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State/Territory Name: Oklahoma

State Plan Amendment (SPA) #: 17-0006

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Dallas Regional Office
1301 Young Street, Suite 833
Dallas, Texas 75202

DIVISION OF MEDICAID & CHILDREN'S HEALTH - REGION VI

October 19, 2017

Our Reference: SPA OK 17-006

Becky Pasternik-Ikard
Chief Executive Officer
4345 N. Lincoln Blvd.
Oklahoma City, Oklahoma 73105

Dear Ms. Pasternik-Ikard:

Enclosed is a copy of approved Oklahoma State Plan Amendment (SPA) No. 17-006, with an effective date of July 1, 2017. This amendment was submitted to allow for hospice services concurrently with medical and curative services for children, and to correct age limitation language for individuals in receiving inpatient psychiatric care.

This letter affirms that OK 17-006 is approved effective July 1, 2017 as requested by the State.

We are enclosing the CMS-179 and the following amended or new plan pages.

- Attachment 3.1-A, Page 7
- Attachment 4.19-B, Page 28.4
- Attachment 4.19-B, Page 28.4a

If you have any questions regarding this matter you may contact Stacey Shuman at 214-767-6479, or by email at stacey.shuman@cms.hhs.gov.

Sincerely,

[redacted]

Bill Brooks
Associate Regional Administrator

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 17-06

2. STATE: Oklahoma

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2017

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS A NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
1905(o)(1) and 2110(a)(23) of the Social Security Act

7. FEDERAL BUDGET IMPACT
a. FFY 2017 $ $391,539
b. FFY 2018 $ $1,530,359

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-A, Page 7
Attachment 4.19-B, Page 28.4
Attachment 4.19-B, Page 28.4a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-A, Page 7; TN# 90-24
Attachment 4.19-B, Page 28.4; TN # 90-12
None; New Page

10. SUBJECT OF AMENDMENT
Hospice care concurrent treatment for children & correction in stated age for inpatient psychiatric facility services for individuals under 21 years of age

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED
The Governor does not review State Plan material.

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Becky Pasternik-Ikard

14. TITLE
Chief Executive Officer

15. DATE SUBMITTED
July 27, 2017

16. RETURN TO
Oklahoma Health Care Authority
Attn: Tywanda Cox
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
27 July, 2017

18. DATE APPROVED
19 October, 2017

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
1 July, 2017

20. SIG
[redacted]

21. TYPED NAME
Bill Brooks

22. TITLE
Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS
c: Becky Pasternik-Ikard
Tywanda Cox

FORM CMS-179 (07/92)

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 [ ] No limitations [X] 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: 27 July, 2017
Date Approved: 19 October 2017
Effective Date: 1 July 2017
Transmittal Number: 17-006

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.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
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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, as noted below, 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.

Effective for services provided on or after April 1, 2014, the rates will be decreased by 3.25%.

Effective for services on or after July 1, 2014, the rates will be reduced by an additional 7.75%.

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.