Table of Contents

State/Territory Name: Oklahoma

State Plan Amendment (SPA) #: 25-0006-A

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

May 20, 2025

Christina Foss
State Medicaid Director
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

Re: Oklahoma State Plan Amendment (SPA) – 25-0006-A

Dear Director Foss:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 25-0006A. This amendment proposes to expand the Hospice Benefit to all Medicaid members provided they meet the criteria for hospice, and the hospice benefit is within the scope of their categorical eligibility.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act Section 1905(o). This letter informs you that Oklahoma's Medicaid SPA TN 25-0006-A was approved on May 16, 2025, with an effective date of January 1, 2025.

Enclosed are copies of Form CMS-179 and approved SPA pages to be incorporated into the Oklahoma State Plan.

If you have any questions, please contact Stacey Steiner at (469) 904-1068 or via email at Stacey.Steiner@cms.hhs.gov.

Sincerely,

Shantrina Roberts, Acting Director
Division of Program Operations

Enclosures

cc: Kasie McCarty, OHCA
Heather Cox, OHCA

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

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 25-0006A

2. STATE: OK

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
1/1/2025

5. FEDERAL STATUTE/REGULATION CITATION
SSA 1905(a)(18) and 1905(o)

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ 20,403
b. FFY 2026 $ 27,204

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-A, page 7
Attachment 3.1-A, page 7a-3
Attachment 4.19-B, Introduction, page 1
Attachment 4.19-B, page 13
Attachment 4.19-B, page 14

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-A, page 7; TN# 18-0002
[redacted]
Attachment 4.19-B, Introduction, page 1; TN# 24-0022
Attachment 4.19-B, page 13; TN# 15-0004
[redacted]

9. SUBJECT OF AMENDMENT
Expansion of Hospice Benefit to all Medicaid members so long as they meet the criteria for hospice and its within the scope of their categorical eligibility.

10. GOVERNOR'S REVIEW *(Check One)*
( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED:
The governor's office does not review state plan material.

12. TYPED NAME
Melody Anthony

13. TITLE
Interim State Medicaid Director

14. DATE SUBMITTED
February 21, 2025

15. RETURN TO
Oklahoma Health Care Authority
Attn: Melody Anthony
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

cc: Kasie McCarty, Heather Cox

FOR CMS USE ONLY

16. DATE RECEIVED
February 21, 2025

17. DATE APPROVED
May 16, 2025

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
January 1, 2025

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL
Shantrina Roberts

21. TITLE OF APPROVING OFFICIAL
Acting Director, Division of Program Operations

22. REMARKS
5/20/25: Pen and Ink change authorized by state on May 19, 2025 to Section 8 to remove references to pages not superseded by this SPA.

Instructions on Back

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

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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 (in accordance with section 1905(o) of the Act).

[X] Provided [ ] No limitations [X] Provided in accordance with section 2302 of the Affordable Care Act

[X] With limitations* [ ] Not Provided:

*Description provided on attachment

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

18. Hospice care

Hospice care is provided in accordance with section 1905(o) and 1905(a)(18) of the Social Security Act.

Hospice services are provided 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. Election of hospice for individuals age 21 and over 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.

Individuals 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.

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. The purpose of the prior authorization is to collect information for medical necessity and is not intended to limit the hospice benefit in amount, duration, or scope.

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.

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		
F. Clinic Services and Observation/Treatment Room	Attachment 4.19-B, Page 1b	October 1, 2019
H. Partial Hospitalization Program Services		October 1, 2019 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, 2019
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
Personal Care Services	Attachment 4.19-B, Page 11	January 1, 2024
Nurse Midwife Services	Attachment 4.19-B, Page 12	October 1, 2019
Hospice Care	Attachment 4.19-B, Page 13	January 1, 2025
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	September 1, 2024
• 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
• Hospice Services	Attachment 4.19-B, Page 28.4	October 1, 2019

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 January 1, 2025, 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 CMS Medicaid daily hospice rates, effective October 1 annually, and applying the Oklahoma statewide hospice 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 Care *(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 bereavement counseling and 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. Nursing 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.