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State/Territory Name: Oklahoma

State Plan Amendment (SPA) #: 26-0005

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 65106

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

Medicaid and CHIP Operations Group

November 17, 2026

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

Re: Oklahoma State Plan Amendment (SPA) 26-0005

Dear Director Miller:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 26-0005. This amendment proposes to update the targeted case management (TCM) for individuals with Intellectual Disabilities and Related Conditions provider qualifications, including degree and experience criteria, and removes outdated or duplicative language.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations at 42 Code of Federal Regulation (CFR) §440.169. This letter informs you that Oklahoma's Medicaid SPA TN 26-0005 was approved on November 17, 2026, effective July 1, 2026.

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 Mai Le-Yuen via email at mai.le-yuen@cms.hhs.gov.

Sincerely,

[redacted]

Megan K. Buck, Director
Division of Program Operations

Enclosures

cc: Heather Cox

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: 26 — 0005

2. STATE: OK

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

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

4. PROPOSED EFFECTIVE DATE
July 1, 2026

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 440.169

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2026 $ 0
b. FFY 2027 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Supplement 1 to Attachment 3.1-A, Pages 8-8e

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Supplement 1 to Attachment 3.1-A, Pages 8, 8a, 8c-8e (TN # 08-09), 8b (TN #20-0006)

9. SUBJECT OF AMENDMENT

Updates Developmental Disabilities Services targeted case management case manager qualification requirements, including degree and experience criteria, and removes outdated or duplicative language. Budget neutral; effective July 1, 2026.

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.

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Melissa Miller

13. TITLE
State Medicaid Director

14. DATE SUBMITTED
September 29, 2026

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

cc: Heather Cox, Grace Tierney

FOR CMS USE ONLY

16. DATE RECEIVED
September 29, 2026

17. DATE APPROVED
November 17, 2026

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2026

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Megan K. Buck

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

22. REMARKS

11/13/26: State gave permission for pen & ink change to revised 179 to reflect correct TN for page 8b.

Instructions on Back

State Plan under Title XIX of the Social Security Act
State/Territory: Oklahoma

TARGETED CASE MANAGEMENT SERVICES
Persons with Developmental Disabilities

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

The target group is individuals with intellectual disabilities and/or related conditions who are requesting or served by a DDS 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): 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.

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- 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:
    - services are being furnished in accordance with the individuals' care plan;
    - services in the care plan are adequate; and
    - 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 changes needed.

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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 441.18(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 DDSD Provider.**

Case Manager Qualifications:

1. **a. Possess a bachelor's degree in any field and one year of experience working directly with persons with intellectual disabilities ~~of~~ or other developmental disabilities or in social work, case management, special education, psychology, counseling, vocational rehabilitation, physical therapy, occupational therapy, speech therapy, nursing or closely related field. 4 years of experience working directly with persons with intellectual disabilities or any of the fields listed above may be substituted in lieu of the bachelor's degree on a 1:1 basis;**

   OR

   b. Possess a valid permanent Oklahoma license to practice nursing issued by the Oklahoma State Board of Nursing, or a valid interim work permit or a temporary license issued by the Oklahoma State Board of Nursing, and one year of experience working directly with persons with intellectual disabilities or other developmental disabilities. An individual practicing under an interim work permit or temporary license must obtain a permanent Oklahoma nursing license within the timeframe required by the Oklahoma Board of Nursing;

AND

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Persons with Developmental Disabilities

2. 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.**

AND

3. 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 quality 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.

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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: (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 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.

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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 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))