individuals in Agency Settings – Refer to Attachment 4.19-B, Page 24 for services provided by individuals employed by public health, a government or private behavioral health agency, or local school settings.

Except as otherwise noted in the plan, the rates are the same for both governmental and private providers of behavioral health practitioner services. All rates are published on the Agency's website www.okhca.org/behavioral-health.

State: Oklahoma
Date Received: 8 August, 2018
Date Approved: 20 August, 2018
Effective Date: 1 July, 2018
Transmittal Number: 18-20

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

8. Payment for blood and blood fractions

Inpatient - Payment is made to blood banks for blood or blood fractions used for inpatient care when the cost of blood is not included in the per diem cost of the hospital.

Outpatient - Payment is made to a physician, clinic, outpatient hospital or blood bank for blood and/or blood fractions when these products are required for the treatment of a congenital or acquired disease of blood. Claims for blood are screened through the regular computer stream against eligibility files to assure that no payment is made beyond the scope of the program.

Effective for claims filed on and after April 1, 1986 payment for care, services and supplies is made in accordance with the statewide procedure-based reimbursement methodology established by the state. Reimbursement limits per procedure are determined based on a review of previous payment amounts set by DHS and Medicare methodologies. The base limits for each procedure were established through comparison of the 75th percentile of both DHS and Medicare. The lower of DHS or Medicare was chosen as an initial base. Comparable procedures were then subjected to a procedure by procedure analysis in terms of complexity or degree of difficulty. A Procedure Review committee consisting of medical professionals made the final determination. Adjustments to the payment limits on an individual procedure will be considered by the Procedure Review Committee on a periodic or as needed basis as requested by medical providers. The payment will not exceed the total allowable amount for comparable services under comparable circumstances under Medicare in the aggregate.

APPROVED BY DHHS/HCFA/DPO
DATE: 3-2-87
TRANSMITTAL NO: ~~Revised 4-1-86~~

METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

RESERVED PAGE

State: OKLAHOMA
Date Received: 29 SEPTEMBER, 2016
Date Approved: 5 APRIL, 2017
Effective Date: 1 SEPTEMBER, 2016
Transmittal Number: 16-0023

RESERVED 08-01-2020

METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment for other services and supplies

(a) Prosthetics and orthotics are reimbursed at the Medicare non-rural pricing.

(b) Eyeglasses
Reimbursement for eyeglass materials is set at a flat rate for the frame and the single vision and bifocal vision lenses. All lenses are made of polycarbonate material except in those instances where polycarbonate materials are not appropriate due to the refraction requirements. Polycarbonate will not be reimbursed separately. Refraction and fitting fee are reimbursed separately.

State: Oklahoma
Date Received: 14 September, 2018
Date Approved: 26 November, 2018
Effective Date: 1 October, 2018
Transmittal Number: 18-026

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment for personal care services

The rate for personal care services is based on a 15 minute unit. Payment is made at the most current fee schedule amount.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both public and private providers of the services. The agency's personal care fee schedule rates were set as of October 1, 2019 and are effective for services provided on or after that date. All rates are published on the Agency's website: www.okhca.org/feeschedules.

State: Oklahoma
Date Received: 4 October, 2019
Date Approved: 25 November, 2019
Effective Date: 1 October, 2019
Transmittal Number: 19-0036

State OKLAHOMA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

11. Payment for nurse-midwives

Nurse-midwives services payments are made in accordance with the established fee schedule rates described in Attachment 4.19-B, Page 3, (Payment for physicians' services {including remedial care and services}).

STATE Oklahoma
DATE RECD 09-28-00
DATE APPV'D 12-22-00
DATE EFF 08-01-00
HCFA 179 00-11
A

Revised 08-01-00

TN# 00-11 Approval Date 12-22-00 Effective Date 08-01-00
Supersedes
TN# 92-27

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Delete this page

State: Oklahoma
Date Received: June 30, 2015
Date Approved:
Date Effective: July 1, 2015
Transmittal Number: 15-04

DELETE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Delete this page

State: Oklahoma
Date Received: June 30, 2015
Date Approved:
Date Effective: July 1, 2015
Transmittal Number: 15-04

DELETE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

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State: Oklahoma
Date Received: June 30, 2015
Date Approved:
Date Effective: July 1, 2015
Transmittal Number: 15-04

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Family Planning Services

4.c. Family Planning Services

(1) For each state fiscal year, the state will reimburse no more than 100% of the Medicare practitioner fee schedule rates in effect at the start of the year. As needed, rates will be adjusted to reflect changes in the Medicare rates at the beginning of each new state fiscal year.

(2) Services not covered by Medicare are reimbursed in accordance with the approved methodology as applicable:

(a) Contraceptives are reimbursed with the pharmacy methodology as approved in the current state plan Attachment 4.19-B Page 7.
(b) Lab services are reimbursed with the methodology approved in the current state plan Attachment 4.19-B Page 2-b.
(c) Sterilizations are reimbursed with the methodology approved in the current state plan Attachment 4.19-B Page 1-1a.

The fee schedule is uniformly applied to public and private providers unless otherwise described in the plan. The fee schedules for the above listed services are maintained in the Agency database and posted to the Agency's website (www.okhca.org). The Agency physician fee schedule is updated annually at the start of each State Fiscal year.

STATE Oklahoma
DATE REC'D 10-11-11
DATE APP'D 1/9/2012
DATE EFF 10-1-11
HCFA 179 11-08

A

SUPERSEDES: TN- 05-16

Revised 10-01-2011

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

4.b. Early and periodic screening and diagnosis of individuals under 21 years of age and treatment of conditions found

(a) For each state fiscal year, the state will reimburse no more than 100% of the Medicare practitioner fee schedule rates in effect at the start of the year. As needed, rates will be adjusted to reflect changes in the Medicare rates at the beginning of each new state fiscal year. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of EPSDT services and the fee schedule and any annual/periodic adjustments to the fee schedule are maintained on the Agency computer database, the Agency library, and are available to the public.

(b) Services contained in 1905 (a) and not listed as covered services in the state agency rules/state plan will be provided. Services provided as described in Section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by screening services and not covered in the state plan will be provided if determined to be medically necessary by the appropriate agency staff or consultants. The reimbursement rate for these services will be in accordance with the methodology in Attachment 4.19-B pages 28-28.12.

(c) Additional service categories are reimbursed as follows:

i. Other Diagnostic Screening, Preventive and Rehabilitative Services are reimbursed in accordance with Attachment 4.19-B page 29 or the state-specific child health fee schedule.

ii. Hospital Outpatient services are reimbursed in accordance with Attachment 4.19-B, Page 1.

iii. Dental services will be reimbursed in accordance with Attachment 4.19-B page 5.

iv. Hearing aids and hearing aid accessories are reimbursed in accordance with the methodology in Attachment 4.19-B page 10.

v. Personal Care services will be reimbursed in accordance with Attachment 4.19-B page 11.

TN# 05-15 Approval Date 6-8-07 Effective Date 8-1-05
Supersedes
TN# 86-18

SUPERSEDES: TN- 86-18

STATE Oklahoma
DATE REC'D 9-30-05
DATE APPV'D 6-8-07
DATE EFF 8-1-05
HCFA 179 05-15

A

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

4b. Early and Periodic screening, diagnostic and treatment (cont'd)

(d) Outpatient Behavioral Health Services in Licensed, Therapeutic Foster Family Homes (TFFHs)

Outpatient behavioral health services in licensed TFFHs is an array of services provided based on the needs of the individual, and includes the following four (4) program components:

i. **Children's Psychosocial Rehabilitation (CPSR) -** Reimbursement will be made in accordance with a state-specific child health fee schedule. A unit of service equals 15 minutes.

ii. **Targeted Case Management (TCM) -** Reimbursement will be made in accordance with the methodology in Attachment 4.19-B, Pages 36 or 37.

iii. **Behavioral Health Practitioner (BHP) Services -** Reimbursement will be made in accordance with the methodology in Attachment 4.19 B, page 16 (a).

iv. **Preventive Services -** Substance Abuse Counseling**.** Reimbursement will be made in accordance with a state-specific child health fee schedule. A unit of service equals a session.

(e) Outpatient Behavioral Health Service Limitations in TFFHs

i. The **CPSR-TBS** rate is based on a reasonable estimate of the salaries and fringe benefits of the QBHA I/QBHA II and overhead costs, including clinical oversight, and assumes a maximum of two (2) individuals per QBHA I in the TFFH at one time or a maximum of one (1) individual per QBHA II in the TFFH at one time. The resulting rate reflects the costs of working as the change agent for the individual's daily living skills as well as the added attention given to their future independent living needs (refer to Att. 3.1.A, Page 1a-6.5b for a description). The rate does not include the costs of: room and board; educational; transportation; or respite care.

ii. **CPSR (IIH and TBS)** rate reimbursement per 15 unit by QBHA type:

Provider type	Rate per 15 minute unit
QBHA I	$9.81
QBHA II	$21.43

State: Oklahoma
Date Received: 30 August, 2019
Date Approved: 18 October, 2019
Effective Date: 1 September, 2019
Transmittal Number: 19-0018

iii. **TCM** - *Avoiding Duplication of Services*: State law requires that a child placed in out-of-home care receive regular contact* by the caseworker, which is documented in an individual service plan (ISP). Based on national level of care guidelines and Treatment Foster Care (TFC) program standards, individuals that meet the medical necessity criteria for treatment provided in TFFHs require a higher intensity of case management to coordinate their service needs, than individuals placed in lower levels of care. The recommended National TFC standards are that, at a minimum, the private agency provide two (2) face-to-face contacts per month that supplement (rather than replace) the planned monthly, contact by the government agency. This active, intensive monitoring of the Individual care plan (ICP) ensures that the individual's needs are adequately addressed in the less restrictive environment. The private provider's activities also include transition planning that begins upon the day of admission, which is related to the child's physical and behavioral health needs. For example, transition includes aftercare planning for continuity of care and treatment, such as linking and ensuring follow-up with a primary care physician for monitoring use of psychotropic medication, follow-up to appropriate outpatient behavioral health services to continue the intervention goals that have been achieved, and community reintegration. The government agency's Medicaid costs for case management (billed in weekly units of service) have been cost allocated in accordance with 42 CFR 441.18(d). The private provider agency has a formal relationship with the government agency to collaborate and integrate the ICP with the government agency's individual service plan, in order to avoid duplication of services.

iv. **CPSR and BHP** services cannot be billed in conjunction with the following:

- Partial Hospitalization/Intensive Outpatient (PHP/IOP);
- Therapeutic Day Treatment (TDT), (unless outlined in the ICP, in order to enhance the child's capacity to remain in the community and included in the IEP);
- Multi-systemic Therapy (MST);
- Facility-based crisis stabilization.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

4b. Early and Periodic screening, diagnostic and treatment (cont'd)

1. Multi-systemic Therapy

Reimbursement for MST services shall be a prospective flat rate for each approved unit of service provided to the member. One quarter hour (15 minutes) is the standard unit of service, which covers both service provision and administrative costs. The rates are based on an average of direct, general and administrative costs which were obtained from providers within the state. Direct costs include those items necessary for the provision of the service such as salaries, benefits, taxes, travel costs, phone, training, and professional clinical consultation. General and administrative costs are 10% of the total direct costs and include building costs, equipment, accounting, billing, office supplies, and management personnel. The resulting rate is $36.51 per 15 minute unit. Services provided by a Master's level clinician are reimbursed at 100% of the rate. Services provided by Bachelor's level staff are reimbursed at 80% of the rate.

TN# 09-03
Supersedes Approval Date 4-17-09 Effective Date 4-1-09
TN#SUPERSEDES. NONE - NEW PAGE

STATE Oklahoma
DATE REC'D 1-22-09
DATE APP'D 4-17-09
DATE EFF 4-1-09
A

SUPERSEDES. NONE - NEW PAGE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

4b. Early and Periodic screening, diagnostic and treatment *(continued)*

Partial Hospitalization Program (PHP)

A uniform rate is paid to governmental and non-governmental providers and to hospital and non-hospital providers.

The reimbursement rate is $160.50 per encounter up to 23 hours and 59 minutes, converted from a blend of the 2010 Medicare two tiered per diem payment approach for partial hospitalization services: one for days with three services (APC172) and one for days with four or more services (APC173).

Physician services, physician assistant services, nurse practitioner and clinical nurse specialist services, qualified psychologist services and services furnished to SNF residents are separately covered and not paid as partial hospitalization services.

State: Oklahoma
Date Received: 1 May, 2019
Date Approved: 17 June, 2019
Effective Date: 1 April, 2019
Transmittal Number: 19-0013

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Renal Dialysis Facilities

Payment is made at the Medicare allowable facility rate. This rate includes all services which Medicare has established as an integral part of the dialysis procedure.

Effective for services provided on or after July 1, 2012, payment is made at the Medicare wage adjusted base rate.

The ESRD PPS is a single payment to ESRD facilities that will cover all the resources used in furnishing an outpatient dialysis treatment; the supplies and equipment that administer dialysis, drugs, biological, lab tests, and training and support services. Separately billable items include: vaccines, telehealth, and blood and blood products.

State: Oklahoma
Date Received: 14 September, 2018
Date Approved: 26 November, 2018
Effective Date: 1 October, 2018
Transmittal Number: 18-026

Pen and Ink Correction:
Date corrected 12/20/18 sss

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Anesthesiologists

Effective January 1, 2014, the anesthesia procedure codes listed in the 2014 CPT Code Book (CPT Codes 00100 through 01966 and 01968 through 01999) are eligible for reimbursement based on a formula involving base units and time units multiplied by a conversion factor approved by the agency's internal rate setting committee. The CPT Codes are subject to published clinical edits and will be updated concurrently with the annual publication of the American Medical Association's CPT Code Book (CPT ® is a registered trademark of the American Medical Association).

Anesthesia CPT Code 01967 will be reimbursed at a maximum reimbursement amount set by agency's internal rate setting committee for one unit of service regardless of the base and time units involved in the procedure.

Anesthesia CPT Code 01996 will be reimbursed at a maximum reimbursement amount based on a formula involving base units and multiplied by the current conversion factor regardless of the time units involved in the procedure.

For services rendered effective January 1, 2008, the base unit values for the anesthesia codes (CPT Codes 00100 through 01966 and 01968 through 01999) were taken from the 2008 American Association of Anesthesiologist (ASA) Relative Value Guide. Additional units are not eligible to be added to the ASA base value for additional difficulty.

Anesthesia time means the time during which the anesthesia provider (physician or CRNA) providing anesthesia is present (face to face) with the patient. It starts when the anesthesia provider begins to prepare the patient for induction of anesthesia in the operating room or equivalent area and ends when the anesthesia provider is no longer furnishing anesthesia services to the patient. The anesthesia time must be documented in the medical record with begin and end times noted.

Physicians and CRNAs should report a quantity of one (1) for each minute of anesthesia time. For example, if anesthesia time is thirty-seven (37) minutes, the quantity would be reported as 37. The program will convert the actual minutes reported to anesthesia time units. One anesthesia time unit is equivalent to 15 minutes of anesthesia time.

The following formula provides an example of how an anesthesiologist will be reimbursed:

If the ASA RVU (base) for an anesthesia procedure is 4.00 and the surgery lasts 90 minutes (time = 6 units) with a maximum allowable CF of $39.00 the reimbursement is calculated as follows:

(4b+6u) x $39.00 = $390.00

Time is reported in "units" where each unit is expressed in 15 minute increments and will be as follows:

State: Oklahoma
Date Received: 14 September, 2018
Date Approved: 26 November, 2018
Effective Date: 1 October, 2018
Transmittal Number: 18-026

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Anesthesiologists *(continued)*

Time (in Minutes)	Unit(s) Billed
1-15	1.0
16-30	2.0
31-45	3.0
46-60	4.0
61-75	5.0
76-90	6.0
91-105	7.0
106-120	8.0
Etc.	

State: Oklahoma
Date Received: 14 September, 2018
Date Approved: 26 November, 2018
Effective Date: 1 October, 2018
Transmittal Number: 18-026

Effective January 1, 2008, Anesthesia Healthcare Common Procedure Coding System (HCPC) modifiers must be reported for each anesthesia service billed and will determine the rate of reimbursement to each provider for anesthesia services. The modifiers are as follows:

2014 Published HCPC Modifier	Description	Payment Rate
AA	Anesthesia services performed personally by Anesthesiologist.	100%
AD	Medical supervision by a physician: more than four concurrent anesthesia procedures	Current Flat Rate; no time units
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals	50%
QX	CRNA or AA service: with medical direction by a physician	50%
QY	Anesthesiologist medically directs one CRNA or AA	50%
QZ	CRNA or AA services	80%

Certified Registered Nurse Anesthetists (CRNA)

Modifiers must be reported for each anesthesia service billed and will determine the rate of reimbursement to each provider for anesthesia services. Payment is made to CRNAs at a rate of 80 percent of the allowable for physicians for anesthesia services without medical direction and at a rate of 50 percent of the allowable when medically directed.

Anesthesiologist Assistants

Modifiers must be reported for each anesthesia service billed and will determine the rate of reimbursement to each provider for anesthesia services. Payment is made to Anesthesiologist Assistants at a rate of 80 percent of the allowable for physicians for anesthesia services without medical direction and at a rate of 50 percent of the allowable when medically directed.

Effective February 1, 2010, payment will not be made to anesthesiologists, CRNAs or AAs for three national coverage determinations which relate to serious, preventable errors in medical care. These errors include surgery performed on wrong body part, surgery performed on wrong patient, and wrong surgery performed on patient.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Physician Assistants

Payment is made to physician assistants at 20 percent of the surgery allowable for physicians when service is assisting a surgeon at surgery.

All other services are reimbursed at 100 percent of the physician allowable.

Effective February 1, 2010, payment will not be made to physician assistants for three national coverage determinations which relate to serious, preventable errors in medical care. These errors include surgery performed on wrong body part, surgery performed on wrong patient, and wrong surgery performed on patient.

State: Oklahoma
Date Received: 14 September, 2018
Date Approved: 26 November, 2018
Effective Date: 1 October, 2018
Transmittal Number: 18-026

State: OKLAHOMA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Nutritional Services

Payment is made for Nutritional Services in accordance with the methodology described in attachment 4.19-B, Page 3. Payment is made to providers for services as other diagnostic, screening, preventive and rehabilitative services. The fee schedule is uniformly applied to public and private providers unless otherwise described in the plan. The fee schedules for the above listed services are maintained on the Agency computer database, the Agency library, and are available to the public.

STATE Oklahoma	A
DATE REC'D 9-30-05	
DATE APP'VD 6-9-06	
DATE EFF 8-1-05	
HCFA 179 05-18	

SUPERSEDES TN: 04-03

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES OTHER TYPES OF CARE

Case Management Services For Adults Age 18 And Over Who Are Chronically/Severely Mentally Ill And Children Who Are In Imminent Risk Or Are In Out-Of Home Placement Due To Psychiatric Or Substance Abuse Reasons

A. Unit Definition and Rates:

The rate(s) were developed from the average salaries and wages from the Bureau of Labor Statistics for mental health and rehabilitative workers in Oklahoma plus a factor of 30% for benefits. A 10% factor was added for general and administrative costs.

Standard case managers have caseloads of 30-35 consumers. Intensive case management caseloads are smaller, between 10 and 15 consumers. Typically, to produce a high fidelity wraparound process, a facilitator can facilitate between 8 and 10 families. The rates and hours for Intensive Case Mangers and Wraparound Facilitators were adjusted based on the lower caseloads. A unit of service is equivalent to fifteen (15) minutes.

Targeted Case Management Benefit 1915 (g)					
Code	**Mod 1**	**Description**	**Rate**	**Unit**	**Annual Hours Per Provider**
T1016		BH Case Manager III, Master's Wraparound Facilitator	$22.34	15 minutes	812
T1016		BH Case Manager III, Master's-Intensive	$20.31	15 minutes	812
T1016		BH Case Manger III, Master's	$13.98	15inutes	1,141
T1016		BH Case Manger II, Bachelor's Wraparound Facilitator	$16.75	15 minutes	812
T1016		BH Case Manager II, Bachelor's-Intensive	$15.23	15 minutes	812
T1016		BH Case Manager II, Bachelor's	$10.83	15 minutes	1,141
T1016		BH Case Manager I, Paraprofessional	$7.68	15 minutes	1,141

B. Effective Date

The agency's fee schedule rate was set as of January 1, 2009 and is effective for service provided on or after that date. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published on the agency's website @ www.okhca.org.

C. Effective for services provided on or after 04-01-10, the rates in effect on 03-31-10 will be decreased by 3.25%.

State OKLAHOMA

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE**

Case Management Services for Persons Under Age 21 Who are in Imminent Risk of Out-of-home Placement for Psychiatric or Substance Abuse Reasons or are in Out-of-home Placement Due to Psychiatric or Substance Abuse Reasons.

Payment rates are established using a relative value unit (RVU) fee schedule. A monetary conversion factor (CF) will be used to determine the overall level of payment to providers for each service. The conversion factor is based on 1996 utilization and payment data (baseline). The formula for calculating the rate for each service is as follows:

RVU x CF = Rate

The conversion factor used to calculate the rates for services furnished to adults in public mental health facilities (and for providers who contract with the State mental health agency) is cost related, to ensure the financial solvency of these facilities who provide a broad array of mental health services, and are mandated by the State to bear responsibility for indigent mental health services.

The conversion factor used to calculate the rates for services to all children and for adults in private facilities is baseline adjusted, in order to result in payment rates that are comparable to those paid to private physicians and/or other non-physician practitioners, for mental health services covered elsewhere under the State Plan.

STATE OK
DATE RECD 12-31-97
DATE APPVD 3-31-98
DATE EFF 10-1-97
HCFA 179 97-18

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Revised 10-01-97

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Clinic Services

(a) **Base fee to all governmental and non-government clinics**
Beginning August 1, 2005, for each state fiscal year, the State will reimburse no more than 100 percent of the Medicare non-facility practitioner fee schedule rates in effect at the start of the calendar year. As needed, rates will be adjusted to reflect changes in the Medicare rates at the beginning of each new state fiscal year. The rates will be applicable to the geographic area where each clinic is located. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of clinic services and the fee schedule and any annual/periodic adjustments to the fee schedule is published on the agency public website at www.okhca.org.

(b) **Governmental Public Health Clinic Providers**

(1) Clinic Services that are not covered under the base fee method above will be paid using a Medicaid -specific Public Health Clinic fee schedule. Reimbursement for these services will not exceed 100 percent of the equivalent Medicare non-facility practitioner fee schedule or Medicaid dental fee schedule rates in effect at the start of the calendar year.

(2) **Public Health Nursing Services**

2.1 Payments are made for Public Health Nursing Services as described in 2.1(a) below using an encounter rate. The State utilizes existing Medicare methodology for Level 1 APC Clinics to establish the Public Health Nursing Services encounter rate.

2.1(a) Qualified Public Health Nursing Services include:

- health promotion and patient education (does not include nutritional counseling by nutritionist);
- medication management;
- nursing assessment and execution of medical regime including administration of medications and treatment;
- administration of injectable medications; and
- family planning follow-up encounter visits.

TN# 11-09 Approval Date 2-3-12 Effective Date 10-1-11
Supersedes
TN# 05-17

SUPERSEDES: TN- 05-17

STATE Oklahoma
DATE REC'D 11-8-11
DATE APPV'D 2-3-12
DATE EFF 10-1-11
HCFA 179 11-09

A

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Clinic Services

2.2 Limitations:

- Encounters are limited to one per day and cannot be billed on the same day as preventive exams (e.g. EPSDT or family planning);
- Labs and drugs are separately reimbursable.

2.3 This methodology applies to services provided on or after October 1, 2011. The fee schedule is available on the Agency's public website.

STATE Oklahoma
DATE REC'D 11-8-11
DATE APPV'D 2-3-12
DATE EFF 10-1-11
HCFA 179 11-09

A

New Page 10-01-2011

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

9. Clinic Services *(continued)*

(d) **State-Operated Freestanding Community Mental Health Centers (CMHCs) and Private Outpatient Behavioral Health Clinics**

Behavioral health practitioner (BHP) services provided by state operated, freestanding CMHCs and Private Outpatient Behavioral Health Clinics on or after July 1, 2018 that are enrolled, qualified clinics approved by the state shall be reimbursed by the Medicaid fee schedule described on Attachment 4.19-B, Page 29 section 13.d.1(A) of the practitioner employed or contracted with the clinic. Physician services provided in the clinic setting are reimbursed using the reimbursement methodology found on Attachment 4.19-B, Page 3.

Federal regulations (42 CFR §447.321) require that the payment system not pay more for clinic services than a reasonable estimate of what Medicare would pay for Medicaid equivalent services in the aggregate.

(e) **Supplemental Payments for Behavioral Health Community Networks (BHCN)**

Eligibility Criteria

- In order to maintain access and sustain improvement in clinical and non-clinical care, supplemental payments will be made to BHCNs that meet the following criteria:
    - Must be a freestanding governmental or private provider organization that is certified by and operates under the guidelines of the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) as a Community Mental Health Center (CMHC) and;
    - Participates in behavioral quality improvement initiatives based on measures determined by and in a reporting format specified by the Medicaid agency.

The state affirms that the clinic benefit adheres to the requirements at 42 CFR 440.90 and the State Medicaid Manual at 4320 regarding physician supervision.

State: Oklahoma
Date Received: 28 September, 2018
Date Approved: 8 November, 2018
Effective Date: 1 July, 2018
Transmittal Number: 18-0029

Revised 07-01-18

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

9. **Clinic Services** (continued)

Payment Method

(a) Two supplemental payment pools by type of provider consisting of state governmental and private providers will be established. The payment pools will be calculated based on the difference between 100 percent of the Medicare non facility physician fee schedule and the base Medicaid fee schedule (which is 75 percent of the Medicare fee schedule) multiplied by volume associated with paid claims data from the State's MMIS.

(b) For State fiscal year 2009, State governmental providers will receive 100 percent of the difference between the base Medicaid rate and the payment ceiling, which is 100 percent of the applicable Medicare rate. For State fiscal year 2009, private providers will receive 50 percent of the difference between the base Medicaid rate and the payment ceiling.

(c) Supplemental payment to private providers will be further differentiated, depending on whether the provider is a state designated CMHC. Supplemental payments to CMHC private providers will equal 90 percent of the available payment pool amount as defined in part (b). Supplemental payment to private, non-CMHCs equals the remaining ten percent of the payment pool. The criteria for the pool payments are based on individual levels of performance on twelve measures. The twelve measures consist of:

1) Outpatient Crisis Service Follow-up within 8 Days
2) Inpatient/Crisis Unit Follow-up within 7 Days
3) Reduction in Drug Use
4) Engagement: Four Services within 45 Days of Admission
5) Medication Visit within 14 Days of Admission
6) Access to Treatment - Adults
7) Improvement in CAR Score: Interpersonal Domain
8) Improvement in CAR Score: Medical/Physical Domain
9) Improvement in CAR Score: Self Care/Basic Needs Domain
10) Inpatient/Crisis Unit Community Tenure of 180 Days
11) Peer Support: % of Clients Who Receive a Peer Support Service
12) Access to Treatment - Children

STATE Oklahoma
DATE REC'D. 6-30-10
DATE APP'VD 2-28-11
DATE EFF 4-1-10
HCFA 179 10-27
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Total pool payments will be made quarterly to the ODMHSAS, for encounters with dates of service associated with paid claims from Oklahoma's MMIS in the prior quarter. The ODMHSAS will make payment to providers. A voluntary reassignment form will be on file.

(d) All rates are published on the agency's website located at www.okhca.org. A uniform rate is paid to governmental and non-governmental providers.

(e) Effective for services provided on or after 04-01-10, the rates in effect on 03-31-10 will be decreased by 3.25%.

New Page 04-01-10

State: OKLAHOMA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

1. Payment will be made for other services described in Section 1905(a) covered under the State Plan.

Service		Citation
a. Prosthetic Devices	Same as other services and supplies	Attachment 4.19-B
b. Podiatrists	Same as physicians services	Attachment 4.19-B
c. Rehabilitative Services	Same as other diagnostic, screening, preventive and rehabilitative services	Attachment 4.19-B
d. Optometrists Services	Same as physicians services	Attachment 4.19-B
e. Eyeglasses	Same as other services and supplies	Attachment 4.19-B

STATE Oklahoma
DATE REC'D 03-29-01
DATE APPV'D 05-09-01
DATE EFF 02-01-01
HCFA 179 OK-01-07
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State: OKLAHOMA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Early and Periodic Screening, Diagnosis and Treatment of Conditions Found (continued)

II. Payment will be made for the following services described in Section 1905(a) and which are not otherwise covered under the State Plan.

a. Emergency Hospital Services – For payment methodology for hospital emergency department, see Attachment 4.19-B, Page 1.

For payment methodology for physician's emergency department services, see Attachment 4.19-B, Page 3.

TN# 01-01 Approval Date 04-20-01 Effective Date 02-01-01
Supersedes
TN# 90-12

STATE Oklahoma
DATE REC'D 03-15-01
DATE APPV'D 04-20-01
DATE EFF 02-01-01
HCFA 179 OK-01-01

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Early and Periodic Screening, Diagnosis and Treatment of Conditions Found (*continued*)

Payment is made for Speech and Audiologist Therapy Services, Physical Therapy Services, and Occupational Therapy Services in accordance with the methodology described in Attachment 4.19-B, Page 3. Reimbursement for OT/PT/ST assistants will equal 85 percent of the payment made to a fully licensed therapist. Licensed speech language pathologist clinical fellows will be paid at the same rate of fully licensed speech language pathologists.

State: OKLAHOMA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-OTHER TYPES OF CARE

Early and Periodic Screening, Diagnosis and Treatment of Conditions Found (continued)

c. Chiropractors - Payment for services will be based on the state-wide procedure based reimbursement methodology established by the State. Reimbursement will be made utilizing established rates for procedures which have been identified by the American Medical Association, Health Care Financing Administration, Medicare Carriers or the Oklahoma Department of Human Services. When no reimbursement rate is available, the rate will be set utilizing basic procedures used in establishing Medicare and Medicaid rates. A Procedure Review Committee consisting of medical professionals will make the final determination. Reimbursement limits per procedure are determined based on a review of comparable services under comparable circumstances as set by DHS and Medicare methodologies. Adjustments to the payment limits on an individual procedure will be periodically considered by the Procedure Review Committee on an as-needed basis as requested by medical providers. Consideration may be given to a payment adjustment to assure availability and accessibility of services primarily due to possible limited availability of services in some geographic locations.

STATE Oklahoma
DATE REC'D JUN 25 1990
DATE APPV'D MAY 28 1992
DATE EFF APR 01 1990
HCFA 179 90-12
A

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

4b. Early and Periodic Screening. Diagnosis and Treatment of Conditions Found *(continued)*

d. Hospice Services

With the exception of payment for physician services, reimbursement for hospice care will be made at one (1) of five (5) predetermined rates for each day in which an individual receives the respective type and intensity of the services furnished under the care of the hospice. A description of the payment for each level of care is as follows:

1. **Routine home care.** The hospice will be paid one of two routine home care rates for each day the patient is in residence, under the care of the hospice, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day. The two-rate payment methodology will result in a higher based payment for days one (1) through sixty (60) of hospice care and a reduced rate for days sixty-one (61) to infinity. A minimum of sixty (60) days gap in hospice services is required to reset the counter, which determines the payment category for the service.

2. **Continuous home care.** Continuous home care is to be provided only during a period of crisis. A period of crisis is the period in which a patient requires continuous care which is primarily nursing care to achieve palliation and management of acute medical symptoms. Either a registered nurse or a licensed practical nurse must provide care and a nurse must provide care for at least half the total period of care. A minimum of eight (8) hours of care must be provided during a twenty-four (24) hour day, which begins and ends at midnight. This care need not be continuous and uninterrupted. If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine home care.

3. **Inpatient respite care.** The hospice will be paid at the inpatient respite care rate for each day the recipient is in an approved inpatient facility and is receiving respite care. Payment for respite care may be made for a maximum of five (5) days including the date of admission but not counting the date of discharge in any monthly election period. Payment for the sixth and any subsequent day is to be made at the appropriate rate: routine, continuous, or general inpatient rate. Inpatient respite care may be provided in hospital or nursing facility.

4. **General inpatient care.** Payment at the inpatient rate will be made when general inpatient care is provided. No other fixed payment rates will be applicable for a day on which the recipient receives hospice general inpatient care except as described in the section of this plan which discusses payment of physician services.

5. **Service intensity add-on.** Effective January 1, 2016, payment for the Service Intensity Add-On (SIA) will be made for a visit by a registered nurse (RN) or Social Worker when provided in the last seven (7) days of life. Payment for the SIA will be equal to the continuous home care incremental rate multiplied by the increments of nursing provided (up to four [4] hours/sixteen [16] increments total) per day for each day in the last seven (7) days of life.

6. **Other General Reimbursement Items**

   (a) **Date of discharge.** For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the patient dies as an inpatient. When the patient is discharged as deceased, the inpatient rate, either general or respite, is to be paid for the discharge date.

State: Oklahoma
Date Received: 27 July, 2017
Date Approved: 19 October 2017
Effective Date: 1 July 2017
Transmittal Number: 17-006

State: Oklahoma
Date Received: 14 September, 2018
Date Approved: 26 November, 2018
Effective Date: 1 October, 2018
Transmittal Number: 18-026

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

4b. Early and Periodic Screening. Diagnosis and Treatment of Conditions Found *(continued)*

d. Hospice Services *(continued)*

6. **Other General Reimbursement Items**

(b) **Hospice payment rates.** The rates for hospice services are set by applying the full Medicaid daily rate, published annually by CMS for hospice services, then applying any applicable rate reduction percentages to the full Medicaid daily rate. The aforementioned rate methodology is used by the State unless the rate is less than the CMS established floor; in which case, the floor rates are calculated by taking the Medicaid Hospice rates provided by CMS, applying the wage index to the wage component subject to index, and adding the non-weighted amount.

Under the Medicaid hospice benefit, no cost sharing may be imposed with respect to hospice services rendered to Medicaid recipients.

Rates will not be less than Medicaid hospice rates established under Medicare adjusted by the wage index.

7. **Obligation of continuing care**

After the member's Medicare hospice benefit expires, the patient's Medicaid hospice benefits do not expire. The hospice must continue to provide the recipient's care until the patient expires or until the member revokes the election of hospice care.

8. **Payment for physician services**

The basic rates for hospice care represent full reimbursement to the hospice for the costs of all covered services related to the treatment of the member's terminal illness, including the administrative and general activities performed by physicians who are employees of or working under arrangements made with the hospice. The physician serving as the medical director and the physician member of the hospice interdisciplinary group would generally perform these activities. Group activities include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies. The costs for these services are included in the reimbursement rates for routine home care, continuous home care, and inpatient respite care.

Reimbursement for an independent physician's direct patient services is made in accordance with the usual SoonerCare reimbursement methodology for physician services. These services will not be billed by the hospice under the hospice provider number. The only services to be billed by an attending physician are the physician's personal professional services. Costs for services such as laboratory or x-rays are not to be included on the attending physician's billed charges to the Medicaid program. The aforementioned charges are included in the daily rates paid and are expressly the responsibility of the hospice.

9. **Limitations**

Payment is made for home based hospice services for terminally ill individuals with a life expectancy of six months or less when the member and/or family has elected hospice benefits. Services must be prior authorized. A written plan of care must be established before services are provided. The plan of care should be submitted with the prior authorization request.

Hospice care is available for two 90-day periods and an unlimited number of 60-day periods during the remainder of the member's lifetime. A hospice physician or nurse practitioner must have a face to face encounter with the member to determine if the member's terminal illness necessitates continuing hospice care services. The encounter must take place prior to the 180th day recertification and each subsequent recertification thereafter; and the practitioner attests in the medical record that such visit took place.

State: OKLAHOMA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-OTHER TYPES OF CARE

Early and Periodic Screening, Diagnosis and Treatment of Conditions Found (continued)

e. Christian Science Nurses - Payment for services will be based on the state-wide procedure based reimbursement methodology established by the State. Reimbursement will be made utilizing established rates for procedures which have been identified by the American Medical Association, Health Care Financing Administration, Medicare Carriers or the Oklahoma Department of Human Services. When no reimbursement rate is available, the rate will be set utilizing basic procedures used in establishing Medicare and Medicaid rates. A Procedure Review Committee consisting of medical professionals will make the final determination. Reimbursement limits per procedure are determined based on a review of comparable services under comparable circumstances as set by DHS and Medicare methodologies. Adjustments to the payment limits on an individual procedure will be periodically considered by the Procedure Review Committee on an as-needed basis as requested by medical providers. Consideration may be given to a payment adjustment to assure availability and accessibility of services primarily due to possible limited availability of services in some geographic locations.

STATE Oklahoma
DATE REC'D JUN 25 1990
DATE APPV'D MAY 28 1992
DATE EFF APR 01 1990
HCFA 179 90-12
A

State: OKLAHOMA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-OTHER TYPES OF CARE

Early and Periodic Screening, Diagnosis and Treatment of Conditions Found (continued)

f. Dentures - Payment for services will be based on the state-wide procedure based reimbursement methodology established by the State. Reimbursement will be made utilizing established rates for procedures which have been identified by the American Medical Association, Health Care Financing Administration, Medicare Carriers or the Oklahoma Department of Human Services. When no reimbursement rate is available, the rate will be set utilizing basic procedures used in establishing Medicare and Medicaid rates. A Procedure Review Committee consisting of medical professionals will make the final determination. Reimbursement limits per procedure are determined based on a review of comparable services under comparable circumstances as set by DHS and Medicare methodologies. Adjustments to the payment limits on an individual procedure will be periodically considered by the Procedure Review Committee on an as-needed basis as requested by medical providers. Consideration may be given to a payment adjustment to assure availability and accessibility of services primarily due to possible limited availability of services in some geographic locations.

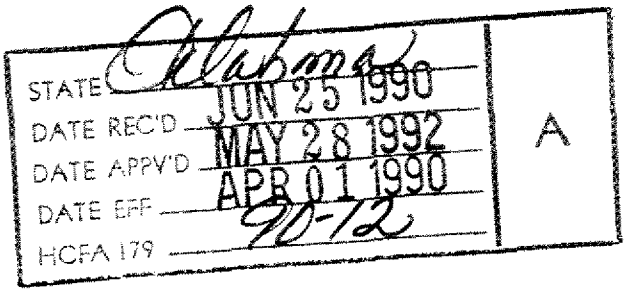
STATE Oklahoma
DATE REC'D JUN 25 1990
DATE APPV'D MAY 28 1992
DATE EFF APR 01 1990
HCFA 179 90-12
A

State: OKLAHOMA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-OTHER TYPES OF CARE

Early and Periodic Screening, Diagnosis and Treatment of Conditions Found (continued)

g. Respiratory Care - Payment for services will be based on the state-wide procedure based reimbursement methodology established by the State. Reimbursement will be made utilizing established rates for procedures which have been identified by the American Medical Association, Health Care Financing Administration, Medicare Carriers or the Oklahoma Department of Human Services. When no reimbursement rate is available, the rate will be set utilizing basic procedures used in establishing Medicare and Medicaid rates. A Procedure Review Committee consisting of medical professionals will make the final determination. Reimbursement limits per procedure are determined based on a review of comparable services under comparable circumstances as set by DHS and Medicare methodologies. Adjustments to the payment limits on an individual procedure will be periodically considered by the Procedure Review Committee on an as-needed basis as requested by medical providers. Consideration may be given to a payment adjustment to assure availability and accessibility of services primarily due to possible limited availability of services in some geographic locations.



METHODS AND STANDARTS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

4.b. Early and Periodic Screening, Diagnosis and Treatment of Conditions Found *(continued)*

h. Private Duty Nursing

PDN base hourly rate is $40/hour. The over-time hourly rate is $48.92/hour but is authorized only for overtime nursing staff hours for persons with tracheostomies or who are ventilator dependent.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. PDN rates are published on the agency website: http://www.okhca.org/feeschedules.

State: Oklahoma
Date Received: 26 September, 2016
Date Approved: 29 November, 2016
Effective Date: 1 September, 2016
Transmittal Number: 16-25

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Physical Therapist

Payment is made for Physical Therapist in accordance with the methodology described in attachment 4.19-B, Page 3. Reimbursement for physical therapy assistants will equal 85 percent of the payment made to a fully licensed therapist. The fee schedule is uniformly applied to public and private providers unless otherwise described in the plan. The fee schedules for the above listed services are maintained on the Agency website at www.okhca.org.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Occupational Therapist

Payment is made for Occupational Therapist in accordance with the methodology described in attachment 4.19-B, Page 3. Reimbursement for occupational therapy assistants will equal 85 percent of the payment made to a fully licensed therapist. The fee schedule is uniformly applied to public and private providers unless otherwise described in the plan. The fee schedules for the above listed services are maintained on the Agency website at www.okhca.org.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Speech Language Pathologist

Payment is made for Speech Language Pathologist in accordance with the methodology described in attachment 4.19-B, Page 3. Reimbursement for speech language pathology assistants will equal 85 percent of the payment made to a fully licensed therapist. Licensed speech language pathologist clinical fellows will be paid at the same rate of fully licensed speech language pathologists. The fee schedule is uniformly applied to public and private providers unless otherwise described in the plan. The fee schedules for the above listed services are maintained on the Agency website at www.okhca.org.

State: OKLAHOMA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-OTHER TYPES OF CARE

Early and Periodic Screening, Diagnosis and Treatment of Conditions Found (continued)

k. Christian Science Sanatoria - Payment for services will be based on the state-wide procedure based reimbursement methodology established by the State. Reimbursement will be made utilizing established rates for procedures which have been identified by the American Medical Association, Health Care Financing Administration, Medicare Carriers or the Oklahoma Department of Human Services. When no reimbursement rate is available, the rate will be set utilizing basic procedures used in establishing Medicare and Medicaid rates. A Procedure Review Committee consisting of medical professionals will make the final determination. Reimbursement limits per procedure are determined based on a review of comparable services under comparable circumstances as set by DHS and Medicare methodologies. Adjustments to the payment limits on an individual procedure will be periodically considered by the Procedure Review Committee on an as-needed basis as requested by medical providers. Consideration may be given to a payment adjustment to assure availability and accessibility of services primarily due to possible limited availability of services in some geographic locations.

STATE Oklahoma
DATE REC'D JUN 25 1990
DATE APPV'D MAY 28 1992
DATE EFF APR 01 1990
HCFA 179 90-12
A

State: OKLAHOMA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-OTHER TYPES OF CARE

Early and Periodic Screening, Diagnosis and Treatment of Conditions Found (continued)

1. Other Practitioners-Licensed Clinical Social Workers - Payment for medically necessary services, when preauthorized, will be based on the state-wide procedure based reimbursement methodology established by the State. Reimbursement will be made utilizing established rates for procedures which have been identified by the American Medical Association, Health Care Financing Administration, Medicare Carriers or the Oklahoma Department of Human Services. When no reimbursement rate is available, the rate will be set utilizing basic procedures used in establishing Medicare and Medicaid rates. A Procedure Review Committee consisting of medical professionals will make the final determination. Reimbursement limits per procedure are determined based on a review of comparable services under comparable circumstances as set by DHS and Medicare methodologies. Adjustments to the payment limits on an individual procedure will be periodically considered by the Procedure Review Committee on an as-needed basis as requested by medical providers. Consideration may be given to a payment adjustment to assure availability and accessibility of services primarily due to possible limited availability of services in some geographic locations.

STATE Oklahoma
DATE REC'D JUN 25 1990
DATE APPV'D MAY 28 1992
DATE EFF APR 01 1990
HCFA 179 90-12
A

New 04-01-90

TN# 90-12 Approval Date MAY 28 1992 Effective Date APR 01 1990
Supersedes
TN# None New Page

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

4b. Early and Periodic screening, diagnostic and treatment *(continued)*

Applied Behavior Analysis (ABA) Services

Payment for ABA services is made in accordance with the methodology described in Attachment 4.19-B, Page 3.

State: Oklahoma
Date Received: 26 June, 2019
Date Approved: 23 September, 2019
Effective Date: 1 July, 2019
Transmittal Number: 19-0007

New 07-01-19

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

13.d. Rehabilitative Services

13.d.1. Outpatient Behavioral Health and Substance Use Disorder Treatment Services

A. Outpatient Behavioral Health Services in Agency Setting

Services provided by public and private programs as described on Attachment 3.1-A Page 6a-1.1 through Attachment 3.1-A Page 6a-1.3 shall be reimbursed using a state specific fee schedule based on type and level of practitioner employed by the agency. The types of service and minimum qualified practitioners are described in Attachment 3.1.A Page 6a-1.3a through 6a-1.3e. The rate for each service is a set fee per unit of service. All rates are published on the Agency's website www.okhca.org/behavioral-health.

(1) Behavioral Health Practitioners (BHPs)

Payment rates are established for services provided by qualified Level I and Level II (A) BHPs using a state developed fee schedule. Level II (B) BHPs are paid at 90% of the Level II (A) fee schedule.

(2) Other Qualified Staff

Other qualified agency staff include Behavioral Health Rehabilitation Specialists (BHRS), Certified Alcohol and Drug Counselors (CADCs), Certified Peer Recovery Support Specialists (CPRSS or RSS), and Registered Nurses (RNs). Services are paid based on a state-specific fee schedule.

B. Partial Hospitalization Program (PHP)

The reimbursement rate is $160.50 per encounter up to 23 hours and 59 minutes, converted from a blend of the 2010 Medicare two tiered per diem payment approach for partial hospitalization services: one for days with three services (APC172) and one for days with four or more services (APC173).

Physician services, physician assistant services, nurse practitioner and clinical nurse specialist services, qualified psychologist services, and services furnished to SNF residents are separately covered and not paid as partial hospitalization services.

PHP reimbursement is all-inclusive of the service components, with the exception of the following:

- Physician services;
- Medications; and/or
- Psychological testing by a licensed psychologist.

C. EPSDT Rehabilitative Services

Rehabilitative services described in Attachment 3.1 Pages 1a-6.5 through1a-6.5f are reimbursed in accordance with the state-specific behavioral health fee schedule. The reimbursement methods for

Multi Systemic Therapy (MST) and Partial Hospitalization (PHP) are found on Attachment 4.19-B Pages 16.2 and 17, respectively.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of outpatient behavioral health and substance use disorder treatment services. All rates are published on the Agency's website www.okhca.org/behavioral-health.

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

13.d Rehabilitative Services (Continued)

13.d.2 Reimbursement for PACT Services

Reimbursement for PACT service components listed in Att. 3.1A page 6a-1.5 through 6a-1.6a provided by multi-disciplinary team members will be made under a fee schedule.

(a) Service Contacts - The fee schedule rate for eligible service contacts by qualified team members is all-inclusive of the service components and will be reimbursed per 15-minute unit, using a Procedure code for PACT. The unit costs were derived from the 2006 average salaries and wages for physicians as reported in the Bureau of Labor Statistics website for occupations for Oklahoma, and actual provider reported costs for the other staffing composition required for a caseload of 100. The rate also accounts for employee benefits, indirect costs, clinical oversight and supervision. Total costs were divided by the annual available productive time. In order to account for the fact that Medicaid enrollment for adults enrolled in PACT may not be continuous, the average caseload of 100 for a team of 10 assumed in the methodology was adjusted by a standardized enrollment continuity ratio for Oklahoma (75.6%) to account for lapses in coverage. The source document for the continuity ratio is from Table 1, “Improving Medicaid’s Continuity and Quality of Care”, by L. Ku. Targeted Case Management (TCM) service contacts are separately billable.

(b) Health Home services. PACT service components share much in common with Health Home requirements. In order to avoid duplication, a portion of the rate for equivalent service contacts was allocated to Health Home services. This portion was based on PACT team place of treatment, using the 2003 *National Program Standards for Assertive Community Treatment Teams*, which has a goal of 75% of services to be provided *in vivo*, (non office-based, non-facility) or in the community. Therefore the PACT rate described in (a) above will be reduced by 25% for any consumer that does not opt-out of Health Homes.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of PACT services. The agency's fee schedule rate was set as of January 1, 2015 and is effective for services provided on or after that date. All rates are published on the Agency's website www.okhca.org.

State: Oklahoma
Date Received: June 30, 2015
Date Approved: January 27, 2016
Date Effective: April 1, 2015
Transmittal Number: 15-06

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

13.d.3 Reimbursement for CCBH Rehabilitative services

A. Payment for Established/Existing Clients

Program users that receive preliminary screening and risk assessment to determine acuity of needs directly from the CCBH prior to or concurrent with the receipt of additional CCBH services are considered established/existing clients of a CCBH. Reimbursement for CCBH rehabilitative services provided to these clients will be one of three provider-specific monthly bundled rates. The monthly bundled rate varies by category and level of service intensity.

State: Oklahoma
Date Received: 8 March, 2019
Date Approved: 4 June, 2019
Effective Date: 1 July, 2019
Transmittal Number: 19-0010

Standard Population (StdPop) – CCBH users not in special populations.
Special Populations (SpPop):

SpPop1 – Adults (ages eighteen (18) and over) with Serious Mental Illness (SMI) including those with or co-occurring substance use disorder (SUD); and
SpPop2 – This population includes children and youth (ages six (6) through twenty-one (21)) with Serious Emotional Disturbance (SED) and complex needs, including those with co-occurring mental health and substance use disorders.

The appropriate monthly bundled rate will be paid when a CCBH program delivers at least one CCBH bundled code, which includes one of the services specified in A. (1) and (2) below, and when a valid individual procedure code is reported for the calendar month.

(1) **Rehabilitative Services** – The monthly bundled rate **is inclusive of all services described in** Attachment. 3.1-A**,** Page 6a-1.14 to Page 6a-1.16 (1-9) with the following exceptions:

- **Behavioral Health Integrated (BHI) Services** – Do not trigger a monthly bundled payment when billed alone in a calendar month but may be reimbursed at the fee-for-service (FFS) rate. (See 13.d.3.E. within Attachment 4.19-B for more information on care coordination service delivery).

(2) **Other State Plan Covered Services** – The monthly bundled rate also includes services covered elsewhere in the plan (see table below) with the following exception:

- **Behavioral Health Screenings** when billed without a CCBH Rehabilitation service in a calendar month.

CCBH Activity / Service	Medicaid Authority	State Plan Page
Crisis Urgent Recovery Center Intervention Services	• Clinic Services • EPSDT Rehabilitative Services	Attachment 3.1-A, Page 4a-1.4 (b) Attachment 3.1-A, Pages 1a-6.5 (iii)
Behavioral Health Initial and Comprehensive Assessment	• Other Practitioners' Services • Physician Services	Attachment 3.1-A, Page 3a-1a (b) and (c) Attachment 3.1-A, Page 2a-2 (5)
Primary Care Screening and Monitoring of Health Risk	• EPSDT Screenings • Physician Services	Attachment 3.1-A, Page 1a-6 (A) Attachment 3.1-A, Page 2a-2 (5)
Targeted Case Management	• Targeted Case Management	Supp. to Attachment 3.1-A, Page 1b
Outpatient Mental Health and Substance Abuse Services u/21	• EPSDT Rehabilitative Services	Attachment 3.1-A, Page 1a-6.5a items A and B
Peer/Youth Family Caregiver Supports. Under 21 Outpatient Substance Abuse Prevention Counseling, Under 21	• EPSDT Rehabilitative Services • EPSDT Prevention	Attachment 3.1-A, Page 1a 6.5b – item Iv and v; Page 1a-6.5c -items vi-ix Attachment 3.1-A, Page 1a-6.6 item 9

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

13.d.3 Reimbursement for CCBH Rehabilitative services *(continued)*

B. CCBH Payments for Non-Established Clients

Non-established CCBH clients are those program users that receive crisis services directly from the CCBH without receiving a preliminary screening and risk assessment by the CCBH and those referred to the CCBH directly from other outpatient behavioral health agencies for pharmacologic management. Payments for services provided to non-established clients will be separately billable:

1. **Crisis Assessment and Intervention Services** – For crisis assessment and intervention services described on Page 6a-1.14, section 13.d.3.D(1) and urgent recovery clinic services described in Attachment 3.1-A, Page 1a-6.5 section (iii) and Page 4a-1.4(b), payment is made based on the methodology in Attachment 4.19-B, Page 29, Item 13.d.1(A), and Attachment 4.19-B, page 24, with the following exception:
   - Facility-based crisis stabilization services provided to clients receiving crisis services directly from a CCBH but who are established at another CCBH at the time of service provision.

2. **Care Coordination for Drug and Specialty Court Referrals** – In addition to the psychiatrist evaluation paid on a fee-for-service basis, separate payment may be made for at least 15 minutes of clinical staff time directed by a physician, per calendar month. The rate is $45 per encounter. Drug and Specialty Court case managers bill as usual to Medicaid.

C. Development of CCBH Rates

1. **Existing CCBH Services –** Monthly rates were developed based on provider-specific cost report data from the fourth quarter of state fiscal year (SFY) 2018 (April 1, 2018 to June 30, 2018). The rates include allowable CCBH costs for services rendered by a certified provider, including all qualifying sites of the certified provider established prior to July 1, 2019.

2. **New CCBH Services**
   a. For CCBHs that are certified by ODMHSAS between July 1, 2019 and September 30, 2021:
      i. The State will establish an interim monthly bundled rate by reference to 90% of the average rates of existing urban CCBHs. Providers will be required to file the most recent 12-month cost report that encompasses the first full year of activity in the CCBH program.
      ii. Provider-specific monthly bundled rates will be set based on the first full year (12-month) cost report, inflated to the midpoint of the rate year by the March update of the Medicare Economic Index (MEI), and will be effective on the July 1 following the end of the cost report year.
      iii. Claims paid at the interim monthly bundled rates before the provider-specific monthly bundled rate is established will be subject to retroactive adjustment upon implementation of the provider-specific monthly bundled rate. The State will perform a mass adjustment in the MMIS. Claims will be re-adjudicated once pricing is updated in the MMIS.

   b. For CCBHs that are certified by ODMHSAS beginning October 1, 2021:
      i. The State will establish interim monthly bundled rates by reference to 90% of the average standard and special population rates of existing urban and rural CCBHs.
      ii. Provider-specific monthly bundled rates will be established once the CCBH submits the first audited cost report with 12 months of actual cost and visit data for CCBH services under this Plan. The provider-specific monthly bundled rates will be established upon notification to the provider.
      iii. All claims paid at the interim monthly bundled rates before the provider-specific monthly bundled rates are established will be subject to retroactive adjustment. The State will perform a mass adjustment in the MMIS. Claims will be re-adjudicated once pricing is updated in the MMIS.

   c. For qualifying CCBH sites transitioning from the Section 223 Demonstration to the State Plan, the provider-specific monthly bundled rates will be the approved demonstration rates.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

13.d.3 Reimbursement for CCBH Rehabilitative services *(continued)*

D. Reimbursement for Special Populations

Effective July 1, 2019, the State will review care needs and rates for clients assigned to special population categories every 90 days to determine a need for continued stay at this level of service intensity and if the client has been admitted for an inpatient psychiatric hospital stay. If the client has been admitted during this time period, the State will pay the provider the standard rate for services rendered to that client.

E. Rate Rebasing and Rate Adjustments

Effective October 1, 2021, CCBH provider-specific monthly bundled rates will be updated as follows:

1. Provider-Specific Rate Rebasing

CCBH monthly bundled rates are rebased two years following rate establishment and two years following the last rebasing. Rates are rebased by dividing the total annual allowable CCBH costs from the CCBH's most recent 12-month audited cost report by the total annual number of CCBH Medicaid and non-Medicaid visits during that 12-month time period. The resulting rate is trended from the midpoint of the cost year to the midpoint of the rate year using the March update of the Medicare Economic Index (MEI).

2. Rate Adjustments for MEI Updates

Payment rates are updated between rebasing periods annually by trending each provider-specific rate by the March update of the MEI for primary care services. Rates are trended from the midpoint of the previous state fiscal year to the midpoint of the following year using the MEI.

3. Rate Adjustments for Changes in Scope

CCBH providers may request a rate adjustment for changes in scope expected to change individual CCBH provider payment rates by 2.5 percent or more. The provider must submit information to the State regarding changes in the scope of services, including changes in the type, intensity, or duration of services, the expected cost of providing the new or modified services, and any projected increase or decrease in the number of visits resulting from the change. Projections are subject to review by a Certified Public Accounting firm and the State. Provider-specific rate adjustments for changes in scope are subject to approval by the State and permitted once per year. The adjustments will take effect with annual rate updates.

The agency's fee schedule rates for CCBH services were set as of October 1, 2021 and are effective for services provided on and after that date. All rates are published on the Agency's website at okhca.org/behavioral-health.

F. Avoiding Duplication of Payment for Care Management/Coordination

Individuals eligible for CCBH services are eligible for all needed Medicaid covered services; however, duplicate payment is prohibited. The State will assure that CCBH care coordination (CC) and payments will not duplicate other state plan or waiver CC activities. The State will avoid duplication through MMIS edits and person-centered planning processes to advance an approach to health care that emphasizes recovery, wellness, trauma-informed care, and physical-behavioral health integration.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

13.d.5. Residential Substance Use Disorder (SUD) Reimbursement

Residential SUD services as described on Attachment 3.1-A page 6a-1.21 through Attachment 3.1-A, page 6a-1.23 will be reimbursed using a state-specific bundled per diem fee schedule, refer to chart below. Bundled per diem rates established are based on historical cost-based data from state-contracted providers. Rates were developed through provider surveys from 1998 to 2019. Effective July 1, 2022, rate development includes analysis of other states' rates paid for similar services.

42 CFR 431.107 requires that each provider or organization furnishing services agree to keep any records necessary to disclose the extent of services the provider furnishes to beneficiaries and, on request, furnish the Medicaid agency any information maintained and any information regarding payments claimed by the provider for furnishing services under the plan. The State assures that it will review data in order to develop and revise economic and efficient rates, as necessary.

Rates do not include costs related to room and board or other unallowable facility costs. Physician direct services and medications are separately billable and not part of the residential SUD per diem payment. Treatment services for dependent children are separately billable as outpatient behavioral health services, refer to Attachment 3.1-A, page 1a-6.3 through page 1a-6.

ASAM Level of Care (LOC)	Placement Criteria	Per Diem Rate
3.1	Clinically Managed Low-Intensity Residential Services for Adolescents (Services provided at this level of care include at least six (6) hours per week of a combination of services that may include individual, group, and/or family therapy, skill development, community recovery support, care management, and crisis intervention services as per Section C in Attachment 3.1-A, Page 6a-1.23.)	$75.00
	Clinically Managed Low-Intensity Residential Services for Adults (Services provided at this level of care include at least six (6) hours per week of a combination of services that may include individual, group, and/or family therapy, skill development, community recovery support, care management, and crisis intervention services as per Section C in Attachment 3.1-A, Page 6a-1.23.)	$75.00

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

13.d.5. Residential Substance Use Disorder (SUD) Reimbursement *(continued)*

ASAM Level of Care (LOC)	Placement Criteria	Per Diem Rate
3.3	Clinically Managed Population-Specific High Intensity Residential Services for adults only (Services provided at this level of care include at least twenty-four (24) hours per week of a combination of services that may address both substance use and co-occurring mental health needs. These services may include individual, group, and family therapy, skill development, community recovery support, care management, and crisis intervention services as per Section C in Attachment 3.1-A, Page 6a-1.23.)	$160.00
3.5	Clinically Managed Medium-Intensity Residential Services for Adolescents (Services provided at this level of care include at least twenty-four (24) hours per week of a combination of services that may include individual, group, and family therapy, skill development, community recovery support, care management, and crisis intervention services as per Section C in Attachment 3.1-A, Page 6a-1.23. Adolescents attending academic training are required to be provided a minimum of fifteen (15) hours per week of services.)	$160.00
	Clinically Managed High-Intensity Residential Services for Adults (Services provided at this level of care include at least twenty-four (24) hours per week of a combination of services that may include individual, group, and family therapy, skill development, community recovery support, care management, and crisis intervention services as per Section C in Attachment 3.1-A, Page 6a-1.23.)	$140.00
	Clinically Managed Medium-Intensity Residential Services for Adolescents, *Intensive* (Level 3.5 *intensive* provides the types of services listed under Level 3.5; however, the required number of treatment hours at level 3.5 intensive is at least thirty-seven (37) hours per week of a combination of services.)	$180.00
	Clinically Managed High-Intensity Residential Services for Adults, *Intensive* (Level 3.5 *intensive* provides the types of services listed under Level 3.5; however, the required number of treatment hours at level 3.5 *intensive* is at least thirty-seven (37) hours per week of a combination of services.)	$180.00

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

13.d.5. Residential Substance Use Disorder (SUD) Reimbursement *(continued)*

ASAM Level of Care (LOC)	Placement Criteria	Per Diem Rate
3.7	Medically Monitored High-Intensity Inpatient Services for Adolescents (Facilities must provide 24 hour, 7 days a week physician supervision, as well as 24 hour, 7 days a week monitoring from licensed nurses to members who are withdrawing or are intoxicated from alcohol or other drugs but are not experiencing medical or neurological symptoms that would require hospitalization. Medications are prescribed and administered if needed. A combination of services that may be provided includes individual, group, and family therapy, skill development, community recovery support, care management, and crisis intervention services as per Section C in Attachment 3.1-A, Page 6a-1.23.)	$300.00
	Medically Monitored Intensive Inpatient Services Withdrawal Management for Adults (Facilities must provide 24 hour, 7 days a week physician supervision, as well as 24 hour, 7 days a week monitoring from licensed nurses to members who are withdrawing or are intoxicated from alcohol or other drugs but are not experiencing medical or neurological symptoms that would require hospitalization. A combination of services that may be provided includes individual, group, and family therapy, skill development, community recovery support, care management, and crisis intervention services as per Section C in Attachment 3.1-A, Page 6a-1.23.)	$300.00

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

13.d.5. Residential Substance Use Disorder (SUD) Reimbursement (*continued)*

Residential Family-Based Treatment – Services as described on Attachment 3.1-A page 6a-1.21 and Attachment 3.1-A, page 6a-1.22 will be reimbursed using a state-specific bundled per diem fee schedule, refer to chart below.

42 CFR 431.107 requires that each provider or organization furnishing services agree to keep any records necessary to disclose the extent of services the provider furnishes to beneficiaries and, on request, furnish the Medicaid agency any information maintained and any information regarding payments claimed by the provider for furnishing services under the plan. The State assures that it will review data in order to develop and revise economic and efficient rates, as necessary.

Rates do not include costs related to room and board or other unallowable facility costs. Physician direct services and medications are separately billable and not part of the residential SUD per diem payment. Treatment services for dependent children are separately billable as outpatient behavioral health services, refer to Attachment 3.1-A, page 1a-6.3 through page 1a-6.

ASAM LOC	Placement Criteria	Per Diem Rate
3.1	Individuals with Dependent Children and Pregnant Women (Treatment hour requirements and types of services provided are the same as those indicated for the respective level of care, with the exception that the treatment hours required for level 3.5 *intensive* in specialty programs is thirty-five (35) hours per week of treatment services.)	$117.00
3.5		$180.00
3.5, *Intensive*		$250.00

Performance-Based Payments
For the period beginning October 1, 2020, and until changed by amendment, qualifying non-IMD facilities with 16 beds or less can earn a performance-based payment in the amount of 10% of qualifying per diem payments. To be eligible for these performance-based payments, providers must meet or exceed all state-defined benchmarks for the following metrics during the quarterly reporting period:

ASAM Level 3.1, 3.3, and 3.5 Providers

Measure	Benchmark
Percent of members admitted to/engaged in a lower level of care behavioral health service within seven (7) days of discharge	60% minimum
Percent of members who complete treatment	60% minimum
Percent of members who experience a reduction in drug use for all drugs of choice	85% minimum
Percent of members who are readmitted to the same or higher level of care behavioral health service within ninety (90) days of discharge	10% maximum

ASAM Level 3.7 Providers

Measure	Benchmark
Percent of members admitted to/engaged in a lower level of care behavioral health service within seven (7) days of discharge	60% minimum
Percent of members who complete treatment	60% minimum
Percent of members who are readmitted to the same or higher level of behavioral health care service within ninety (90) days of discharge	10% maximum

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

13.d.5. Residential Substance Use Disorder (SUD) Reimbursement (*continued)*

Performance-Based Payments *(continued)*

Calculation of Payment
Each quarter, data from Medicaid claims and prior authorization requests will be analyzed to identify each facility's performance compared to the benchmarks. If a provider meets the minimum benchmark for all measures during the measurement period, all paid per diem Medicaid claims for residential treatment during the measurement period will be identified. To calculate the bonus amount, the amount paid for each claim is multiplied by .1 to provide a 10% performance-based payment. Each quarter, previous payments will be reviewed to identify if any claims which received a performance-based payment were recouped or overpaid. Any recoupment/overpayment will be reduced from current and/or future performance-based payments.

Measure Definition and Data Sources

1. **Planned discharge**: Percent of members discharged from facility with a planned discharge, based on reported discharge type. At discharge, facilities are required to submit a prior authorization request with a completed Client Data Core (CDC) to indicate the member has left the facility or that level of treatment.
2. **Readmission within 90 days**: Percent of members readmitted to the same or higher level of substance use disorder treatment within 90 days of discharge. The CDC is used to identify discharge date and any subsequent admission to identify if the member was readmitted to the same or higher level of treatment within 90 days of discharge.
3. **Follow up after discharge within 7 days**: Percent of members who receive behavioral health treatment at a lower level of care within 7 days of discharge. Using both the Medicaid claims and the CDC data, after a member has been discharged, the data is reviewed to identify if a member enrolled in or received a behavioral health service in a lower level of care within 7 days of discharge.
4. **Reduction in drug use:** Percent of members discharged from facility who reported a reduction in drug use in the past 30 days, based on CDC data. Within the CDC, members may report up to three drugs of choice at admission into treatment. At discharge, facilities are required to submit a CDC to indicate the member has left the agency or that level of treatment. To meet the measure, members must report reduced frequency of use for all drugs of choice on the CDC at discharge

The State will monitor the provision of the quantity and type of services to ensure services are provided in accordance with ASAM criteria and meet medical needs of members through prior authorization review, service quality review, and claims audits.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

13.d. Rehabilitative Services *(continued)*

13.d.6. Alternative Treatments for Pain Management

Payment is made to providers of alternative treatments for pain management in accordance with the methodologies described in Attachment 4.19-B, Page 3 and Page 28.2.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of alternative non-pharmacological treatments for pain management.

State OKLAHOMA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES OTHER TYPES OF CARE

Certified Pediatric Nurse Practitioners Services

Certified Pediatric Nurse Practitioners (known as Advanced Practice Nurses under the Nurse Practice Act of Oklahoma) services payments are made in accordance with the established fee schedule rates described in Attachment 4.19-B, Page 3, (Payment for physicians' services {including remedial care and services}).

STATE Oklahoma
DATE RECD 09-28-00
DATE APPV'D 12-22-00
DATE EFF 08-01-00
HCFA 179 00-11
A

Revised 08-01-00

TN# 00-11 Approval Date 12-22-00 Effective Date 08-01-00
Supersedes
TN# 92-27
(only obsolete Page is 90-17 Page)

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES OTHER TYPES OF CARE

Case Management Services for High Risk Pregnant Women, First Time Pregnant Women and Their Infants, and Developmentally Disabled Children 0-3 Years of Age

A. Unit Definition and Rates:

The rate(s) were developed from the average salaries and wages from the Bureau of Labor Statistics for mental health and rehabilitative workers in Oklahoma plus a factor of 30% for benefits. A 10% factor was added for general and administrative costs. A unit of service is equivalent to fifteen (15) minutes.

Classification	Rate	Unit Basis	Annual Hours / Provider
Case Manager for 1st time mothers, RN	$13.98	15 min	1,141
Case Manager, Masters	$13.98	15 min	1,141
Case Manager Bachelor's	$10.83	15 min	1,141
Case Manager Less than Bachelor's	$ 7.68	15 min	1,141

B. Effective Date

The agency's fee schedule rate was set as of January 1, 2009, and is effective for service provided on or after that date. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published on the agency's website @ www.okhca.org.

Effective for services provided on or after 04-01-10, the rates in effect on 03-31-10 will be decreased by 3.25%.

SUPERSEDES: TN- 08-05

STATE Oklahoma
DATE REC'D 6-30-10
DATE APP'VD 9-17-10
DATE EFF 4-1-10
HCFA 179 10-28

A

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

4b. Early and Periodic screening, diagnostic and treatment (cont'd)

(h) Outpatient Behavioral Health Services in Licensed, Private Residential Group Homes.

i. It is expected that behavioral health services in group home settings are an array of treatment services provided in one day that includes the program requirements. Refer to Att. 4.19 B page 39 for the fee schedule.

ii. **Case Management - Reimbursement** will be made in accordance with the methodology in Attachment 4.19-B, Pages 36 or 37.

iii. Outpatient Behavioral health services in group home settings may not be billed in conjunction with PHP/IOP, TDT or MST.

State: Oklahoma
Date Received: June 30, 2013
Date Approved: November 18, 2015
Date Effective: April 1, 2013
Transmittal Number: 13-12

The agency's fee schedule rate was set as of April 1, 2013 and is effective for service provided on or after that date. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of EPSDT Services, and any annual/periodic adjustments are published on the agency's website @ www.okhca.org

Revised 04-01-2013

State OKLAHOMA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment for Birthing Center Services

Payment to a birthing center on behalf of a Medicaid client is an all-inclusive facility payment and represents payment in full for the birthing center services. Separate payment will be made for the midwife or physician obstetrical care, delivery and postpartum care as appropriate.

Listed below is the methodology used to arrive at the birthing center payment rate:

(1) The statewide hospital maternity level of care per diem rate was allowed for the mother and child.

(2) The average acute care inpatient hospital weighted fixed capital rate for maternity level of care was allowed as an add-on component of the maternity level of care for the mother and the child.

(3) There was a geographic adjustment made for birthing centers in rural and urban areas. Based on a 1990 study by KPMG Peat Marwick, maternity level provided in urban counties was 5.63% higher than the statewide median maternity operating costs and rural hospitals were 3.59% lower than the statewide median.

A birthing center will be designated as an urban or rural entity based on the definition of urban and rural counties used by the Medicare program for reimbursement purposes. The urban areas (counties) are those inside the Metropolitan Statistical Areas (MSA) and the rural areas (counties) are those outside the MSA.

(4) The statewide average length of stay in an inpatient hospital for mother and child is 2.7 days. According to Dr. Roger Deapen of the Oklahoma State Health Department, 28,259 of the 47,759 or 59% of all deliveries during 1991 had no risk factors. The length of stay average of 2.7 days was adjusted for low risk deliveries by multiplying 59% x 2.7 days to arrive at an average length of stay for low risk deliveries of 1.6 days. Birthing centers delivery costs average 33% less than hospital delivery.

STATE Oklahoma A
DATE REC'D 12-30-93
DATE APP'VD 2-3-94
DATE EFF 10-11-93
HCFA 179 93-20

New 10-11-93

METHODS AND STANDARDS OF REIMBURSEMENT
OTHER TYPES OF CARE

Critical Access Hospitals (CAHs)

Critical Access Hospitals must meet the requirements of 42 CFR §485.606 for payment under this section.

A. Effective October 1, 2005, inpatient critical access hospital services will be reimbursed in accordance with the methodology defined in Attachment 4.19 A. of this plan.

B. Effective October 1, 2005, outpatient critical access hospital services will be reimbursed in accordance with the methodology defined in Attachment 4.19 B, page 1, of this plan.

STATE Oklahoma
DATE REC'D 8-2-05
DATE APPVD 10-31-05
DATE EFF 10-1-05
HCFA 179 05-07
A

SUPERSEDES TN 03-22

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

The target group includes children under age 18 who are assessed as at risk of abuse or neglect as defined in Title 10A §1-1-105 of the Oklahoma Statutes and who are in emergency, temporary or permanent custody of the Department of Human Services (DHS) or in voluntary status who are placed in out-of-home care or trial adoption.

Government Providers

Providers are reimbursed a fee for service rate for a weekly unit of service which is based on non reconciled cost to provide targeted case management services. The basis for the rate consists of cost reported quarterly by the government provider. This includes direct cost for case management staff and agency overhead and indirect service costs necessary to provide the service.

The rate is modified quarterly on a calendar year basis to reflect non reconciled cost reported by the provider. The rate for the first quarter is based on cost reported for the most recently completed fiscal year. It is computed by dividing the annual cost base (as described above), including a prior period adjustment necessary to adjust prior years' allowable costs against total billable amounts, by a projected annual number of weekly units of service. The maximum annual number of billable units of service is estimated by taking the current population known to be receiving case management services multiplied by 52.

A unit of service equals one calendar week in which there must occur at least one face-to-face contact between the beneficiary and TCM provider that is documented as such.

Private Providers

Private providers will be paid in accordance with the methodology in Attachment 4.19-B, Page 22 of this plan.

Non-Duplication of Services

Payment for TCM services under the plan do not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private provider of case management for children at risk of abuse or neglect and the fee schedule and any annual/periodic adjustments to the fee schedule are published ion the agency website at www.okhca.org. The agency's fee schedule rate is set as of December 1, 2010 and is effective for services on or after that date.

STATE Oklahoma
DATE REC'D 8-2-11
DATE APP'D 10-31-11
DATE EFF 7-1-11
HCFA 179 11-06

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

The target group includes children under age 18 who are assessed as at risk of abuse or neglect as defined in Title 10A §1-1-105 of the Oklahoma Statutes and who are involved in, or at serious risk of involvement with the juvenile justice system (excludes those who are involuntarily in secure custody of law enforcement or judicial systems)

Government Providers

The reimbursement methodology is based upon qualifying costs for the eligible population from the 2009 Cost Allocation Plan with a unit of service equal to one week. The TCM unit rate is a prospective flat rate based on a qualifying TCM worker contact with the client in the target population or with some other person on behalf of the client during the claim period.

The weekly rate covers both service provision and administrative costs. The rates are based on an average of direct, general and administrative and information technology costs which were obtained from provider agencies within the state. Direct costs include those items necessary for the provision of the service such as salaries, benefits, travel costs, phone, training, and professional clinical consultation. General and administrative costs and information technology are 4% of the total direct costs. The resulting rate is $299.44 per week based on 23,349 contacts per year.

Private Providers

Private providers will be paid in accordance with the methodology in Attachment 4.19-B, Page 22 of this plan.

Non-Duplication of Services

Payment for TCM services under the plan do not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private provider of case management for children at risk of abuse or neglect and the fee schedule and any annual/periodic adjustments to the fee schedule are published ion the agency website at www.okhca.org. The agency's fee schedule rate is set as of December 1, 2009 and is effective for services on or after that date.

STATE Oklahoma
DATE REC'D 3-31-08
DATE APP'V'D 8-19-10
DATE EFF 12-1-09
HCFA 179 08-08

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Revised 12-01-09

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

The target group is persons with mental retardation and/or related conditions who are served by the Home and Community Based Services (HCBS) Waiver; or individuals who reside in institutions and have requested HCBS and receive TCM prior to entering the waiver; or who are being assessed for admission to the HCBS Waivers.

The Developmental Disabilities Services Division Targeted Case Management (DDSDTCM) rate is based on the weekly cost per case to provide targeted case management services. The cost base consists of the annualized cost of direct case management staff, including applicable agency overhead and indirect service costs, which have been computed and allocated in accordance with the Oklahoma Department of Human Services' cost allocation plan. This plan including its methodologies for allocating costs to state and federal programs is reviewed and approved by the Department of Health and Human Services' Division of Cost Allocation. The weekly rate is computed by dividing the annual cost base, including a prior period adjustment necessary to reconcile prior years' allowable costs against total billable amounts, by a projected annual number of weekly units of service. The maximum annual number of billable units of service is estimated to be 130,000. Units of service are defined as one calendar week of targeted case management, provided that a minimum of one contact meeting the description of targeted case management was provided, with or on behalf of an eligible recipient, and documented for the calendar week.

On a quarterly basis, the actual year-to-date costs of providing services will be compared with invoiced amounts to determine any over or under recovery of Federal Financial Participation. The rate for subsequent service periods will be adjusted to accommodate this variance. Subsequent to the end of the state fiscal year, a final reconciliation between final allowable costs and total billed amounts will be performed. Any over or under recovery of funding will be factored into the following year's rate computation.

Payment for TCM services under the plan do not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private provider of case management for children with severe emotional disturbances and the fee schedule and any annual/periodic adjustments to the fee schedule are published on the agency website at www.okhca.org. The agency's fee schedule rate is set as of December 1, 2009, and is effective for services on or after that date.

Revised 03-03-08

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Residential Behavioral Management Services (RBMS)

(a) Organized Health Care Delivery Systems:

(1) Oklahoma Department of Human Services: The Oklahoma Department of Human Services (DHS) is an Organized Health Care Delivery Systems (OHCDS) with health care services identified as a component of its mission. The OHCDS provides RBMS per the requirements established on Attachment 3.1-A, Page 6a-1.1. The Oklahoma DHS RBMS levels of care are as follows:

- **(i)** **Level C** – Minimum supervision and treatment
- **(ii)** **Level D** – Close supervision and treatment
- **(iii)** **Level D+** – Highly intensive supervision and treatment
- **(iv)** **Level E** – Maximum supervision and treatment
- **(v)** **Level E+** – Maximum supervision and treatment
- **(vi)** **Level E Enhanced** – Maximum supervision and treatment
- **(vii)** **Intensive Treatment Services (ITS) Group Home** –Maximum supervision and treatment; Crisis and stabilization intervention treatment

(2) Oklahoma Office of Juvenile Affairs: The Oklahoma Office of Juvenile Affairs (OJA) is an Organized Health Care Delivery Systems (OHCDS) with health care services identified as a component of its mission. The OHCDS provides RBMS per the requirements established on Attachment 3.1-A, Page 6a-1.1.RBMS are limited to a maximum of one service per day, per eligible member. The OJA RBMS levels of care:

- **(i)** **Level D+** – Highly intensive supervision and treatment
- **(ii)** **Level E** – Maximum supervision and treatment

State: Oklahoma
Date Received: 26 July, 2019
Date Approved: 18 October, 2019
Effective Date: 1 September, 2019
Transmittal Number: 19-0006

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Residential Behavioral Management Services (RBMS) *(continued)*

Per Diem Rates: A per diem rate will be established for each level of care in which residential behavioral management services (RBMS) are provided. RBMS are limited to a maximum of one service per day, per eligible member. The total is then divided by the number of available beds for the applicable level of care. The allocation of RBMS costs to Title XIX funds are as follows:

(1) Direct Care Staff Salary Costs: Staff salary costs are calculated using state salary and benefit package guidelines for similar jobs. Direct care positions within a group home consist of direct care staff, supervisors, nurses, therapists, program director, and administrative staff.

(i) Direct care staff perform basic living skills redevelopment, social skills redevelopment, and behavioral redirection to members in the facility during all times each member is awake and not in school, whether on or off campus. See Attachment 3.1-A, Page 1a-6.5g for a description of RBMS service components. The direct care staff time is partially funded by Medicaid which is calculated as follows: 24 hours in a day, minus 8 hours for average sleep time per day, minus 2.96 hours for average school time per day (*Oklahoma requires 1,080 per year*); this equals 13.04 hours per day for RBMS service components, or 54.34% of the day or:

State: Oklahoma
Date Received: 26 July, 2019
Date Approved: 18 October, 2019
Effective Date: 1 September, 2019
Transmittal Number: 19-0006

The direct care time is allocated to Medicaid as follows:

24 hours per day
8 hours of sleep time per day
- 2.96 hours average time in school (Oklahoma requires 1,080 per year)
13.04 hours allocated to Medicaid (54.34% of a 24-hour day)

(ii) Therapist and nurse salaries are 100% compensable under Title XIX. See Attachment 3.1-A, Page 1a-6.5g for a description of RBMS service components.

(2) Facility and Operational Costs: Facility costs are based on the Oklahoma Child Care licensing standard for the minimum square footage of living quarters for each resident. That square footage is then grossed up to include common spaces, administrative office space, and activity areas. The total square footage is used to calculate the total facility cost by using the standard rent estimates for Oklahoma. Operational costs are inclusive of trauma focused therapeutic programs and training as well as administrative costs (i.e., accounting, billing, human resources, etc.). Operational and facility costs are partially eligible for Medicaid reimbursement. To allocate the partial portions of the facility and operational costs to Medicaid, the following calculation is used:

The percent of facility and operational costs allocated to Medicaid is as follows:

$$\frac{(54.34\% \times \text{Direct Care Salaries} + \text{Therapist Salaries} + \text{Nurse Salaries})}{(\text{Direct Care Salaries} + \text{Therapist Salaries} + \text{Nurse Salaries})}$$

(i) When the calculation is applied to each level of care the percent of Medicaid differs based on the differences in the number of direct care staff needed for that particular staffing ratio and facility size along with the number of therapist and nurses needed for that particular level of care.

STATE Oklahoma
DATE RECD 3-30-06
DATE APPVD 6-14-06
DATE EFF 1-1-06
HCFA 179 06-03
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency OKLAHOMA

SUPERSEDES: NONE - NEW PAGE

MEDICAID PROGRAM: REQUIREMENTS RELATING TO REIMBURSEMENT FOR COVERED OUTPATIENT DRUGS

Citation (s)		Provision (s)
1927(d)(2) and 1935(d)(2)	1.	The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit –Part D.
	___	**The following excluded drugs are covered:**
	☐	(a) agents when used for anorexia, weight loss, weight gain (see specific drug categories below)
	☐	(b) agents when used to promote fertility (see specific drug categories below)
	☐	(c) agents when used for cosmetic purposes or hair growth (see specific drug categories below)
	☐	(d) agents when used for the symptomatic relief cough and colds (see specific drug categories below)
	X	(e) prescription vitamins and mineral products, except prenatal vitamins and fluoride (see specific drug categories below)
	X	(f) nonprescription drugs (see specific drug categories below)

New Page 01-01-06

STATE Oklahoma	A
DATE RECD 3-30-06	
DATE APP'VT 6-14-06	
DATE EFF 1-1-06	
HCFA 179 06-03	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency OKLAHOMA

SUPERSEDES: NONE - NEW PAGE

MEDICAID PROGRAM: REQUIREMENTS RELATING TO REIMBURSEMENT FOR COVERED OUTPATIENT DRUGS

Citation (s)		Provision (s)
1927(d)(2) and 1935(d)(2)	☐	(g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific drug categories below)
	X	(h) barbiturates (see specific drug categories below)
	X	(i) benzodiazepines (see specific drug categories below)
		(The Medicaid agency lists specific category of drugs below)
		For (e), (f), (h), and (i) above, drugs for non-Medicare eligible individuals are covered for Medicare eligible individuals.
	__	**No excluded drugs are covered.**

New Page 01-01-06

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Diabetes Self-management Training (DSMT) Services

Payment is made for DSMT services in accordance with the methodology described in Attachment 4.19-B, Page 3.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
MEDICATION-ASSISTED TREATMENT

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29. Medication-Assisted Treatment (MAT)

Medication-assisted treatment services, including the drug component, the provider component, and the behavioral health component, are reimbursed on a fee-for-service basis.

A. Office Based Opioid Treatment (OBOT) services are reimbursed on a fee-for-service basis.
   1. The State will cover all forms of drugs and biologicals that the Food and Drug Administration has approved or licensed for MAT to treat opioid use disorder (OUD).
   2. Payment for unbundled prescribed drugs administered by a provider in an OBOT setting are reimbursed per the methodology in Attachment 4.19-B, Page 7a.
   3. Payment for unbundled prescribed drugs prescribed for the treatment of opioid-use disorder, if dispensed by a pharmacy, are reimbursed per the methodology in Attachment 4.19-B, Pages 7 and 7a.
   4. Payment for unbundled OBOT Provider services will be reimbursed per the methodology in Attachment 4.19-B, Page 3 for physicians, per the methodology in Attachment 4.19-B, Page 21 for physician's assistants, and per the methodology in Attachment 4.19-B, Page 32 for advanced practice registered nurses.
   5. Payment for unbundled OBOT behavioral health services noted within Attachment 3.1-A, Page 11c are reimbursed per the methodology for rehabilitative services, refer to Attachment 4.19-B, Page 29 at 13d.1.(A).

B. Opioid Treatment Program (OTP) services are reimbursed on a fee-for-service basis.
   1. The State will cover all forms of drugs and biologicals that the Food and Drug Administration (FDA) has approved or licensed for MAT to treat opioid use disorder (OUD).
   2. Unbundled prescribed drugs dispensed or administered by an OTP MAT Provider, an OTP Exempt MAT Provider, or a Medication Unit Affiliated with an OTP within an OTP setting are reimbursed per the methodology in Attachment 4.19-B, Page 7a.
   3. Unbundled prescribed drugs prescribed for the treatment of opioid-use disorder, if dispensed by a pharmacy, are reimbursed per the methodology in Attachment 4.19-B, Pages 7 and 7a.
   4. Payment for unbundled OTP Provider services are reimbursed per the methodology in Attachment 4.19-B, Page 3 for physicians, per the methodology in Attachment 4.19-B, Page 21 for physician's assistants, and per the methodology in Attachment 4.19-B, Page 32 for advanced practice registered nurses.
   5. Payment for unbundled OTP behavioral health services are reimbursed per the methodology in Attachment 4.19-B, Page 29 at 13d.1.(A).

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

13.c Preventive Services

Doula services payments are made in accordance with the established fee schedule rates described in Attachment 4.19-B, Page 3: Payment for physicians' services (includes medical and remedial care and services).

Reimbursement for doula services will be made based on a percentage of the physician fee schedule, according to the type of visit:

- For prenatal and postpartum visits, payment will be made at 40% of the physician fee schedule.
- For labor & delivery visits, payment will be made at 40% of the physician fee schedule for a cesarean delivery-only visit, or at 65% for vaginal delivery-only, vaginal delivery after previous cesarean delivery, or cesarean delivery following vaginal delivery attempt.
- Doula providers will use the appropriate code modifier for all procedure codes.

The agency's fee schedule rate was set as of July 1, 2023 and is effective for services provided on or after that date. All rates are published on the agency's website at http://www.okhca.org/feeschedules.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Vaccine Administration and Administration of Advisory Committee on Immunization Practices (ACIP)-Recommended Vaccine Services

The OHCA will follow the Agency's current reimbursement methodologies found at Attachment 4.19-B, Page 3 for vaccine administration. For vaccines administered under the Pediatric Immunization Program the Agency will follow the current reimbursement methodologies found at Page 66(b).

Vaccines are paid as per the current reimbursement methodology found at Attachment 4.19-B, Page 3

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
ROUTINE PATIENT COST IN QUALIFYING CLINICAL TRIALS

30. Coverage of Routine Patient Cost in Qualifying Clinical Trials

Reimbursement for routine patient costs associated with qualified clinical trials follows the existing rate methodology approved within the Oklahoma State Plan for the individual service/item provided.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: OKLAHOMA

METHODS AND STANDARDS FOR ESTABLISHING PAY RATES – OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State plan), if applicable, the Medicare agency uses the following general method for payment.

1. Payments are limited to State Plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

   For specific Medicare services which are not otherwise covered by this State Plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item 1 & 2 of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR".

3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in item ___ of this attachment, for those groups and payments listed below and designated with the letters "NR".

4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in item ___ of this attachment (see 3. above).

STATE Oklahoma
DATE RECD 9-1-05
DATE APPVD 10-21-05
DATE EFF 8-1-05
HCFA 179 05-04

A

02-08

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: OKLAHOMA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Claims

QMBs:	Part A MR/NR	Deductibles	MR/NR	Coinsurance
	Part B MR/NR	Deductibles	MR/NR	Coinsurance
Other Medicaid Recipients	Part A MR/NR	Deductibles	MR/NR	Coinsurance
	Part B MR/NR	Deductibles	MR/NR	Coinsurance
Dual Eligible (QMB Plus):	Part A MR/NR	Deductibles	MR/NR	Coinsurance
	Part B MR/NR	Deductibles	MR/NR	Coinsurance

State: Oklahoma
Date Received: 28 March, 2013
Date Approved: 5 August, 2014
Date Effective: 1 January, 2013
Transmittal Number: 13-04

Revised 01-01-13

TN# 13-04 Approval Date 8/5/14 Effective Date 1/1/13
Supersedes
TN# 05-04

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment of Deductible and Coinsurance for Medicare Part A and Part B Claims

1. Payment of Deductible and Coinsurance for Medicare Part A Claims:

   For Qualified Medicare Beneficiaries (QMB) and Qualified Medicare Beneficiaries with full Medicaid benefits (QMB Plus), the Medicaid agency uses the following method for specific Medicare hospital services, psychiatric hospital services, and psychiatric residential facility (PRTF) services which are not specifically addressed elsewhere in the State Plan:

   Deductible – 75%
   Coinsurance – 25%

   For crossover claims on services that were rendered on or after January 1, 2016, payment for skilled nursing facility services will be made at 20 percent of the Medicare rate for coinsurance and deductible, if any.

2. Payment of Deductible and Coinsurance for Medicare Part B Claims:

   The Medicaid agency uses the following method for specific Medicare medical services and dialysis services which are not specifically addressed elsewhere in the State Plan:

   Deductible – 100%
   Coinsurance – 46.25%

   For Indian health service (IHS) clinics and transportation, payment is made at a rate of 100 percent of the deductible and 100 percent of the coinsurance.

State: Oklahoma
Date Received: 1 May, 2019
Date Approved: 16 July, 2019
Effective Date: 1 April, 2019
Transmittal Number: 19-0002

Revised 04-01-19

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: OKLAHOMA

Payment for Reserved Beds in Long-Term Care Facilities

Payments are made to reserve a bed during a recipient's temporary absence from a nursing facility or an ICF/IID facility pursuant to the provisions of 42CFR 447.40.

Effective for services on or after July 1, 2014, payment is not made to a nursing facility for hospital leave days. Therapeutic leave days are limited to seven (7) days per calendar year.

Payment will be made at fifty (50) percent of the established rate for nursing facility services for therapeutic leave days.

Payment is made to reserve a bed in an intermediate care facility for individuals with intellectual disabilities (other than periods of inpatient hospitalization). Payments are made for therapeutic leave days not to exceed a maximum of 14 consecutive days per absence, with a maximum of 60 days in a calendar year for ICF/IID recipients.

Payment for therapeutic leave days will be made at seventy-five (75) percent of the established rate, for therapeutic leave days for ICF/IID facilities.

State: Oklahoma
Date Received: 9/30/14
Date approved: 12/16/14
Date Effective: 7/01/14
Transmittal Number: OK 14-0025

Revised 07-01-14

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

STANDARD NURSING FACILITY SERVING ADULTS

Prospective rates of payment shall be reviewed, at a minimum, annually for Oklahoma nursing facilities serving adults (NF's). The rates in effect will be determined pursuant to these methods and standards and approved by the Oklahoma Health Care Authority Board in advance of the rate periods. The rates are established based on analyses of cost reports and other relevant cost information, the use of national and, where appropriate, Oklahoma-specific trends in costs, including trends in salary levels and changes in minimum wage levels, analyses of the economic impact of changes in law or regulations, and discussions with recognized representatives of the nursing home industry.

Effective October 1, 2019, subject to the availability of funds, the average rate for nursing facilities shall be equal to the statewide average cost as derived from audited cost reports for state fiscal year (SFY) 2018, ending June 30, 2018, after application of an adjustment that is calculated from the average of cost report audit adjustments from the five, immediately-preceding state fiscal years; provided, however, that this average shall exclude the highest and lowest cost report audit adjustments from the five-year period prior to calculation. The average cost for nursing facilities shall then be adjusted for inflation.

The rates are at, or above, the level that the Oklahoma Health Care Authority (OHCA) finds reasonable and adequate to reimburse the costs that must be incurred by economically and efficiently operated facilities to the extent specified by 42 U.S.C. Section 1396a(a)(13)(A).

If payments exceed the Upper Payment Level (UPL) in aggregate, the OHCA will recoup payments proportionate to the nursing facility's contribution to the amount exceeding the UPL.

A. COST ANALYSES

The Oklahoma Health Care Authority (OHCA) is principally responsible for implementing the Medicaid (SoonerCare) program in Oklahoma. OHCA staff will prepare necessary analyses to support the rate determination process. Part of the process will be to analyze the costs as reported by the facilities.

1. UNIFORM COST REPORTS

Each SoonerCare participating nursing facility must submit, on uniform cost reports designed by the Authority, cost and related statistical information necessary for rate determinations.

a. **Reporting Period.** Each nursing facility must prepare the cost report to reflect the allowable costs of services provided during the immediately preceding fiscal year ending June 30. Where the ownership or operation is commenced, a fractional year report is required for each period of time the NF was in operation during the year.

b. **Reporting Deadline.** The report must be filed by October 31 of each following year. Extensions of not more than 15 days may be granted on a showing of just cause.

c. **Accounting Principles**. The report must be prepared on the basis of generally accepted accounting principles and the accrual basis of accounting, except as otherwise specified in the cost report instructions.

d. **Signature**. The cost report shall be signed by an owner, partner or corporate officer of the NF, by an officer of the company that manages the NF, and by the person who prepared the report, either physically or through use of the secure website reporting system.

State: Oklahoma
Date Received: October 2, 2019
Date Approved: December 4, 2019
Date Effective: October 1, 2019
Transmittal Number: 19-0031-B

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

STANDARD NURSING FACILITIES SERVING ADULTS (CONTD)

e. **Audits of Cost Reports**. The Authority will conduct desk reviews to verify the completeness and mathematical accuracy of all totals and extensions in each cost report. Census information may be independently verified through other OHCA sources. In addition, a sample number of cost reports will be audited independently by an auditor retained by OHCA. Any NF that is subject to an audit is required to make its records available to OHCA and to any auditor engaged by OHCA

2. ALLOWABLE AND UNALLOWABLE COSTS

Only "allowable costs" may be included in the cost reports. (Costs should be net of any offsets or credits.) Allowable costs include all items of SoonerCare-covered expense that NF's incur in the provision of routine (i.e., non-ancillary) services. "Routine Services include, but are not limited to, regular room, dietary and nursing services, minor medical and surgical supplies, over-the-counter medications, transportation, and the use and maintenance of equipment and facilities essential to the provision of routine care. Allowable costs must be considered reasonable, necessary and proper, and shall include only those Costs that are considered allowable for Medicare purposes and that are consistent with federal Medicaid requirements. The guidelines for allowable costs in the Medicare program are set forth in the Medicare Provider Reimbursement Manual ("PRM"), HCFA-Pub. 15. Ancillary items reimbursed outside the NF rate should not be included in the NF cost report and are not allowable costs. Quality of Care assessment fees are allowable costs for reporting purposes. OHCA reserves the right to exclude from its analysis unallowable costs, whether included in the cost report or not.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

STANDARD NURSING FACILITIES SERVING ADULTS *(continued)*

B. RATE SETTING PROCESS

Beginning July 1, 2007, the Oklahoma Health Care Authority uses the following method to adjust rates of payment for nursing facilities:

1. DEFINITIONS*:*

Base Rate Component is the rate in effect on June 30, 2005, defined as $103.20 per day. Included in the base rate is the QOC Fee. Any changes to the base rate will be made through future Plan changes if required. For the rate period beginning September 01, 2012, the base rate will be $106.29. For the rate period beginning July 1, 2013, the base rate will be $107.24. For the rate period beginning July 1, 2016, the base rate will be $107.57 per patient day. For the rate period beginning July 1, 2017, the base rate will be $107.79 per patient day. For the rate period beginning July 1, 2018, the base rate will be $107.98 per patient day. For the rate period beginning October 1, 2018, the base rate will be $108.12 per patient day. For the rate period beginning July 1, 2019, the base rate will be $108.31 per patient day. For the rate period beginning October 1, 2019, fifty percent (50%) of new funding shall be allocated toward an increase of the existing base rate and distributed accordingly. For the rate period beginning October 1, 2019, the base rate will be $120.57 per patient day. For the rate period beginning July 1, 2020, the base rate will be $121.30 per patient day. For the rate period beginning July 1, 2021, the base rate will be $123.22 per patient day. For the rate period beginning July 1, 2022, the base rate will be $123.47 per patient day.

Direct Care Cost Component is defined as the component established based on each facilities' relative expenditures for Direct Care which are those expenditures reported on the annual costs reports for salaries (including professional fees and benefits), for registered nurses, licensed practical nurses, nurse aides, and certified medication aides.

Other Cost Component is defined as the component established based on monies available each year for all costs other than direct care and incentive payment totals, i.e., total allowable routine and ancillary costs (including capital and administrative costs) of nursing facility care less the Direct Care Costs and incentive payment totals.

Incentive Rate Component is defined as the component earned each quarter under the Pay-for-Performance (PFP) program.

Rate Period is defined as the period of time between rate calculations.

2. GENERAL:

The estimated total available funds will include the estimated savings or loss to the program as a result of the automatic cost of living adjustment on Social Security benefits as published in the federal register and the resulting effect to the spend-down required of the recipients. For Regular Nursing facilities, the effect is $.32 per day for each one (1) percent change in the SSI determined from the average effect of SSI increases from CY 2004 to CY 2009.

Individual rates of payment will be established as the sum of the Base Rate plus add-ons for Direct Care, Other Costs, and the Pay-for-Performance (PFP) Quality of Care Rating System.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

STANDARD NURSING FACILITIES SERVING ADULTS *(continued)*

3. PROCESS:
Annually, any funds over and above those to cover the Base Rate plus the estimated Pay-for-Performance (PFP) Program payments will be used to create two pools of funds used to establish the rate components for *other costs* and *direct care costs*.

1. An *Other Costs* Pool (30 % of the available funds, after meeting estimated base rate and incentive payments) is used to establish a uniform statewide rate component (defined as the total pool divided by the total estimated Medicaid days of service).

2. A *Direct Care Cost* Pool (70% of the available funds, after meeting estimated base rate and incentive payments) is used to establish facility specific add-ons based on relative expenditures for direct care for SoonerCare clients as follows:

Step One: The OHCA will construct an array of the facilities' allowable Direct Care per patient day (as reported on the cost report for the most recent reporting period), with each facility's value in the array being the lesser of actual cost per day or a ceiling set at the 90th percentile of the array of all facilities.

Step Two: For each facility in the array, the Direct Care Cost established in step one will be multiplied by their estimated annual SoonerCare days and added together to calculate the aggregate estimated SoonerCare direct care cost. The estimated annual SoonerCare days will be determined by using MMIS data from the latest available annual period paid days. In the case of facilities with less than a year's experience, then the OHCA will determine an estimate from any available actual data for that facility or like facilities.

Step Three: The Direct Care Pool of available funds will be divided by the aggregate estimated SoonerCare Cost determined in step two to determine an add-on percent for Direct Care.

Step Four: The Direct Care add-on for each facility will be determined by applying the percent calculated in step three to each facility's per patient day Direct Care Value determined in step one.

Step Five: The sum of the Base Rate and add-ons for Direct Care and Other Costs will be the facility specific rate for the period. The only exceptions to this logic are for homes that do not file a report and for new homes established in the current rate period. For homes not filing a cost report, the rate will not include the direct care component and will be the sum of the base rate plus the Other Cost add-on, only.

State: Oklahoma
Date Received: October 2, 2019
Date Approved: DEC 04 2019
Date Effective: October 1, 2019
Transmittal Number: 19-0031-B

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

STANDARD NURSING FACILITIES SERVING ADULTS *(continued)*

For new facilities beginning operations in the current rate period, the rate will be the median of those established rates for the year.

For the rate period beginning 01/01/12, the total available pool amount for establishing the rate components described in 1 and 2 is $102,318,569.
For the rate period beginning 09/01/12, the total available pool amount for establishing the rate components described in 1 and 2 is $147,230,204.
For the rate period beginning 07/01/13, the total available pool amount for establishing the rate components described in 1 and 2 is $162,205,189.
For the rate period beginning 07/01/14, the total available pool amount for establishing the rate components described in 1 and 2 is $158,391,182.
For the rate period beginning 07/01/16, the total available pool amount for establishing the rate components described in 1 and 2 is $158,741,836.
For the rate period beginning 07/01/17, the total available pool amount for establishing the rate components described in 1 and 2 is $160,636,876.
For the rate period beginning 07/01/18, the total available pool amount for establishing the rate components described in 1 and 2 is $158,938,847.
For the rate period beginning 10/01/18, the total available pool amount for establishing the rate components described in 1 and 2 is $174,676,429.
For the rate period beginning 07/01/19, the total available pool amount for establishing the rate components described in 1 and 2 is $186,146,037.
For the rate period beginning 10/01/19, the total available pool amount for establishing the rate components described in 1 and 2 is $220,482,316.
For the rate period beginning 07/01/20, the total available pool amount for establishing the rate components described in 1 and 2 is $250,302,699.
For the rate period beginning 07/01/21, the total available pool amount for establishing the rate components described in 1 and 2 is $251,196,155.
For the rate period beginning 07/01/22, the total available pool amount for establishing the rate components described in 1 and 2 is $242,806,077.

3. Since July 1, 2007, Nursing Facilities Serving Adults and AIDS Patients have been able to earn additional reimbursement for “points” earned in an Oklahoma Quality Rating Program. This program, which was originally called “Focus on Excellence,” was revised by statute in 2019, and is now called “Pay-for-Performance”.

Pay-for-Performance (PFP) Program
For the period beginning October 1, 2019, and until changed by amendment, qualifying facilities participating in the pay-for-performance program have the potential to earn an average of the $5.00 quality incentive per Medicaid patient per day. Facility(s) baseline is calculated annually and will remain the same for a 12-month period. Facility(s) will meet or exceed five-percent (5%) relative improvement or the CMS national average each quarter for the following metrics:

(1) Decrease percent of high risk/unstageable pressure ulcer for long stay residents;
(2) Decrease percent of unnecessary weight loss for long stay residents;
(3) Decrease percent of use of anti-psychotic medications for long stay residents; and
(4) Decrease percent of urinary tract infection for long stay residents.

If either quality metric listed above is substituted or removed by CMS; an alternative CMS Long Stay quality metric may be chosen.

Payment to nursing facilities for meeting the metrics will be awarded quarterly as follows:

- A facility may earn a minimum of $1.25 per Medicaid patient per day for each qualifying metric.
- A facility receiving a scope and severity tag deficiency of “I” or greater from the Oklahoma State Department of Health will forfeit the PFP incentive for the quarter out of compliance.
- Funds that remain as a result of payment not earned, shall be pooled and redistributed to facilities who achieve the metrics each quarter based on facilities’ individual performance in the PFP program.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

STANDARD NURSING FACILITIES SERVING ADULTS *(continued)*

Reserved page.

State: Oklahoma
Date Received: October 2, 2019
Date Approved: DEC 04 2019
Date Effective: October 1, 2019
Transmittal Number: 19-0031-B

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

STANDARD NURSING FACILITIES SERVING ADULTS *(continued)*

Reserved page.

State: Oklahoma
Date Received: October 2, 2019
Date Approved: DEC 04 2019
Date Effective: October 1, 2019
Transmittal Number: 19-0031-B

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

STANDARD NURSING FACILITIES SERVING ADULTS *(continued)*

Reserved page.

State: Oklahoma
Date Received: October 2, 2019
Date Approved: DEC 04 2019
Date Effective: October 1, 2019
Transmittal Number: 19-0031-B

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

4. QUALIFY OF CARE FEE ASSESSMENTS

56 Okla. Stat. § 2002 requires that all licensed nursing facilities pay a statewide average per patient day Quality of Care assessment fee based on the maximum allowed percentage under federal law of the average gross revenue per patient day. Gross revenues are defined as Gross Receipts (i.e. total cash receipts less donations and contributions). The assessment is an allowable cost and a part of the base rate component. The OHCA was directed to collect the assessment, assess penalties for late payment and deposit the assessments into a "Quality of Care Fund" and make payments from said fund for the purposes listed in the Bill.

5. SPECIALIZED SERVICES

Payment will be made for non-routine nursing facility services identified in an individual treatment plan prepared by the State MR Authority. Services are limited to individuals approved for NF and specialized services as the result of a PASSR/MR Level II screen. The per diem add-on is calculated as the difference in the statewide average standard private MR base rate and the statewide NF facility standard base rate. If the Standard private MR average base rate falls below the standard nursing facility base rate or equals the standard facility base rate for regular nursing facilities the payment will not be adjusted for specialized services.

6. COSTS OF COMPLIANCE WITH OMNIBUS BUDGET RECONCILIATION ACT

(OBRA) OF 1987

All of the costs of compliance appear in provider cost reports used to develop rates. Therefore, no further adjustment or add-on is required.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

STANDARD NURSING FACILITY SERVING AIDS PATIENTS

A statewide prospective rate of payment shall be reviewed, at a minimum, annually for Oklahoma Nursing Facilities serving AIDS patients. The rate in effect will be determined pursuant to these methods and standards and approved by the Oklahoma Health Care Authority Board in advance of the rate period. The rate is established based on analyses of cost reports and other relevant cost information, the use of national and, where appropriate. Oklahoma-specific trends in costs, including trends in salary levels and changes in minimum wage levels, analyses of the economic impact of changes in law or regulations, and discussions with recognized representatives of the nursing home industry.

The rate is at, or above, the level that the Oklahoma Health Care Authority (OHCA) finds reasonable and adequate to reimburse the costs that must be incurred by economically and efficiently operated facilities to the extent specified by 42 U.S.C. Section 1396a(a)(13)(A).

A. COST ANALYSES

The Oklahoma Health Care Authority (OHCA) is principally responsible for implementing the Medicaid (SoonerCare) program in Oklahoma. OHCA staff will prepare necessary analyses to support the rate determination process. Part of the process will be to analyze the costs as reported by the facilities.

1. UNIFORM COST REPORTS

Each SoonerCare-participating nursing facility must submit on uniform cost reports designed by the Authority, cost and related statistical information necessary for rate determinations.

a. Reporting Period. Each nursing facility must prepare the cost report to reflect the allowable costs of services provided during the immediately preceding fiscal year ending June 30. Where the ownership or operation is commenced, a fractional year report is required for each period of time the NF was in operation during the year.

b. Reporting Deadline. The report must be filed by October 31 of each year. Extensions of not more than 15 days may be granted on a showing of just cause.

c. Accounting Principles. The report must be prepared on the basis of generally accepted accounting principles and the accrual basis of accounting, except as otherwise specified in the cost report instructions.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
FOR NURSING FACILITIES

STANDARD NURSING FACILITY SERVING AIDS PATIENTS (CONTD)

d. Signature. The cost report shall be signed by an owner, partner or corporate officer of the NF, by an officer of the company that manages the NF, and by the person who prepared the report, either physically or through use of the secure website reporting system.

e. Audits of Cost Reports. The Authority will conduct a desk review to verify the completeness and mathematical accuracy of all totals and extensions in each cost report. Census information may be independently verified through other OHCA sources. In addition, a sample number of cost reports will be audited independently by an auditor retained by OHCA. Any NF that is subject to an audit is required to make its records available to OHCA and to any auditor engaged by OHCA.

2. ALLOWABLE AND UNALLOWABLE COSTS

Only "allowable costs" may be included in the cost reports (Costs should be net of any offsets or credits.) Allowable costs include all items of SoonerCare covered expense that NF's incur in the provision of routine (i.e., non-ancillary) services. "Routine services include, but are not limited to, regular room, dietary and nursing services, minor medical and surgical supplies, over-the-counter medications, transportation, and the use and maintenance of equipment and facilities essential to the provision of routine care. Allowable costs must be considered reasonable, necessary and proper, and shall include only those costs that are considered allowable for Medicare purposes and that are consistent with federal Medicaid requirements. The guidelines for allowable costs in the

Medicare program are set forth in the Medicare Provider Reimbursement Manual ("PRM"), HCFA-Pub. 15. Ancillary items reimbursed outside the NF Aids rate should not be included in the cost report and are not allowable costs. Quality of Care assessment fees are allowable costs for reporting purposes.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

STANDARD NURSING FACILITY SERVING AIDS PATIENTS *(continued)*

B. RATE SETTING PROCESS

1. DEFINITIONS AND METHODOLOGY

Base Rate Component is the rate component representing the allowable cost of the services rendered in an AIDS nursing facility and for the period beginning November 1, 2010, is $178.64, the difference in the costs reported for aids facilities and regular nursing facilities plus the average rate for November 1, 2010 for regular nursing facilities, not including the incentive payment component ($193.79 less $138.17 plus $123.02); or $178.64 per patient day. For the rate period beginning September 1, 2012, the Base Rate Component will be $192.50. For the rate period beginning July 1, 2013, the Base Rate Component will be $196.95. For the rate period beginning July 1, 2014, the Base Rate Component will be $197.49. For the rate period beginning July 1, 2016, the Base Rate Component will be $199.19 per patient day. For the rate period beginning July 1, 2017, the Base Rate Component will be $200.01 per patient day. For the rate period beginning July 1, 2018, the Base Rate Component will be $201.32 per patient day. For the rate period beginning October 1, 2018, the Base Rate Component will be $207.86 per patient day. For the rate period beginning July 1, 2019, the Base Rate Component will be $209.50 per patient day. For the rate period beginning October 1, 2019, the Base Rate Component will be $213.10 per patient day. For the rate period beginning July 1, 2020, the Base Rate Component will be $215.00 per patient day. For the rate period beginning July 1, 2021, the Base Rate Component will be $224.05 per patient day. For the rate period beginning July 1, 2022, the Base Rate Component will be $226.97 per patient day.

(A) *56 Okla. Stat.* § 2002 requires that all licensed nursing facilities pay a statewide average per patient day *Quality of Care assessment fee* based on maximum percentage allowed under federal law of the average gross revenue per patient day. Gross revenues are defined as Gross Receipts (i.e., total cash receipts less donations and contributions). *The assessment is an allowable cost as it relates to Medicaid services and a part of the base rate component.*

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

STANDARD NURSING FACILITY SERVING AIDS PATIENTS *(continued)*

(C) Beginning January 1. 2010 the base rate component was and will be adjusted annually on January 1, in an amount equal to the estimated savings or loss to the program as a result of the automatic cost of living adjustment on Social Security benefits as published in the Federal Register and the resulting effect to the spend-down required of the recipients. For Regular Nursing Facilities the effect is $.32 per day for each one (1) percent change in the SSI determined from the average effect of SSI increases from CY 2004 to CY 2009. For Nursing Facilities and facilities serving AIDS patients, the effect is $.32 per day for each one (1) percent change in the SSI determined from the average effect of SSI increases from CY 2004 to CY 2009.

Incentive Rate Component Nursing Facilities Serving AIDS Patients are eligible for additional reimbursement for participation in and points earned in the Oklahoma Pay-for-Performance (PFP) Quality Rating Program. The points earned and additional reimbursements available are the same as those detailed in 4.19-D, in the description covering this program in the Standard Nursing Facilities Serving Adults section of this plan.

State: Oklahoma
Date Received: October 2, 2019
Date Approved: DEC 04 2019
Date Effective: October 1, 2019
Transmittal Number: 19-0031-B

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

STANDARD NURSING FACILITY SERVING VENTILATOR – DEPENDENT PATIENTS

A statewide enhanced reimbursement rate shall be reviewed, at a minimum, annually for nursing facilities (NFs) serving ventilator-dependent patients.

Definitions – Reimbursement is limited to the average standard rate paid to NFs serving adults plus an enhancement for ventilator patients. The enhanced payment is an amount reflecting the additional costs of meeting the specialized care needs of ventilator-dependent patients. To qualify for the enhanced payment, a facility must (1) not have a waiver under Section 1919(b)(4)(C)(ii) of the Social Security Act, and (2) submit a treatment plan and most recent doctor's orders and/or hospital discharge summary to the Oklahoma Health Care Authority for prior authorization.

Rate Determination – The add-on rate is determined prospectively as follows:

1. The estimated cost of direct care personnel is calculated using ventilator care-related criteria developed by the State of Minnesota. The criteria identifies the tasks, caregiver time estimate (in minutes per day) and caregivers (RN, LPN, etc.) required to complete each element of care on a daily basis. (For blood gas tasks, a respiratory therapist was substituted for the RN).

2. Each care giver time estimate, within each task category, is added together to arrive at a total caregiver time estimate within each task category. The total caregiver time estimate is converted to hours per day. It is then multiplied by a projected hourly wage rate by class of caregiver to arrive at a cost per day for each caregiver within each task category. Each cost per day for each caregiver is added together to arrive at a total caregiver cost within each task category. Each total caregiver cost is added together to arrive at a total caregiver cost to complete all identified tasks. The projected hourly wage rates were derived from the most recently available NF cost reports.

3. A factor for fringe benefits is calculated by dividing total employee benefits by total salaries and wages. The total caregiver cost to complete all identified tasks is multiplied by the factor for fringe benefits to arrive at a fringe benefit cost. The fringe benefit cost is added back into the total caregiver cost to complete all identified tasks to arrive at an adjusted total caregiver cost. Total employee benefits and total salaries and wages were derived from the most recently available NF cost reports.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

Reserve page

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

Reserve page

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

Reserve page

Reserved 07-01-21

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

Reserve page

Reserved 07-01-21

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

4. Based on provider input, and other survey information, the estimated average hours of specialized care required by ventilator-dependent patients was 9 hours per day. Each caregiver time estimate within each task category was added together to arrive at a total time estimate to complete all identified tasks, which was 13.69 hours. The adjusted total caregiver cost is multiplied by the ratio of 9 hours divided by 13.69 hours to arrive at a specialized caregiver cost.

5. The total patient care cost from the most recently available NF cost reports was calculated. The total patient care costs include nursing personnel including nursing employee benefits, medical director including employee benefits, social and ancillary service personnel including employee benefits, contract nursing, other contract personnel, medical equipment, dietary, drugs and medical supplies.

6. The difference between 24 hours and the estimated average hours of specialized care required by ventilator-dependent patients (9 hours) is divided by 24 hours. It is then multiplied by the total patient care cost which is then added to the specialized caregiver cost to arrive at the total 24 hour cost of patient care.

7. Five percent of the total patient care cost will be allowed for the additional cost of medical supplies not reimbursed by Medicare. A $4.00 per day adjustment will be allowed for nutritional therapy. Both additional costs are added back into the total 24 hour cost of patient care.

8. The difference between the total 24 hour cost of patient care (step 6) and the total patient care cost (step 5) is the add-on for ventilator patients.

9. The add-on for ventilator patients was inflated to the midpoint of the rate year using the fourth quarter publication of the Data Resources Inc., (DRI) Nursing Facility Marketbasket Index's forecast.

Cost Report Requirements – Uniform cost reports will be required of each nursing facilities and the State will provide for periodic audits of such reports. Facilities will be required to submit a separate cost report for ventilator care.

Adjustments – The add-on rate will be inflated when standard NF rates are changed by the fourth quarter publication of the Data Resources Inc., (DRI) Nursing Facility Marketbasket Index's forecast to the midpoint of the State Fiscal Year of the rate change.

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
FOR NURSING FACILITIES**

STANDARD NURSING FACILITY SERVING VENTILATOR-DEPENDENT PATIENTS *(continued)*

Rate Determination *(continued)*

The add-on rate for nursing facility serving ventilator-dependent patients will be established prospectively according to the methods described above until a reimbursement rate can be derived from the cost reports which will reasonably reimburse the cost of an economic and efficient provider for ventilator patient care.

For the period beginning January 1, 2004, no adjustment will be made to the add-on.

For the rate period beginning July 1, 2006, the statewide add-on will be increased by 9.155%.

For the rate period beginning April 1, 2010, the statewide add-on will be decreased by 3.25%.

For the rate period beginning July 1, 2021, the statewide add-on will be increased by 37.81%.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

PUBLIC INTERMEDIATE CARE FACILITES FOR THE MENTALLY RETARDED

Reimbursement for public ICF's/MR shall be based on each facility's reasonable and allowable cost and shall be paid on an interim basis with an annual retroactive adjustment. Reasonable costs shall be based on Medicare principles of cost reimbursement.

Service Fee 56 Okla. Stat. § 2002 requires that all licensed nursing facilities pay a statewide average per patient day Quality of Care assessment fee based on the maximum percentage allowed under federal law of the average gross revenue per patient day. Gross revenues are defined as Gross Receipts (i.e. total cash receipts less donations and contributions). The assessment is an allowable cost as it relates to Medicaid services.

STANDARD PRIVATE INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICF'S/MR)

A statewide prospective rate of payment shall be reviewed, at a minimum, annually for Oklahoma standard private intermediate care facilities for the mentally retarded. The rate will be determined pursuant to these methods and standards and approved by the Oklahoma Health Care Authority Board in advance of the rate period.

The rate will be established based on analyses of cost reports and other relevant cost information, the use of national and, where appropriate, Oklahoma-specific trends in costs, including trends in salary levels and changes in minimum wage levels, analyses of the economic impact of changes in law or regulations, and discussions with recognized representatives of the nursing home industry.

The rate is at, or above, the level that the Oklahoma Health Care Authority (OHCA) finds reasonable and adequate to reimburse the costs that must be incurred by economically and efficiently operated facilities to the extent specified by 42 U.S.C. Section 1396a(a)(13)(A).

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

A. COST ANALYSES

The Oklahoma Health Care Authority (OHCA) is principally responsible for implementing the Medicaid program in Oklahoma. OHCA staff will prepare necessary analyses to support the rate determination process, as described below.

1. UNIFORM COST REPORTS

Each Medicaid-participating ICF/MR facility must submit, on uniform cost reports designed by the Authority, cost and related statistical information necessary for rate determination.

a. **Reporting Period.** Each ICF/MR facility must prepare the cost report to reflect the allowable costs of services provided during the immediately preceding fiscal year ending June 30. Where the ownership or operation is commenced, a fractional year report is required, covering each period of time the ICF/MR was in operation during the year.

b. **Report Deadline.** The report must be filed by October 31 of each year. Extensions of not more than 15 days may be granted on a showing of just cause.

c. **Accounting Principles.** The report must be prepared on the basis of generally accepted accounting principles and the accrual basis of accounting, except as otherwise specified in the cost report instructions.

d. **Signature.** The cost report shall be signed by an owner, partner or corporate officer of the ICF/MR, by an officer of the company that manages the NF, and by the person who prepared the report.

e. **Audits of Cost Reports.** The Authority will conduct a desk review to verify the completeness and mathematical accuracy of all totals and extensions in each cost report. Census information may be independently verified through other OHCA sources. In addition, a sample number of cost reports will be audited independently by an auditor retained by OHCA. Any ICF/MR that is subject to an audit is required to make its records available to OHCA and to any auditor engaged by OHCA.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

2. ALLOWABLE AND UNALLOWABLE COSTS

Only "allowable costs" may be included in the cost reports. (Costs should be net of any offsets or credits.) Allowable costs include all items of Medicaid-covered expense that ICF'S/MR incur in the provision of routine (i.e., non-ancillary) services. "Routine services include, but are not limited to, regular room, dietary and nursing services, minor medical and surgical supplies, over-the-counter medications, transportation, and the use and maintenance of equipment and facilities essential to the provision of routine care. Allowable costs must be considered reasonable, necessary and proper, and shall include only those costs that are considered allowable for Medicare purposes and that are consistent with federal Medicaid requirements. (The guidelines for allowable costs in the Medicare program are set forth in the Medicare Provider Reimbursement Manual ("PRM"), HCFA-Pub. 15.) Ancillary items reimbursed outside the NF rate should not be included in the ICF/MR cost report and are not allowable costs. Quality of Care assessment fees are allowable costs for reporting purposes.

3. COMPUTATION OF THE STATEWIDE FACILITY BASE RATE

Cost reports used to calculate the rate were those filed for the year ended June 30, 1999. ("base year"). A state plan will be submitted when costs are rebased. A description of the calculation of the base per diem rates for the periods beginning September 01, 2000, October 01, 2000, and December 01, 2000 are as follows:

A. Primary Operating Costs

1. Determine the weighted mean primary operating per diem by summing all reported primary operating expenses of all standard ICF/MR facilities and dividing by total period patient days. Primary operating costs consists of all non-capital costs excluding administrative services.

2. Determine the audit adjustment per diem to be extrapolated to all reporting facilities based on the desk reviews and independent sample audit findings. The audit adjustment is based on an average of the difference between the reported costs and audited costs. If no audit file is available, an average audit adjustment will be determined from the average audit adjustments for the last five available periods.

For the rate period beginning 09-01-01 an audit adjustment which reflects the latest available audit data will be made. This adjust-ment will be made to the base primary operating cost before trending forward to the midpoint of the state fiscal year of the rate period by the factors defined in 3.A.4, below. The new adjustment will be the difference between the factor determined in the previous rate as defined above and the average of the three most current available years audit data on file.

3. Determine the adjusted primary operating per diem by subtracting the audit adjustment per diem (step 2) from the weighted mean primary operating costs per diem determined in step 1.

4. Trend forward the adjusted primary operating per diem from the midpoint of the base year to the midpoint of the rate period state fiscal year using the inflation update factors. The Authority will use the update factors published in the Data Resources, Inc., ("DRI") nursing home without capital marketbasket index for the fourth calendar quarter of the previous fiscal year.

   For example, for the rates effective July 1, 1997, the Authority used the update factors for the fourth quarter of calendar year 1996.

B. Administrative Services

An imputed administrative services allowance will be used in lieu of actual owner/administrator salary and non-salary compensation. The imputed administrative services allowance is the state-established limit or value for the purposes of calculating the reimbursement rate.

The base allowance will be the same as that determined for the regular Nursing facilities. The allowance will be trended forward in the same manner as in 3.A.4, above.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

C. Capital

An imputed allowance will be used in lieu of actual depreciation, interest, and lease related to facilities and equipment. The imputed allowance is determined by dividing the total reported costs (from the base year cost reports) for the regular nursing facilities, plus that for the regular nursing facilities serving aids patients, plus that for the private standard intermediate care facilities for the mentally retarded plus that for the private specialized (16 bed or less) M/R facilities by the total "adjusted days" for those facilities. The "adjusted" days are determined by multiplying the allowable days from the base year cost report by a factor of .93 (i.e. adjust to a 93% occupancy level). To account for inflation this imputed capital allowance will be trended forward to the rate period state fiscal year by the Marshall-Swift replacement cost multipliers for facilities with Class C construction (District Comparative Cost Multipliers, Central Region) published in the January index of the year preceding the rate change period.

D. Adjustment For Change In Law Or Regulation

The Authority also considers possible effects on rate year costs compared to base year costs that might not be fully accounted for by the DRI index described above. Inasmuch as the index is an estimate of actual and forecasted national rates of change in the price of nursing home goods and services, DRI is not specific to any state. Thus during a given period, it might not sufficiently account for the economic effects of changes in federal laws or regulations which have a disparate impact on Oklahoma, or of changes in state laws, rules or circumstances that only affect Oklahoma.

The following circumstances may cause an adjustment to rate year costs: additional costs incurred to meet new requirements imposed by government regulatory agencies, taxation, authorities, or applicable law (e.g., minimum staffing requirements, social security taxation of 501(c) (3) corporations, minimum wage change, etc.) and implementation of federal or state court orders and settlement agreements.

OHCA will evaluate available financial or statistical information, including data submitted on cost reports and special surveys to calculate any base rate adjustment. These adjustments will become permanent until such time a state plan amendment is submitted to rebase the rates.

Per HB 2019, the Oklahoma 2001 Health Care initiative, the following adjustments will be made.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

1. For the rate period beginning September 1, 2000 the OHCA has calculated an Oklahoma Specific additional cost of expected increase in Liability insurance rates. The rate will be adjusted by an additional $.51 for the expected cost. The amount of additional cost was determined from a sample of nursing facility invoices from the 1999 and 2000 fiscal years and from data from the base year cost reports. The total sample costs for 1999 were compared to the total sample costs for 2000 to get an overall percent of increase. Total available days from the base year cost report was divided by 365 to estimate the number of beds which in turn was multiplied by an estimated annual cost of $100 per bed (per industry survey) to get an annual estimate for the rate year period. The resulting cost was divided by the total patient days from the base year cost reports and multiplied by the percent increase from above to determine the added cost per day.

   This add-on will be trended forward by the same method as in 3.A.4, above.

2. For the rate period beginning September 1, 2000 the OHCA has calculated the additional cost of new direct care staffing requirements. These new requirements are to maintain staff-to-patient ratios of 1:8, 1:12 and 1:17 for the three 8 hours shifts for day, evening and night, usually beginning at 8:00 a.m., 4:00 p.m. and 12:00 a.m., respectively. The rate will be adjusted the cost of maintaining a level of staffing that is at 86.5% of the base year level above the minimum requirement.

   This adjustment is calculated as follows:

   1. Determine the direct care hours per day from the base year cost report data for all private facility types.
   2. Determine the direct care cost per day (including benefits) of the hours determined in 1 from the base year cost reports.
   3. Adjust the hours per day for the effect of the minimum wage requirement of HB 2019 by multiplying the factor determined in 2 by the percent of the cost of the minimum wage increase to the total salaries and benefits in the base period.
   4. Determine the amount of hours per day in the base period that actual direct care hours exceeds the minimum requirement.

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED**

5. Apply a factor of .865 (86.5%) to the amount determined in 4. This is the estimated amount that the facilities will remain above the minimum required hours.
6. Add the amount determined in 5 to the amount of new required minimum hours per day to get the expected level of hours per day for the rate period. Divide the expected level of hours by the level of hours in the base year to get a percent increase.
7. The cost per day is determined by multiplying the percent in 6 by the cost in 3 to get the add-on. For the period beginning 09-01-00 this amount is $2.22.

The direct care staff-to-patient ratios required and the employees to be included in the ratios are defined in Section1-1925.2 of Title 63 of the Oklahoma Statutes. In general, direct care staff includes any nursing or therapy staff providing hands-on care. Prior to Sept. 1, 2002 Activity and Social Work staff not providing hands-on care are allowable. On Sept. 1, 2002 Activity and Social Work staff not providing hands-on care shall not be included in the direct care staff-to-patient ratios. The direct care staff-to-patient ratios will be monitored by the Authority through required monthly Quality of Care Reports. These reports and rules may be found in the Oklahoma Administrative Code at OAC 317:30-5-131.2. This section of the Code also includes rules for penalties for non-timely filing and the methods of collection of such penalties. Non compliance with the required staff-to-patient ratios will be forwarded to the Oklahoma State Department of Health who in turn under Title 63 Section 1-1912 through 1-1917 of the Oklahoma Statutes (and through the Oklahoma Administrative Act Code at 310:675) will determine "willful" non-compliance. The Health Department will inform the Authority as to any penalties to collect by methods noted in OAC 317:30-5-131.2.

This add-on will be trended forward by the same method as in 3.A.4, above.

3. 56 Okla. Stat. § 2002 requires that all licensed nursing facilities pay a statewide average per patient day Quality of Care assessment fee based on the maximum percentage allowed under federal law of the average gross revenue per patient day. Gross revenues are defined as Gross Receipts (i.e. total cash receipts less donations and contributions). The assessment is an allowable cost and a part of the base rate component as it relates to Medicaid services.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES

STANDARD PRIVATE INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICFs/IID) *(continued)*

A. COST ANALYSES *(continued)*

3. COMPUTATION OF THE STATEWIDE FACILITY BASE RATE *(continued)*

D. Adjustment For Change In Law Or Regulation *(continued)*

4. For the rate period beginning December 1, 2000, the provider assessment fee set at September 1, 2000 will be adjusted to compensate for the actual fee determined by the surveys of data received.

5. For the rate period beginning December 1, 2000, the provider assessment fee set at September 1, 2000 will be adjusted to compensate for the actual fee determined by the surveys of data received. The rate adjustment needed for this decreased cost is $(1.20). Surveys were sent to the nursing facilities collecting revenue and patient day data for calendar 1999. Per HB2019 this data was to be used to set provider fee assessment rates for the different facility types. The assessment fee for the period beginning 09-01-00 was set at $4.77. This adjustment is needed for the remainder of the state fiscal year to appropriately reflect the actual costs and adjust for the estimated assessment reimbursement portion of the rate set at 09-01-00 and revised at 10-01-00 (see D.3 above). The adjustment needed was determined by multiplying the difference between the estimated assessment in the rates at 09-01-00 and the actual assessments from the surveys by the total months that a difference occurred and dividing this total by the estimated days remaining in the rate period. After the initial rate period, these adjustments will be amended to an annual basis.

6. HB 2019 directed the Nursing Facilities and ICFs/IID to provide for dentures, eyeglasses, and non-emergency transportation attendants for Medicaid clients in nursing facilities. For the rate period beginning December 1, 2000, the rate adjustment for the estimated cost of these added items of coverage is $2.45 per day.

   The costs were determined as follows:

   For the transportation travel attendant, the base year cost report average hourly cost for a social worker was brought forward to the rate state fiscal year and an adjustment made for the effects of minimum wage and benefits. The cost of two FTE's per 100 bed home were determined by multiplying that total by 2080. From the cost report data percent of occupancy, it was estimated that this 100 bed home would have 29,000 patient days which when divided into the cost of the two FTE's gives an add-on of $1.78 per day.

   For the cost of dentures, it was estimated that 50% of the 25,000 Medicaid clients need dentures once every three years. That correlates to an average of 4,165 services per year. The cost of those services was estimated at the Medicaid rates for one upper or lower one re-base and one reline (codes D5130, D5214, D5720 and D5751), or $567.47. This cost times the number of services divided by the estimated Medicaid patient days is the add-on needed for these services.

State: Oklahoma
Date Received: February 23, 2018
Date Approved: April 6, 2018
Date Effective: January 1, 2018
Transmittal Number: 18-12

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES

STANDARD PRIVATE INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF'S/IID) *(continued)*

A. COST ANALYSES *(continued)*

3. COMPUTATION OF THE STATEWIDE FACILITY BASE RATE *(continued)*

D. Adjustment For Change In Law Or Regulation *(continued)*

For the cost of eyeglasses, the total number of services needed is 75% of the 25,000 total population of Medicaid patients. It is estimated that 80% of those need services, or 15,000. The average cost per service was determined to be the total for one lens plus one frame plus one exam (codes W0105 to 0109, V2020 and 92002/92012). This total average cost per service is multiplied by the estimated total services per year and divided by the total estimated Medicaid days to get the per diem add-on.

This add-on will be trended forward by the same method as in 3.A.4, above.

7. For the rate period beginning December 1, 2000, the OHCA has added $2.69 to the rate to cover the loss of the "major fraction thereof" provision in meeting the minimum direct care staffing requirements. The add-on was determined as follows:

1. The additional hours needed to cover the loss of the "major fraction thereof" provision in meeting the minimum staffing requirements was determined by arraying the required hours for levels of patients from 17 to 136 with the provision and without the provision. The average percent change in required hours was determined.
2. The per day cost of the direct care salaries plus benefits was determined from the base year cost reports.
3. The cost per day determined in 2 was multiplied by the percent determined in 1 to determine the rate add-on required to fund the loss of the "major fraction thereof" provision.

This add-on will be trended forward by the same method as in 3.A.4, above.

E. Statewide Base Rate

The statewide facility base rate is the sum of the primary operating per diem, the administrative services per diem, the capital per diem and the adjustments for changes in law or regulation.

State: Oklahoma
Date Received: February 23, 2018
Date Approved: April 6, 2018
Date Effective: January 1, 2018
Transmittal Number: 18-12

Revised 01-01-18

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES

STANDARD PRIVATE INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICFs/IID) *(continued)*

A. COST ANALYSES *(continued)*

4. RATE ADJUSTMENTS BETWEEN REBASING PERIODS

Beginning January 1, 2010, the rates will be adjusted annually on January 1, in an amount equal to the estimated savings or loss to the program as a result of the automatic cost of living adjustment on Social Security benefits as published in the Federal Register and the resulting effect to the spend-down required of the recipients. The estimated total funds will include the estimated savings or loss to the program as a result of the automatic cost of living adjustment on Social Security benefits as published in the federal register and the resulting effect to the spend-down required of the recipients. For Standard Private Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) the effect is $.22 per day for each one (1) percent change in the SSI determined from the average effect of SSI increases from CY 2004 to CY 2009.

For the rate period beginning July 1, 2006, the statewide rate will be increased by 10.32%.

For the rate period beginning July 1, 2008, the statewide rate will be increased by 4.57%.

For the rate period beginning April 1, 2010, the statewide rate will be decreased by 2.81%.

For the rate period beginning September 1, 2012, the statewide rate will be increased by 1.93%.

For the rate period beginning July 1, 2013, the statewide rate will be increased by 0.56%.

For the rate period beginning July 1, 2016, the statewide rate will be increased by 0.2951%, resulting in a rate of $122.32 per patient per day.

For the rate period beginning July 1, 2017, the statewide rate will be increased by 0.3104%, resulting in a rate of $122.77 per patient per day.

For the rate period beginning October 1, 2018, the statewide rate will be increased by 3.47%, resulting in a rate of $127.49 per patient per day.

For the rate period beginning July 1, 2020, the statewide rate will be increased by 0.2024% resulting in a rate of $128.72 per patient per day.

For the rate period beginning July 1, 2021, the statewide rate will be increased by 0.6046% resulting in a rate of $129.79 per patient per day.

For the rate period beginning July 1, 2022, the statewide rate will be increased by 3.45% resulting in a rate of $135.61 per patient per day.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES

Delete page

State: Oklahoma
Date Received: February 23, 2018
Date Approved: April 6, 2018
Date Effective: January 1, 2018
Transmittal Number: 18-12

Deleted 01-01-18

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES

Delete page

State: Oklahoma
Date Received: February 23, 2018
Date Approved: April 6, 2018
Date Effective: January 1, 2018
Transmittal Number: 18-12

Deleted 01-01-18

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
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Delete page

State: Oklahoma
Date Received: February 23, 2018
Date Approved: April 6, 2018
Date Effective: January 1, 2018
Transmittal Number: 18-12

Deleted 01-01-18

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

SPECIALIZED PRIVATE ICF/MR FACILITIES 16 BED OR LESS

A separate statewide prospective rate of payment shall be reviewed, at a minimum, annually for specialized private intermediate care facilities for the mentally retarded with 16 beds or less (SF's/MR/16). These facilities must meet the higher direct care staffing requirements for licensure established by the Oklahoma State Department of Health for an SF/MR/16 serving severely impaired residents. SF'S/MR/16 must serve at least one severely or profoundly retarded resident or one who is moderately retarded and who is medically fragile or has serious physical or emotional problems. The rate will be determined pursuant to these methods and standards and approved by the Oklahoma Health Care Authority Board in advance of the rate period.

The rate will be established based on analyses of cost reports and other relevant cost information, the use of national and, where appropriate, Oklahoma-specific trends in costs, including trends in salary levels and changes in minimum wage levels, analyses of the economic impact of changes in law or regulations, and discussions with recognized representatives of the nursing home industry.

The rate is at, or above, the level that the Oklahoma Health Care Authority (OHCA) finds reasonable and adequate to reimburse the costs that must be incurred by economically and efficiently operated facilities to the extent specified by 42 U.S.C. Section 1396a(a)(13)(A).

A. COST ANALYSES

The Oklahoma Health Care Authority (OHCA) is principally responsible for implementing the Medicaid program in Oklahoma. OHCA staff will prepare necessary analyses to support the rate determination process, as described below.

1. UNIFORM COST REPORTS

Each Medicaid-participating SF/MR/16 facility must submit, on uniform cost reports designed by the Authority, cost and related statistical information necessary for rate determination.

a. **Reporting Period.** Each SF/MR/16 facility must prepare the cost report to reflect the allowable costs of services provided during the immediately preceding fiscal year ending June 30. Where the ownership or operation is commenced, a fractional year report is

required, covering each period of time the SF/MR/16 was in operation during the year.

f. **Report Deadline.** The report must be filed by October 31 of each year. Extensions of not more than 15 days may be granted on a showing of just cause.

g. **Accounting Principles.** The report must be prepared on the basis of generally accepted accounting principles and the accrual basis of accounting, except as otherwise specified in the cost report instructions.

h. **Signature.** The cost report shall be signed by an owner, partner or corporate officer of the SF/MR/16, by an officer of the company that manages the NF, and by the person who prepared the report.

i. **Audits of Cost Reports.** The Authority will conduct a desk review to verify the completeness and mathematical accuracy of all totals and extensions in each cost report. Census information may be independently verified through other OHCA sources. In addition, a sample number of cost reports will be audited independently by an auditor retained by OHCA. Any SF/MR/16 that is subject to an audit is required to make its records available to OHCA and to any auditor engaged by OHCA.

2. **ALLOWABLE AND UNALLOWABLE COSTS**

Only "allowable costs" may be included in the cost reports. (Costs should be net of any offsets or credits.) Allowable costs include all items of Medicaid-covered expense that SF'S/MR/16 incur in the provision of routine (i.e., non-ancillary) services. "Routine services include, but are not limited to, regular room, dietary and nursing services, minor medical and surgical supplies, over-the-counter medications, transportation, and the use and maintenance of equipment and facilities essential to the provision of routine care. Allowable costs must be considered reasonable, necessary and proper, and shall include only those costs that are considered allowable for Medicare purposes and that are consistent with federal Medicaid requirements. (The guidelines for allowable costs in the Medicare program are set forth in the Medicare Provider Reimbursement Manual ("PRM"), HCFA-Pub. 15.) Ancillary items reimbursed outside the SF/MR/16 rate should not be included in the ICF/MR cost report and are not allowable costs. Quality of Care assessment fees are allowable costs for reporting purposes.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

3. **COMPUTATION OF THE STATEWIDE FACILITY BASE RATE**

Cost reports used to calculate the rate were those filed for the year ended June 30, 1999. ("base year"). A state plan will be submitted when costs are re-based. A description of the calculation of the base per diem rates for the periods beginning September 01, 2000, October 01, 2000, and December 01, 2000 are as follows:

A. Primary Operating Costs

1. Determine the weighted mean primary operating per diem by summing all reported primary operating expenses of all standard SF/MR/16 facilities and dividing by total period patient days. Primary operating costs consists of all non-capital costs excluding administrative services,

2. Determine the audit adjustment per diem to be extrapolated to all reporting facilities based on the desk reviews and independent sample audit findings. The audit adjustment is based on an average of the difference between the reported costs and audited costs. If no audit file is available, an average audit adjustment will be determined from the average audit adjustments for the last five available periods.

   For the rate period beginning 09-01-01 an audit adjustment which reflects the latest available audit data will be made. This adjust-ment will be made to the base primary operating cost before trending forward to the midpoint of the state fiscal year of the rate period by the factors defined in 3.A.4, below. The new adjustment will be the difference between the factor determined in the previous rate as defined above and the average of the three most current available years audit data on file.

3. Determine the adjusted primary operating per diem by subtracting the audit adjustment per diem (step 2) from the weighted mean primary operating costs per diem determined in step 1.

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED**

4. Trend forward the adjusted primary operating per diem from the midpoint of the base year to the midpoint of the rate period state fiscal year using the inflation update factors. The Authority will use the update factors published in the Data Resources, Inc., ("DRI") nursing home without capital market basket index for the fourth calendar quarter of the previous fiscal year.

   For example, for the rates effective July 1, 1997, the Authority used the update factors for the fourth quarter of calendar year 1996.

B. Administrative Services

An imputed administrative services allowance will be used in lieu of actual owner/administrator salary and non-salary compensation. The imputed administrative services allowance is the state-established limit or value for the purposes of calculating the reimbursement rate.

The base allowance will be the same as that determined for the regular Nursing facilities. The allowance will be trended forward in the same manner as in 3.A.4, above.

C. Capital

An imputed allowance will be used in lieu of actual depreciation, interest, and lease related to facilities and equipment. The imputed allowance is determined by dividing the total reported costs (from the base year cost reports) for the regular nursing facilities, plus that for the regular nursing facilities serving aids patients, plus that for the private standard intermediate care facilities for the mentally retarded plus that for the private specialized (16 bed or less) M/R facilities by the total "adjusted days" for those facilities. The "adjusted" days are determined by multiplying the allowable days from the base year cost report by a factor of .93 (i.e. adjust to a 93% occupancy level). To account for inflation this imputed capital allowance will be trended forward to the rate period state fiscal year by the Marshall-Swift replacement cost multipliers for facilities with Class C construction (District Comparative Cost Multipliers, Central Region) published in the January index of the year preceding the rate change period.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

D. Adjustment For Change In Law Or Regulation

The Authority also considers possible effects on rate year costs compared to base year costs that might not be fully accounted for by the DRI index described above. Inasmuch as the index is an estimate of actual and forecasted national rates of change in the price of nursing home goods and services, DRI is not specific to any state.
Thus during a given period, it might not sufficiently account for the economic effects of changes in federal laws or regulations which have a disparate impact on Oklahoma, or of changes in state laws, rules or circumstances that only affect Oklahoma.

The following circumstances may cause an adjustment to rate year costs: additional costs incurred to meet new requirements imposed by government regulatory agencies, taxation, authorities, or applicable law (e.g., minimum staffing requirements, social security taxation of 501(c) (3) corporations, minimum wage change, etc.) and implementation of federal or state court orders and settlement agreements.

OHCA will evaluate available financial or statistical information, including data submitted on cost reports and special surveys to calculate any base rate adjustment. These adjustments will become permanent until such time a state plan amendment is submitted to rebase the rates.

Per HB 2019, the Oklahoma 2001 Health Care initiative, the following adjustments will be made.

1. For the rate period beginning September 1, 2000 the OHCA has calculated an Oklahoma Specific additional cost of expected increase in Liability insurance rates. The rate will be adjusted by an additional $.51 for the expected cost. The amount of additional cost was determined from a sample of nursing facility invoices from the 1999 and 2000 fiscal years and from data from the base year cost reports. The total sample costs for 1999 were compared to the total sample costs for 2000 to get an overall percent of increase. Total available days from the base year cost report was divided by 365 to estimate the number of beds which in turn was multiplied by an estimated annual cost of $100 per bed (per industry survey) to get an annual estimate for the rate year period. The resulting cost was divided by the total patient days from the base year cost reports and multiplied by the percent increase from above to determine the added cost per day.

   This add-on will be trended forward by the same method as in 3.A.4, above.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

2. For the rate period beginning September 1, 2000 the OHCA has calculated the additional cost of new direct care staffing requirements. These new requirements are to maintain staff-to-patient ratios of 1:8, 1:12 and 1:17 for the three 8 hours shifts for day, evening and night, usually beginning at 8:00 a.m., 4:00 p.m. and 12:00 a.m., respectively. The rate will be adjusted for the cost of maintaining a level of staffing that is at 86.5% of the base year level above the minimum requirement. This adjustment is calculated as follows:

   1. Determine the direct care hours per day from the base year cost report data for all private facility types.
   2. Determine the direct care cost per day (including benefits) of the hours determined in 1 from the base year cost reports.
   3. Adjust the hours per day for the effect of the minimum wage requirement of HB 2019 by multiplying the factor determined in 2 by the percent of the cost of the minimum wage increase to the total salaries and benefits in the base period.
   4. Determine the amount of hours per day in the base period that actual direct care hours exceeds the minimum requirement.
   5. Apply a factor of .865 (86.5%) to the amount determined in 4. This is the estimated amount that the facilities will remain above the minimum required hours.
   6. Add the amount determined in 5 to the amount of new required minimum hours per day to get the expected level of hours per day for the rate period. Divide the expected level of hours by the level of hours in the base year to get a percent increase.
   7. The cost per day is determined by multiplying the percent in 6 by the cost in 3 to get the add-on. For the period beginning 09-01-00 this amount is $2.22.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES

SPECIALIZED PRIVATE ICFs/IID 16 BED OR LESS

A. COST ANALYSES *(continued)*

3. COMPUTATION OF THE STATEWIDE FACILITY BASE RATE *(continued)*

D. Adjustment for Change in Law or Regulation *(continued)*

The direct care staff-to-patient ratios required and the employees to be included in the ratios are defined in Section 1-1925.2 of Title 63 of the Oklahoma Statutes. In general, direct care staff includes any nursing or therapy staff providing hands-on care. Prior to Sept. 1, 2002, Activity and Social Work staff not providing hands-on care are allowable. On Sept. 1, 2002, Activity and Social Work staff not providing hands-on care shall not be included in the direct care staff-to-patient ratios. The direct care staff-to-patient ratios will be monitored by the Authority through required monthly Quality of Care Reports. These reports and rules may be found in the Oklahoma Administrative Code at OAC 317:30-5-131.2. This section of the Code also includes rules for penalties for non-timely filing and the methods of collection of such penalties. Non-compliance with the required staff-to-patient ratios will be forwarded to the Oklahoma State Department of Health who in turn under Title 63 Section 1-1912 through 1-1917 of the Oklahoma Statutes (and through the Oklahoma Administrative Act Code at 310:675) will determine "willful" non-compliance. The Health Department will inform the Authority as to any penalties to collect by methods noted in OAC 317:30-5-131.2.

This add-on will be trended forward by the same method as in 3.A.4, above.

3. 56 Okla. Stat. § 2002 requires that all licensed nursing facilities pay a statewide average per patient day Quality of Care assessment fee based on the maximum percentage allowed under federal law of the average gross revenue per patient day. Gross revenues are defined as Gross Receipts (i.e., total cash receipts less donations and contributions). The assessment is an allowable cost and a part of the base rate component as it relates to Medicaid services.

State: Oklahoma
Date Received: February 23, 2018
Date Approved: April 6, 2018
Date Effective: January 1, 2018
Transmittal Number: 18-12

Revised 01-01-18

APR 06 2018

TN# 18-12 Approval Date _____ Effective Date 1-1-2018

Supersedes TN# 10-35

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES

SPECIALIZED PRIVATE ICFs/IID 16 BED OR LESS

A. COST ANALYSES *(continued)*

3. COMPUTATION OF THE STATEWIDE FACILITY BASE RATE *(continued)*

D. Adjustment for Change in Law or Regulation *(continued)*

4. For the rate period beginning December 1, 2000, the provider assessment fee set at September 1, 2000 will be adjusted to compensate for the actual fee determined by the surveys of data received. The rate adjustment needed for this decreased cost is $(.85). Surveys were sent to the nursing facilities collecting revenue and patient day data for calendar 1999. Per HB2019 this data was to be used to set provider fee assessment rates for the different facility types. The assessment fee for the period beginning 09-01-00 was set at $4.77. This adjustment is needed for the remainder of the state fiscal year to appropriately reflect the actual costs and adjust for the estimated assessment reimbursement portion of the rate set at 09-01-00 and revised at 10-01-00 (see D.3 above). The adjustment needed was determined by multiplying the difference between the estimated assessment in the rates at 09-01-00 and the actual assessments from the surveys by the total months that a difference occurred and dividing this total by the estimated days remaining in the rate period. After the initial rate period, these adjustments will be amended to an annual basis.

5. HB 2019 directed the Nursing Facilities and SF's/MR/16 to provide for dentures, eyeglasses, and non-emergency transportation attendants for Medicaid clients in nursing facilities. For the rate period beginning December 1, 2000, the rate adjustment for the estimated cost of these added items of coverage is $2.45 per day.

The costs were determined as follows:

For the transportation travel attendant, the base year cost report average hourly cost for a social worker was brought forward to the rate state fiscal year and an adjustment made for the effects of minimum wage and benefits. The cost of two FTE's per 100 bed home were determined by multiplying that total by 2080. From the cost report data percent of occupancy, it was estimated that this 100 bed home would have 29,000 patient days which when divided into the cost of the two FTE's gives an add-on of $1.78 per day.

For the cost of dentures, it was estimated that 50% of the 25,000 Medicaid clients need dentures once every three years. That correlates to an average of 4,165 services per year. The cost of those services was estimated at the Medicaid rates for one upper or lower one re-base and one reline (codes D5130, D5214, D5720 and D5751), or $567.47. This cost times the number of services divided by the estimated Medicaid patient days is the add-on needed for these services.

For the cost of eyeglasses, the total number of services needed is 75% of the 25,000 total population of Medicaid patients. It is estimated that 80% of those need services, or 15,000. The average cost per service was determined to be the total for one lens plus one frame plus one exam (codes W0105 to 0109, V2020 and 92002/92012). This total average cost per service is multiplied by the estimated total services per year and divided by the total estimated Medicaid days to get the per diem add-on.

This add-on will be trended forward by the same method as in 3.A.4, above.

State: Oklahoma
Date Received: February 23, 2018
Date Approved: April 6, 2018
Date Effective: January 1, 2018
Transmittal Number: 18-12

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES

SPECIALIZED PRIVATE ICFs/IID 16 BED OR LESS

A. COST ANALYSES *(continued)*

3. COMPUTATION OF THE STATEWIDE FACILITY BASE RATE *(continued)*

D. Adjustment for Change in Law or Regulation *(continued)*

6. For the rate period beginning December 1, 2000 the OHCA has added $6.79 to the rate to cover the loss of the "major fraction thereof" provision in meeting the minimum direct care staffing requirements. The add-on was determined as follows:

   1. The additional hours needed to cover the loss of the "major fraction thereof" provision in meeting the minimum staffing requirements was determined by arraying the required hours for levels of patients from 1 to 16 with the provision and without the provision. The average percent change in required hours was determined.
   2. The per day cost of the direct care salaries plus benefits was determined from the base year cost reports.
   3. The cost per day determined in 2 was multiplied by the percent determined in 1 to determine the rate add-on required to fund the loss of the "major fraction thereof" provision.

   This add-on will be trended forward by the same method as in 3.A.4, above.

E. Statewide Base Rate
The statewide facility base rate is the sum of the primary operating per diem, the administrative services per diem, the capital per diem and the adjustments for changes in law or regulation.

State: Oklahoma
Date Received: February 23, 2018
Date Approved: April 6, 2018
Date Effective: January 1, 2018
Transmittal Number: 18-12

Revised 01-01-18

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES

SPECIALIZED PRIVATE ICFs/IID 16 BED OR LESS

A. COST ANALYSES *(continued)*

4. RATE ADJUSTMENTS BETWEEN REBASING PERIODS

Beginning January 1, 2010, the rates will be adjusted annually on January 1, in an amount equal to the estimated savings or loss to the program as a result of the automatic cost of living adjustment on Social Security benefits as published in the Federal Register and the resulting effect to the spend-down required of the recipients. The estimated total funds will include the estimated savings or loss to the program as a result of the automatic cost of living adjustment on Social Security benefits as published in the federal register and the resulting effect to the spend-down required of the recipients. For Specialized Private Intermediate Care Facilities for Individuals with Intellectual Disabilities 16 Bed or Less, the effect is $.20 per day for each one (1) percent change in the SSI determined from the average effect of SSI increases from CY 2004 to CY 2009.

For the rate period beginning July 1, 2006, the statewide rate will be increased by 10.90%.

For the rate period beginning July 1, 2008, the statewide rate will be increased by 3.90%

For the rate period beginning April 1, 2010, the statewide rate will be decreased by 2.93%.

For the rate period beginning September 1, 2012, the statewide rate will be increased by 1.86%.

For the rate period beginning July 1, 2013, the statewide rate will be increased by 0.30%.

For the rate period beginning July 1, 2016, the statewide rate will be increased by 0.2048%, resulting in a rate of $156.51 per patient per day.

For the rate period beginning July 1, 2017, the statewide rate will be increased by 0.2937%, resulting in a rate of $157.03 per patient per day.

For the rate period beginning October 1, 2018, the statewide rate will be increased by 3.56%, resulting in a rate of $163.04 per patient per day.

For the rate period beginning July 1, 2020, the statewide rate will be increased by 0.0122% resulting in a rate of $163.94 per patient per day.

For the rate period beginning July 1, 2021, the statewide rate will be increased by 0.2557% resulting in a rate of $164.62 per patient per day.

For the rate period beginning July 1, 2022, the statewide rate will be increased by 0.4885% resulting in a rate of $166.61 per patient per day.

The state has a public process in place which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Enhanced Payment Program

A. Overview

This program provides enhanced payment for private ICFs/IID that provide vocational services or day program services or both. The purpose of the enhanced payment is to offset the costs incurred by ICFs/ IID in the provision of vocational services or day program services or both. Residents who qualify for the enhanced program cannot receive the same services or reimbursement under another program.

B. Definitions

For this section, the following definitions shall apply.

1. Vocational Services
   Provides paid employment in a structured vocational training program for residents outside of the resident's home. The type of work will vary but each provider must meet the specific program qualifications for participation. Vocational service programs provide pre-vocational services training, that prepare the residents for employment in a structured educational program. These programs will utilize either a certified job coach or a designated staff, to assist a resident 18 years and older in achieving gainful employment. Other achievements may include, sheltered employment, ongoing employment support, job skills training and/or workshop experience in the community. Vocational services must be provided on an hourly or daily basis, but less than on a 24-hour basis.
2. Day Program Services
   A Day Services program is a life enrichment program that is conducted in a dedicated service location. The organized scheduled programming will vary but must meet the specific program qualifications for participation. Day services programs provide diverse opportunities for residents to participate in the broader community based on the resident's specific care plan. Day program services must be provided on an hourly or daily basis, but less than on a 24-hour basis.
3. Direct costs
   Direct costs are the costs for activities or items associated with day services and/or vocational services programs. These items include salaries and wages of activities staff, day services and vocational staff, and job coaches.
4. Other costs
   Other costs are overhead costs attributable to the provision of day and vocational services. For example, rent, utilities, etc. not already paid for by Medicaid.

C. Care Criteria

Facilities will comply with the following care criteria to receive the enhanced payment:

1. Vocational Services
   Facilities will provide 20 hours of vocational services to at least 40% of their residents each week. Residents must participate at least 9 out of 12 weeks.

State: Oklahoma
Date Received: February 23, 2018
Date Approved: April 6, 2018
Date Effective: January 1, 2018
Transmittal Number: 18-12

lay services to at least 60% of the facility's residents who do not
al program. Residents must participate at least 9 out of 12 weeks.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Enhanced Payment Program *(continued)*

D. Performance Review

Performance reviews will be completed quarterly to ensure the integrity and accountability of the vocational and/or day treatment services provided. Each facility will be reviewed at the least annually. Payments will be withheld from facilities that are not in compliance with reviews.

E. Reimbursement Methodology

1. Initial Payment Rates

   Initial payment rates for ICF/IIDs providing day and vocational services will be established using SFY2021 cost data (inflated to SFY2023).

2. Subsequent payment Rates

   After year one of the program, payment rates will be determined using costs data reported on the most recent cost report of each participating facility. New payment rates will be calculated annually.

3. Payment Allocation

   (i). Seventy percent (70%) of available funds is allocated to Vocational Services

   (ii). Thirty percent (30%) of available funds is allocated to Day Services.

4. Rate Components

   Payment will consist of direct cost and other cost rate components for day services and vocational services programs.

   (i). Vocational Services Rate

   This rate consists of two components: Direct Cost Rate Component and Other Cost Rate Component.

   a. Direct Cost Rate Component
   Seventy percent (70%) of available funds for vocational services will be paid on per day basis to eligible providers that meet the care criteria to help pay for direct program costs. This rate component will be different for each facility. The pool of funds available for this component will be allocated based on the relative direct vocational services costs of all facilities on per day basis capped at the 90th percentile or at a percentile determined by OHCA based on cost trends. For the first year of the program this component will be the same for all providers.

   b. Other Cost Rate Component
   Thirty percent (30%) of available funds for vocational services will be paid on per day basis to all eligible providers that meet the care criteria to help pay for overhead costs attributable to the program. This rate component is the same for all eligible facilities.

April 6, 2018

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Enhanced Payment Program *(continued)*

E. Reimbursement Methodology *(continued)*

4. Rate Components *(continued)*

(ii). Day Services Rate
This rate consists of two components: Direct Cost Rate Component and Other Cost Rate Component.

a. Direct Cost Rate Component
Seventy percent (70%) of available funds for day services will be paid on per day basis to eligible providers that meet the care criteria to help pay for direct program costs. This rate component will be different for each facility. The pool of funds available for this component will be allocated based on the relative direct day services costs of all facilities on per day basis capped at the 90th percentile or at a percentile determined by OHCA based on cost trends. For the first year of the program this component will be the same for all providers.

b. Other Cost Rate Component
Thirty percent (30%) of available funds for day services will be paid on per day basis to all eligible providers that meet the care criteria to help pay for overhead costs attributable to the program. This rate component is the same for all eligible facilities.

F. Payment
Payment will be in the form of a lump sum payment made to facilities on a quarterly basis. The total enhanced payment shall not exceed any applicable federal upper payment limit. If the supplemental payments for eligible ICF/IID result payments that exceed the federal upper payment limit for each respective rate year, each provider's total supplemental payment must be reduced pro-rata so that total payments would be equal to the amount available in the federal upper payment limit.

G. Cost Audit
Each facility will be audited annually as part of the annual cost report reviews to ensure only allowable costs prescribed by Medicare/Medicaid cost reporting principles. As part of the annual audit OHCA will ensure that there are no duplicative costs attributable to base rate and the enhanced payments.

Payments will be recouped from facilities that report unallowable costs. Additional audits can be conducted anytime at the discretion of the OHCA.

April 6, 2018

Citation
AT 79-55

Service - Provider	Definition of Claim
1. Inpatient hospital services other than those provided in an institution for mental diseases or tuberculosis	A bill for services
2a. Outpatient hospital services	A bill for services
2b. Rural health clinic services and other ambulatory services furnished by a rural health clinic	Line item
3. Other laboratory and X-ray services	Line item
4a. Skilled nursing facility services (other than services in an institution for tuberculosis or mental diseases) for individuals 21 years of age or older	Line item
4b. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found	Line item
4c. Family planning services and supplies for individuals of child-bearing age	Line item

Service - Provider	Definition of Claim
5. Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere	Line item
6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law	
a. Podiatrists' Services	Line item
b. Optometrists' Services	Line item
c.	
d. Other practitioners' Services	Line item
7. Home health services	
a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area	Line item

Service - Provider	Definition of Claim
7	
b. Home health aide services provided by a home health agency	Line item
c. Medical supplies, equipment, and appliances suitable for use in the home	Line item
d.	
8.	
9. Clinic services	A bill for services
10. Dental services	Line item
11.	
12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist	
a. Prescribed drugs	Line item
b.	
c. Prosthetic devices	Line item
d. Eyeglasses	Line item

Service - Provider	Definition of Claim
13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan	
a.	
b.	
c.	
d. Rehabilitative services	Line Item
14a.	
14b. Services for individuals age 65 or older in institutions for mental diseases	
(1) Inpatient hospital services	A bill for services
(2)	
(3)	
15. Intermediate care facilities services (Other than such services in an institution for tuberculosis or mental diseases) for persons determined, in accordance with 1902(a)(31)(A) of the Act, to be in need of such care	Line item
a. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions	Line item

Service - Provider	Definition of Claim
16. Inpatient psychiatric facility services for individuals under 22	A bill for services
17. Any other medical care and any other type of remedial care recognized, under State law, specified by the Secretary	
a. Transportation	Line item
b.	
c.	
d.	
e.	
f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and rendered by a qualified person under supervision of a R. N.	A bill for services
18. Crossover Claims	Part A- a bill for services Part B- a bill for services

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Oklahoma

Requirements for Third Party Liability –
Identifying Liable Resources

1. Data exchanges occur for applicants and recipients between the Oklahoma Health Care Authority (OHCA), the Oklahoma Employment Security Commission, Statewide Information Collection Agency (SWICA), and Unemployment Insurance Benefits (UIB) on a weekly basis.

   The SSA wage and earnings file is accessed through the monthly BENDEX with response frequency as determined by the SSA.

   Data exchanges between the OHCA and the State Workers' Compensation Files are performed monthly.

   Oklahoma MMIS uses Diagnosis and Trauma Code edits to process all Medicaid claims. Diagnosis codes ranging from 800 through 999, with some exceptions, are used for the purpose of determining the legal liability of third parties.

2. Each quarter, the MMIS produces reports that determine by trauma code diagnosis, those codes which yield the highest third party collections. OHCA's DSS ad hoc reporting system also allows for the potential to increase the effectiveness of staff time to determine which claims to invest time and resources in order to maximize the return on investment.

   The OHCA TPL Unit monitors timeliness of response to data exchange matches from all sources through supervisory and system controls to assure compliance with the thirty (30) day follow up requirement. Actions to be taken include update of resource files, retro billing processes and follow up for potential casualty claims. All additions, updates and changes are added directly into the MMIS and trigger the appropriate action. Audit trails and dated activity reports verify action is taken within the thirty (30) day timeframe.

   Upon discovery of a potential workers' compensation case, that information is placed on the MMIS recipient file and a retroactive recovery is initiated if the threshold is met. Future claims are then sent directly to the employer's insurance carrier. This information is reviewed at each data match to determine if the case has been settled. Recovery is initiated within 60 days.

TN# 10-33 Approval Date 12-10-2010 Effective Date 7-01-2010
Supersedes
TN# 96-03

SUPERSEDES TN: 96-03

STATE Oklahoma
DATE 9-28-2010
DATE 12-10-2010
DATE 7-01-2010
TN 10-33

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Oklahoma

Requirements for Third Party Liability –
Identifying Liable Resources

All required TPL billing information is entered into the MMIS recipient file. Upon completion, the information is considered valid and verified and results in all future claims being cost avoided, if allowed. On a weekly basis this information is electronically transmitted to OHCA's TPL contractor to initiate the retroactive recovery on all claims previously paid. OHCA has three (3) years from the date of service provided to the Medicaid recipient to submit claims to the insurer for reimbursement. Any action by OHCA to enforce the payment of the claim must be commenced within six (6) years of the submission of the claim by OHCA.

Pursuant to 63 Okla. Stat. § 5051.5, entities that provide health insurance in the state are required to compare data from its files with OHCA. The data provides the state with eligibility and coverage information that enables the state to determine the existence of third party coverage for Medicaid recipients and the necessary information to determine during what period Medicaid recipients may be or may have been covered by the health insurer and the nature of the coverage that is or was provided. This process is an electronic transfer either directly between the insurer and the OHCA or among the insurer, OHCA and OHCA's TPL contractor. OHCA currently matches with all of the major insurers in the state as well as many out of state insurance companies and ERISA plans.

For private insurance, retroactive recoveries are initiated within a week of private health insurance coverage being identified.

3. State motor vehicle accident reports files are not reported on a statewide basis through a central registry in Oklahoma. OHCA cooperates with all 77 Oklahoma counties to obtain data regarding motor vehicle accidents and predominately utilizes information provided by the applicant/recipient, insurance companies and the Oklahoma State Bar Association. The method of cooperating with the counties consist of a follow of trauma code edits. Once a motor vehicle accident is indicated, we work in the county of the accident to obtain the police report. Additionally, the State asks the member to send a report upon the initial contact.

OHCA has strict statutorily authorized claim rights and personal liability may be imposed on attorneys and/or insurance agents that settle claims without OHCA's consent. Oklahoma does not have "no fault" insurance policies in effect.

Revised 07-01-10

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OKLAHOMA

Requirements for Third Party Liability –
Identifying Liable Resources

4. Weekly diagnosis and trauma code editing is performed on all claims. If a claim is paid with a diagnosis in the range of 800 to 999, with some exceptions, and/or accident indicator, the claim is flagged and begins tolling future claims for addition into a TPL casualty case. The claims accumulate for six months or until the cost effective threshold of $500 is reached, at which time the system produces an accident questionnaire which is mailed to the member with a self addressed stamped envelope. The $500.00 threshold is generally met if the Medicaid recipient has an emergency room visit, at least one medication and a follow up visit. OHCA set this minimum threshold based on the fact that this is a predominately manual process and requires more administrative resources. In addition, if an insurance claim is filed, OHCA is statutorily protected regardless of the amount of the claim. If the threshold of $500.00 is not met within six months of the triggering claim, the case will close and no questionnaire is sent to the recipient

   Each questionnaire is reviewed and leads are contacted by letter and/or telephone to determine the extent and availability of third party funds. Upon identification, the information is incorporated into the MMIS. Recovery is initiated within 30 days. A case record is reviewed regularly to allow new related claims to be associated with a case file and to update information for any attorney of record or insurance adjuster/agent. The process is done on a tickler basis. If it is an accident that would incur additional medical review, then the case is set it up to come to a clerk for additional medical review. If no additional medical review is warranted, the next step would be to contact the attorney or contact the court. Which ever step is necessitated, the results would be indicated on the tickler system to go to the appropriate person for follow up. Additionally, one last medical review is done prior to accepting money on any case.

TN# 10-33 Approval Date 12-01-2010 Effective Date 7-01-2010
Supersedes 96-03

SUPERSEDES: TN: 96-03

STATE: Oklahoma
DATE: 9-28-2010
DATE: 12-10-2010
DATE: 7-01-2010
HCFA ID: 10-33

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Requirements for Third Party Liability – Payment of Claims

42 CFR 433.139(b)(3)(ii)(B)

The agency will pay the full amount allowed under the agency's payment schedule for child support enforcement services and seek reimbursement from any liable third party when the third party coverage is through an absent parent, a provider certifies on the Medicaid claim that prior to billing Medicaid, if the provider billed a third party , that payment has not been received from the third party, and that 100 days have been elapsed from date of service.

Section 1902(a)(25)(E)
42 CFR 139(b)(3)(i)

The State shall make payments without regard to third party liability for pediatric preventative services unless a determination related to cost-effectiveness and access to care that warrants cost avoidance for 90 days has been made.

Section 1902(a)(25)(E)

The state shall use standard coordination of benefits cost avoidance when processing claims for prenatal services, including labor and delivery and postpartum care claims.

42 CFR 433.139(f)

Potential third party payer claims (i.e., diagnosis codes, trauma edits, worker's compensation data exchanges) are reported up to six months from the date of accident or until the cost effective threshold of $500.00 is met or exceeded. The threshold amount of $500.00 represents the amount necessary to investigate, submit claims to third party payers and process recoveries. The six month accumulation limit has been determined by claim data to represent the outermost timeframe for which OHCA would identify the initial claim, emergency room visit, related pharmacy claims and follow up visits if necessary.

Recoveries are pursued when private health insurance coverage is identified after OHCA has paid claims for a Medicaid recipient. OHCA's entire population of medical claims is sent to OHCA's TPL contractor on a weekly basis for review.

OHCA has set a $10.00 threshold for seeking reimbursement for health insurance claims. This threshold amount represents the approximate cost of electronically billing resources and receiving electronic transmittals in response and the minimal manual time for processing. OHCA does not accumulate health insurance claims, rather each claim must meet the $10.00 threshold amount or reimbursement is not sought. OHCA's TPL contractor receives a file extract weekly and performs daily billing functions as well as weekly and monthly reviews to correct denied claims.

The OHCA TPL contractor performs retro billing for the agency. The cost effective threshold is an accumulated 10.00 per member therefore, multiple claims can be lumped together to meet this threshold. OHCA pursues three years of back claims initially and for anything that was previously billed, OHCA pursues up to five years from the date of service.

SUPPLEMENT TO ATTACHMENT 4.22

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: OKLAHOMA

STATE LAWS REQUIRING THIRD PARTIES TO PROVIDE
COVERAGE ELIGIBILITY AND CLAIMS DATA

1902(A)(25)(I) The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data, of 1902(a)(25)(I) of the Social Security Act.

STATE Oklahoma
DATE REC'D 5-30-07
DATE APPV'D 7-10-07
DATE EFF 11-1-07
HCFA 179 07-09

A

SUPERSEDES: NONE - NEW PAGE

New Page 11-01-07

TN # 07-09 Approval Date 7-10-07 Effective Date 11-1-07
Supersedes
TN # SUPERSEDES: NONE - NEW PAGE

State: OKLAHOMA

Citation	Sanctions for MCOs and PCCMs
1932(e) 42 CFR 438.726	(a) The State will monitor for violations that involve the actions and failure to act specified in 42 CFR Part 438 Subpart I and to implement the provisions in 42 CFR 438 Subpart I, in manner specified below:
	(b) The State uses the definition below of the threshold that would be met before an MCO is considered to have repeatedly committed violations of section 1903(m) and thus subject to imposition of temporary management:
	(c) The State's contracts with MCOs provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS under 42 CFR 438.730(e).
	X Not applicable; the State does not contract with MCOs, or the State does not choose to impose intermediate sanctions on PCCMs.

STATE Oklahoma
DATE REC'D 9-29-04
DATE APPV'D 11-1-04
DATE EFF 7-1-04
HCFA 179 04-07

A

SUPERSEDES TN 03-12

Revised 7/01/04

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

INCOME AND ELIGIBILITY VERIFICATION PROCEDURES
REQUESTS TO OTHER STATE AGENCIES

No additional information is requested beyond requirements identified in 42 CFR 435.948.

State: Oklahoma
Date Received: 30 March, 2017
Date Approved: 13 June, 2017
Effective Date: 1 January, 2017
Transmittal Number: 17-01

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Oklahoma

METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS TO HOMELESS INDIVIDUALS

For persons with no fixed address or mailing address, mailing arrangements should be explored, e.g., shelters for the homeless, church sponsors, etc. If no mailing address can be secured through this exploration, the Medical ID Card will be sent to the county office for pick-up by the client.

STATE	OK	A
DATE REC'D	JUN 2 9 1987	
DATE APP'V'D	JAN 11 1988	
DATE EFF	JAN 1 1987	
HCFA 179	87-9	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OKLAHOMA

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE

The following is a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives. If applicable States should include definitions of living will, durable power of attorney for health care, durable power of attorney, witness requirements, special State limitations on living will declarations, proxy designation, process information and State forms, and identify whether State law allows for a health care provider or agent of the provider to object to the implementation of advance directives on the basis of conscience.

In Oklahoma, the law regarding advance directives is contained in the Oklahoma Rights of the Terminally Ill or Persistently Unconscious Act, 63 Oklahoma Statutes § 3101 et seq. (Supp. 1992).

Under the law, an individual of sound mind and 18 years old or older may execute at any time an advance directive governing the withholding or withdrawal of life sustaining treatment. The requirements are as follows:

1. The patient must 18 years old or older and of sound mind;
2. The patient must be in "terminally ill" or "persistently unconscious" condition (definitions Okla. Stat. 63 § 3101.3);
3. The document must be signed by the declarant and two witnesses.
   (a) witnesses must be 18 years or older.
   (b) cannot be legatees, devisees or heirs at law.

An advance directive may be revoked in whole or in part at any time and in any manner by the declarant, without regard to the declarant's mental or physical condition. A revocation is effective upon communication to the attending physician or other health care provider by the declarant or a witness to the revocation. (Okla. Stat. 63 § 3101.6)

An advance directive becomes operative when:

1. It is communicated to the attending physician, and
2. Declarant is no longer able to make decisions regarding administration of life-sustaining treatment (Okla. Stat.63 § 3101.5)

TN# 92-20
Supersedes TN# 91-16

STATE Oklahoma
DATE REC'D 10-16-92
DATE APP'VD 10-29-92
9-1-92
92-27

A

Effective Date 9/1/92

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OKLAHOMA

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE (cont'd)

The determination of the attending physician and another physician that patient is a qualified patient shall become a part of the patient's medical record. (Okla. Stat. 63 § 3101.7)

Examples of the advance directives are located in Okla. Stat. 63 § 3101.4.

The original or photocopy of the advance directive shall be part of the declarant's medical record, and if physician or health care provider is unwilling to comply, promptly so advise the declarant.

An advance directive shall be in form according to Sec. 3101.4. It shall designate health care provider/physician, health care proxy, conflicting provision, and other provision. Example in Sec. 3101.4.

STATE Oklahoma DATE REC'D 10-16-92 DATE APPV'D 10-29-92 DATE EFF 9-1-92 HCFA 179 92-20	A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OKLAHOMA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

The State uses other factors described below to determine the seriousness of deficiencies in addition to those described at §488.404(b)(1):

NOT APPLICABLE

STATE Oklahoma
DATE RECD SEP 26 1995
DATE APP JUN 20 1996
DATE EFF JUL 01 1995
HCFA 179 95-17

A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OKLAHOMA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Termination of Provider Agreement: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

Oklahoma
STATE
DATE RECD SEP 26 1995
DATE APPVD JUN 20 1996
DATE EFF JUL 01 1995
HCFA 179 95-17
A

Corrected
Attachment 4.35-C

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OKLAHOMA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Temporary Management: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

___ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

_X_ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

Oklahoma chooses to utilize temporary managers under State licensure law in lieu of temporary managers under Title XIX in immediate jeopardy situations. In cases of widespread actual harm where there is not immediate jeopardy, Oklahoma will use temporary managers under Title XIX, when appropriate.

The Oklahoma State Department of Health (OSDH) has utilized the appointment of receivers in nursing facilities, intermediate care facilities for the mentally retarded, and/or residential care facilities. Effective July 1, 1995, OSDH was given authority to appoint temporary managers under the Nursing Home Care Act in nursing facilities. These temporary managers have the same responsibilities and duties as temporary managers under the enforcement regulations.

State temporary managers provide a more extensive remedy because State temporary managers may be imposed without the consent of the nursing facility.

The criteria to be used in this remedy will be the same as those specified in the enforcement regulation.

The State uses the federal notice requirements specified in 42 CFR 488.402(f).

The factors utilized in determining the selection of alternative remedies are the same as those specified in 42 CFR 488.404.

STATE Oklahoma
DATE RECD SEP 26 1995
DATE APPVD JUN 20 1996
DATE EFF JUL 01 1995
HCFA 179 95-17

A

TN No. 95-17 New 07-01-95
Supersedes TN No. June-New Page Approval Date: 6/20/96 Effective Date: 7/1/95

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OKLAHOMA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Denial of Payment for New Admissions: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

___ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

X Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

Oklahoma chooses to utilize a ban on all admissions under State licensure laws in lieu of denial of payment for new admissions.

The Oklahoma State Department of Health (OSDH) has utilized bans on admissions in nursing facilities, intermediate care facilities for the mentally retarded, residential care facilities, and hospitals. Since 1990, OSDH has successfully utilized bans on all admissions to expedite compliance in nursing facilities that are providing substandard care.

Bans on all admissions provide a more extensive remedy because of the following:

1. All residents residing in nursing facilities, regardless of payment source, are entitled to quality of care provided by nursing facilities.
2. A denial of payment for admissions can be discriminatory to those residents that receive Medicaid as the primary payment source. Providers could continue to admit private pay residents and only deny admission to those needing Medicaid assistance.
3. A ban on all admissions prevents the unknowing public from being introduced into a non-compliant facility.

Since July 1, 1995, under State law, OSDH has utilized bans on admissions in (10) Oklahoma nursing facilities that were determined through Federal and/or State criteria, to be providing substandard care. Of those (10) facilities, substandard care came into compliance within (2) to (45) days. To this date, providers have not requested a hearing concerning the imposition of this State remedy. This alternative remedy has proven to be successful in gaining the cooperation of providers to expedite compliance. Oklahoma's experience has established that poor performing nursing facilities need to concentrate on the areas where non-compliance exists instead of admitting new residents.

The criteria to be used in this remedy will be the same as those specified in the enforcement regulation.

The State uses the federal notice requirements specified in 42 CFR 488.402(f).

The factors utilized in determining the selection of alternative remedies are the same as those specified in 42 CFR 488.404.

STATE A
DATE REC'D SEP 26 1995
DATE APPV'D JUN 20 1996
DATE EFF JUL 1 1995
HCFA 179

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OKLAHOMA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Civil Money Penalty: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE Oklahoma
DATE REC'D SEP 2 6 1995
DATE APPV'D JUN 2 0 1996
DATE EFF JUL 0 1 1995
HCFA 179 95-17
A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OKLAHOMA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

State Monitoring: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE Oklahoma
DATE RECD SEP 26 1995
DATE APP'D JUN 20 1996
DATE EFF JUL 01 1995
HCFA 179 95-17

A

TN No. 95-17
Supersedes TN No. None-New Page

Approval Date: 6/20/96

New 07-01-95
Effective Date: 7/1/95

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OKLAHOMA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Transfer of residents; Transfer of residents with closure of facility: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE Oklahoma
DATE RCVD SEP 26 1995
DATE APP'D JUN 20 1996
DATE EFF JUL 01 1995
HCFA 179 95-17
A

New 07-01-95

TN No. 95-17
Supersedes
TN No. None-New Page
Approval Date: 6/20/96 Effective Date: 7/1/95

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OKLAHOMA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Additional Remedies: Describe the criteria (as required at §1919(h)(2)(A)) for applying the additional remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, or category 3 as described at 42 CFR 488.408).

NOT APPLICABLE

STATE Oklahoma
DATE SEP 26 1995
DATE JUN 20 1996
DATE JUL 01 1995
HCFA 179 95-17
A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OKLAHOMA

DISCLOSURE OF ADDITIONAL REGISTRY INFORMATION

The State discloses social security number, confirmed abuse, aides address, date of birth, sex, test type, certificate number, certification date, notice printed, who modified and modification date, recertification date, certificate printed, where trained and tested and evaluators social security number.

STATE Oklahoma
DATE REC'D APR 06 1993
DATE APPV'D MAY 03 1993
DATE EFF JAN 01 1989
HCFA 179 93-07
A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OKLAHOMA

COLLECTION OF ADDITIONAL REGISTRY INFORMATION

The State collects social security number, confirmed abuse, aide's address, date of birth, sex, test type, certificate number, certification date, notice printed, who modified and modification date, recertification date, certificate printed, where trained and tested and evaluators social security number.

STATE Oklahoma
DATE REC'D APR 06 1993
DATE APPV'D MAY 03 1993
DATE EFF JAN 01 1989
HCFA 179 93-07

A

TN No. 93-07
Supersedes TN No. None-New Page

Approval Date MAY 03 1993

Effective Date New 01-01-89 JAN 01 1989

HCFA ID:

* U.S. Government Printing Office : 1991 - 312-149/40413

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OKLAHOMA

CATEGORICAL DETERMINATIONS

A. Categorical determinations regarding need of nursing facility (NF) services

The State mental health or mental retardation authority may make an advance group determination that NF services are needed in the following categories:

1. **Provisional Admission in Cases of Delirium.** Any person with mental illness, mental retardation or a related condition, as long as that person is not a danger to self and/or others, may be admitted to a Medicaid-certified nursing facility. If the individual is experiencing delirium, a screening will be done immediately after the delirium clears and completed within 7-9 days.

2. **Provisional Admission in Emergency Situations.** Any person with mental illness, mental retardation or a related condition, as long as that person is not a danger to self and/or others, may be admitted to a Medicaid-certified nursing facility for a period not to exceed 7 days pending further assessment in emergency situations requiring protective services. The request for screening will be made immediately upon admission to the NF and completed within 7-9 days.

3. **Respite Care Admission.** Any person with mental illness, mental retardation or a related condition, as long as that person is not a danger to self and/or others, may be admitted to a Medicaid-certified nursing facility to provide respite to in-home caregivers to whom the individual is expected to return following the brief NF stay. Respite care may be granted for up to 15 consecutive days per stay, not to exceed 30 days per calendar year. In rare instances where 15 consecutive days is insufficient, such as the illness of the caregiver, a request for screening will be made within 7-9 days following admission.

STATE	Oklahoma
DATE RECD	10-12-94
DATE APPVD	01-23-96
DATE EFF	07-01-94
HCFA 179	94-19
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OKLAHOMA

CATEGORICAL DETERMINATIONS

B. Categorical determinations regarding need of specialized services (SS).

The State mental health and mental retardation authorities may make categorical determinations that specialized services are not needed in the following categories. In all other cases, a determination that specialized services are needed must be based on a more extensive individualized evaluation.

1. **Provisional Admission in Cases of Delirium.** Any person with mental illness, mental retardation or a related condition, as long as that person is not a danger to self and/or others, may be admitted to a Medicaid-certified nursing facility. If the individual is experiencing delirium, a screening will be done immediately after the delirium clears and completed within 7-9 days.

2. **Provisional Admission in Emergency Situations.** Any person with mental illness, mental retardation or a related condition, as long as that person is not a danger to self and/or others, may be admitted to a Medicaid-certified nursing facility for a period not to exceed 7-9 days pending further assessment in emergency situations requiring protective services. The request for screening will be made immediately upon admission to the NF and completed within 7-9 days.

3. **Respite Care Admission.** Any person with mental illness, mental retardation or a related condition, as long as that person is not a danger to self and/or others, may be admitted to a Medicaid-certified nursing facility to provide respite to in-home caregivers to whom the individual is expected to return following the brief NF stay. Respite care may be granted for up to 15 consecutive days per stay, not to exceed 30 days per calendar year. In rare instances where 15 consecutive days is insufficient, such as the illness of the caregiver, a request for screening will be made within 7-9 days following admission.

STATE Oklahoma
DATE SUBMITTED 10-12-94
DATE APPROVED 01-23-96
DATE EFF 07-01-94
HCFA 179 94-19
A

New 07-01-94

EMPLOYEE EDUCATION ABOUT FALSE CLAIMS RECOVERIES

4.42 Employee Education About False Claims Recoveries

(a) The Medicaid agency meets the requirements regarding establishment of policies and procedures for the education of employees of entities covered by section 1902(a)(68) of the Social Security Act (the Act) regarding false claims recoveries and methodologies for oversight of entities' compliance with these requirements.

(1) Definitions.

(A) An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State Plan approved under title XIX or under any waiver of such plan, totaling at least $5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments to that entity meet the $5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an "entity" (e.g., a state mental health facility or school district providing school-based health services.) A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for ~~thee~~ these purposes, considered to be an entity.

SUPERSEDES: NONE - NEW PAGE

EMPLOYEE EDUCATION ABOUT FALSE CLAIMS RECOVERIES

4.42 Employee Education About False Claims Recoveries (continued)

An entity will have met the $5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in Federal fiscal year 2006. Future determinations regarding an entity's responsibility stemming from the requirements of section 1902(a)(68) will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year.

(B) An "employee" includes any officer or employee of the entity.

(C) A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

(2) The entity must establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. The entity need not create an employee handbook if none already exists.

(3) `An entity shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

SUPERSEDES: NONE - NEW PAGE

SUPERSEDES: NONE - NEW PAGE

EMPLOYEE EDUCATION ABOUT FALSE CLAIMS RECOVERIES

4.42 Employee Education About False Claims Recoveries (continued)

(4) The requirements of this law should be incorporated into each State's provider enrollment agreements.

(5) The State will implement this State Plan amendment on January 1, 2007.

(b) ATTACHMENT 4.42-A describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.

STATE Oklahoma	A
DATE REC'D 3-16-07	
DATE APPV'D 8-10-07	
DATE EFF 1-1-07	
HCFA 179 07-05	

SUPERSEDES: NONE - NEW PAGE

EMPLOYEE EDUCATION ABOUT FALSE CLAIMS RECOVERIES

ATTACHMENT 4.42-A describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.

The Oklahoma Health Care Authority (OHCA) has informed its contractors and vendors of its policies on preventing waste, fraud, and abuse via a letter sent on January 8, 2007 to entities who received or made aggregate payments of $5,000,000 in fiscal year 2006.

The OHCA will compile a list in January of each year of contractors and vendors who met the $5,000,000 payment threshold the previous Federal Fiscal Year and notify them by letter of their responsibilities under the Act by January 31.

During the course of regular program integrity activities, any contractor or vendor reviewed that meets the $5,000,000 payment threshold may also be audited on their compliance with the Act.

The OHCA has added information on compliance with the Act to its vendor and provider contracts.

SUPERSEDES: NONE - NEW PAGE

STATE Oklahoma
DATE REC'D 3-6-07
DATE APP'V'D 8-10-07
DATE EFF 1-1-07
HCFA 179 07-05

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SUPERSEDES: NONE - NEW PAGE

7.2-A Methods of Administration - Civil Rights

This information is available in the Regional Office. See our letter of February 21, 1978, to which was attached a revised "Statement Of Compliance-Implementation of Civil Rights.

APPROVED by DHEW/HCFA/MS
DATE: MAR 20 1978
TRANSMITTAL NO: 78-4