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State/Territory Name: Oklahoma

State Plan Amendments (SPA) #: OK-18-0013

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Children and Adults Health Programs Group

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

Becky Pasternik-Ikard
Medicaid Director
Oklahoma Health Care Authority
4345 N. Lincoln Boulevard
Oklahoma City, OK 73105

OCT 1 8 2018

Dear Ms. Pasternik-Ikard:

I am pleased to inform you that your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA) OK-18-0013, submitted on September 5, 2018, has been approved. The SPA has an effective date of September 1, 2018.

Through this SPA, Oklahoma updates the state's performance goals and strategic objectives, including the addition of the American Community Survey as a tool the state uses to measure progress. The state also updated its tribal consultation process to reflect current policy.

Your title XXI project officer is Ms. Jasmine Aplin. She is available to answer questions concerning this amendment and other CHIP-related issues. Her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-8102
E-mail: Jasmine.Aplin@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Aplin and Mr. Bill Brooks, Associate Regional Administrator (ARA) in our Dallas Regional Office. Mr. Brooks' address is:

Centers for Medicare & Medicaid Services
1301 Young St. Suite 714
Dallas, TX 75202

If you have additional questions, please contact Amy Lutzky, Director, Division of State Coverage Programs (410)786-0721.

Sincerely,

/signed Anne Marie Costello/

Anne Marie Costello
Director

cc:
Mr. Bill Brooks, ARA, CMS Region VI, Dallas

TEMPLATE FOR CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: _____Oklahoma_____
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR 457.40(b))

_____
(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following Child Health Plan for the Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following State officials are responsible for program administration and financial oversight (42 CFR 457.40(c)):

Name: Becky Pasternik-Ikard	Position/Title: Chief Executive Officer
Name: Carrie Evans	Position/Title: Deputy Chief Executive Officer
Name: Tywanda Cox	Position/Title: Chief, Federal & State Authorities

*Disclosure. 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 (CMS-10398 #34). The time required to complete this information collection is estimated to average 80 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

Introduction: Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 105-33 amended the Social Security Act (the Act) by adding a new title XXI, the Children's Health Insurance Program (CHIP). In February 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) renewed the program. The Patient Protection and Affordable Care Act of 2010 further modified the

program.

This template outlines the information that must be included in the state plans and the state plan amendments (SPAs). It reflects the regulatory requirements at 42 CFR Part 457 as well as the previously approved SPA templates that accompanied guidance issued to States through State Health Official (SHO) letters. Where applicable, we indicate the SHO number and the date it was issued for your reference. The CHIP SPA template includes the following changes:

- Combined the instruction document with the CHIP SPA template to have a single document. Any modifications to previous instructions are for clarification only and do not reflect new policy guidance.
- Incorporated the previously issued guidance and templates (see the Key following the template for information on the newly added templates), including:
  - Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
  - Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
  - Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
  - Dental and supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
  - Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
  - Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
  - Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)
- Moved sections 2.2 and 2.3 into section 5 to eliminate redundancies between sections 2 and 5.
- Removed crowd-out language that had been added by the August 17 letter that later was repealed.

The Centers for Medicare & Medicaid Services (CMS) is developing regulations to implement the CHIPRA requirements. When final regulations are published in the Federal Register, this template will be modified to reflect those rules and States will be required to submit SPAs illustrating compliance with the new regulations. States are not required to resubmit their State plans based on the updated template. However, States must use the updated template when submitting a State Plan Amendment.

Federal Requirements for Submission and Review of a Proposed SPA. (42 CFR Part 457 Subpart A) In order to be eligible for payment under this statute, each State must submit a Title XXI plan for approval by the Secretary that details how the State intends to use the funds and fulfill other requirements under the law and regulations at 42 CFR Part 457. A SPA is approved in 90 days unless the Secretary notifies the State in writing that the plan is disapproved or that specified additional information is needed. Unlike Medicaid SPAs, there is only one 90 day review period, or clock for CHIP SPAs, that may be stopped by a request for additional information and restarted after a complete response is received. More information on the SPA review process is found at 42 CFR 457 Subpart A.

When submitting a State plan amendment, states should redline the changes that are being made to the existing State plan and provide a "clean" copy including changes that are being made to the existing state plan.

The template includes the following sections:

1. **General Description and Purpose of the Children's Health Insurance Plans and the Requirements**- This section should describe how the State has designed their program. It also is the place in the template that a State updates to insert a short description and the proposed

effective date of the SPA, and the proposed implementation date(s) if different from the effective date. (Section 2101); (42 CFR 457.70)

2. **General Background and Description of State Approach to Child Health Coverage and Coordination**- This section should provide general information related to the special characteristics of each state's program. The information should include the extent and manner to which children in the State currently have creditable health coverage, current State efforts to provide or obtain creditable health coverage for uninsured children and how the plan is designed to be coordinated with current health insurance, public health efforts, or other enrollment initiatives. This information provides a health insurance baseline in terms of the status of the children in a given State and the State programs currently in place. (Section 2103); (42 CFR 457.410(A))
3. **Methods of Delivery and Utilization Controls**- This section requires a description that must include both proposed methods of delivery and proposed utilization control systems. This section should fully describe the delivery system of the Title XXI program including the proposed contracting standards, the proposed delivery systems and the plans for enrolling providers. (Section 2103); (42 CFR 457.410(A))
4. **Eligibility Standards and Methodology-** The plan must include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. This section includes a list of potential eligibility standards the State can check off and provide a short description of how those standards will be applied. All eligibility standards must be consistent with the provisions of Title XXI and may not discriminate on the basis of diagnosis. In addition, if the standards vary within the state, the State should describe how they will be applied and under what circumstances they will be applied. In addition, this section provides information on income eligibility for Medicaid expansion programs (which are exempt from Section 4 of the State plan template) if applicable. (Section 2102(b)); (42 CFR 457.305 and 457.320)
5. **Outreach-** This section is designed for the State to fully explain its outreach activities. Outreach is defined in law as outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs. The purpose is to inform these families of the availability of, and to assist them in enrolling their children in, such a program. (Section 2102(c)(1)); (42 CFR 457.90)
6. **Coverage Requirements for Children's Health Insurance**- Regarding the required scope of health insurance coverage in a State plan, the child health assistance provided must consist of any of the four types of coverage outlined in Section 2103(a) (specifically, benchmark coverage; benchmark-equivalent coverage; existing comprehensive state-based coverage; and/or Secretary-approved coverage). In this section States identify the scope of coverage and benefits offered under the plan including the categories under which that coverage is offered. The amount, scope, and duration of each offered service should be fully explained, as well as any corresponding limitations or exclusions. (Section 2103); (42 CFR 457.410(A))
7. **Quality and Appropriateness of Care**- This section includes a description of the methods (including monitoring) to be used to assure the quality and appropriateness of care and to assure access to covered services. A variety of methods are available for State's use in monitoring and evaluating the quality and appropriateness of care in its child health assistance program. The section lists some of the methods which states may consider using. In addition to methods, there are a variety of tools available for State adaptation and use with this program. The section lists some of these tools. States also have the option to choose who will conduct these activities. As an alternative to using staff of the State agency administering the program, states have the option to contract out with other organizations for this quality of care function. (Section 2107); (42 CFR

457.495)

8. **Cost Sharing and Payment**- This section addresses the requirement of a State child health plan to include a description of its proposed cost sharing for enrollees. Cost sharing is the amount (if any) of premiums, deductibles, coinsurance and other cost sharing imposed. The cost-sharing requirements provide protection for lower income children, ban cost sharing for preventive services, address the limitations on premiums and cost-sharing and address the treatment of pre-existing medical conditions. (Section 2103(e)); (42 CFR 457, Subpart E)
9. **Strategic Objectives and Performance Goals and Plan Administration**- The section addresses the strategic objectives, the performance goals, and the performance measures the State has established for providing child health assistance to targeted low income children under the plan for maximizing health benefits coverage for other low income children and children generally in the state. (Section 2107); (42 CFR 457.710)
10. **Annual Reports and Evaluations**- Section 2108(a) requires the State to assess the operation of the Children's Health Insurance Program plan and submit to the Secretary an annual report which includes the progress made in reducing the number of uninsured low income children. The report is due by January 1, following the end of the Federal fiscal year and should cover that Federal Fiscal Year. In this section, states are asked to assure that they will comply with these requirements, indicated by checking the box. (Section 2108); (42 CFR 457.750)
11. **Program Integrity**- In this section, the State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Sections 2101(a) and 2107(e); (42 CFR 457, subpart I)
12. **Applicant and Enrollee Protections**- This section addresses the review process for eligibility and enrollment matters, health services matters (i.e., grievances), and for states that use premium assistance a description of how it will assure that applicants and enrollees are given the opportunity at initial enrollment and at each redetermination of eligibility to obtain health benefits coverage other than through that group health plan. (Section 2101(a)); (42 CFR 457.1120)

Program Options. As mentioned above, the law allows States to expand coverage for children through a separate child health insurance program, through a Medicaid expansion program, or through a combination of these programs. These options are described further below:

- **Option to Create a Separate Program-** States may elect to establish a separate child health program that are in compliance with title XXI and applicable rules. These states must establish enrollment systems that are coordinated with Medicaid and other sources of health coverage for children and also must screen children during the application process to determine if they are eligible for Medicaid and, if they are, enroll these children promptly in Medicaid.
- **Option to Expand Medicaid-** States may elect to expand coverage through Medicaid. This option for states would be available for children who do not qualify for Medicaid under State rules in effect as of March 31, 1997. Under this option, current Medicaid rules would apply.

Medicaid Expansion- CHIP SPA Requirements

In order to expedite the SPA process, states choosing to expand coverage only through an expansion of Medicaid eligibility would be required to complete sections:

- 1 (General Description)
- 2 (General Background)

They will also be required to complete the appropriate program sections, including:

- 4 (Eligibility Standards and Methodology)
- 5 (Outreach)
- 9 (Strategic Objectives and Performance Goals and Plan Administration including the budget)
- 10 (Annual Reports and Evaluations).

Medicaid Expansion- Medicaid SPA Requirements

States expanding through Medicaid-only will also be required to submit a Medicaid State Plan Amendment to modify their Title XIX State plans. These states may complete the first check-off and indicate that the description of the requirements for these sections are incorporated by reference through their State Medicaid plans for sections:

- 3 (Methods of Delivery and Utilization Controls)
- 4 (Eligibility Standards and Methodology)
- 6 (Coverage Requirements for Children's Health Insurance)
- 7 (Quality and Appropriateness of Care)
- 8 (Cost Sharing and Payment)
- 11 (Program Integrity)
- 12 (Applicant and Enrollee Protections)

- **Combination of Options-** CHIP allows states to elect to use a combination of the Medicaid program and a separate child health program to increase health coverage for children. For example, a State may cover optional targeted-low income children in families with incomes of up to 133 percent of poverty through Medicaid and a targeted group of children above that level through a separate child health program. For the children the State chooses to cover under an expansion of Medicaid, the description provided under "Option to Expand Medicaid" would apply. Similarly, for children the State chooses to cover under a separate program, the provisions outlined above in "Option to Create a Separate Program" would apply. States wishing to use a combination of approaches will be required to complete the Title XXI State plan and the necessary State plan amendment under Title XIX.

Proposed State plan amendments should be submitted electronically and one signed hard copy to the Centers for Medicare & Medicaid Services at the following address:

Name of Project Officer
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, Maryland 21244
Attn: Children and Adults Health Programs Group
Center for Medicaid and CHIP Services
Mail Stop - S2-01-16

Section 1. General Description and Purpose of the Children's Health Insurance Plans and the Requirements

1.1. The state will use funds provided under Title XXI primarily for (Check appropriate box) (Section 2101)(a)(1)); (42 CFR 457.70):

1.1.1. ☐ Obtaining coverage that meets the requirements for a separate child health program (Sections 2101(a)(1) and 2103); OR

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan (Title XIX) (Section 2101(a)(2)); OR

1.1.3. ☒ A combination of both of the above. (Section 2101(a)(2))

1.1-DS ☐ The State will provide dental-only supplemental coverage. Only States operating a separate CHIP program are eligible for this option. States choosing this option must also complete sections 4.1-DS, 4.2-DS, 6.2-DS, 8.2-DS, and 9.10 of this SPA template. (Section 2110(b)(5))

1.2. ☒ Check to provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

1.3. ☒ Check to provide an assurance that the State complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42 CFR 457.130)

1.4. Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

CHIP Medicaid expansion:
Effective date: 12/01/97

Expansion for children born prior to 10/1/83 who are not yet 18:
Effective date: 11/01/98

Disregard 85% of the FPL from income:
Effective date: 9/01/01

Technical SPA:
Date: 02/24/03

Separate SCHIP program for unborn children:
Effective date: 1/01/08
Implementation Date: 4/01/08

Insure Oklahoma coverage for children:
Effective date: 01/01/10
Implementation date: 02/01/10
Implementation date: 08/01/10 (Expanded ESI)
Implementation date: 09/01/10 (Expanded IP)

Remove Insure Oklahoma coverage for IP children & update waiting period
Implementation date: 01/01/14

Census Income Disregard:
Effective date: 07/01/09
Implementation date: 07/01/09

Health Service Initiatives:
Effective date: 07/01/16
Implementation date: 07/01/16

STBS
Effective date: 01/01/08
Implementation date: 04/01/08

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
OK-14-0002	MAGI Eligibility	CS7	Coverage of targeted low-income children	Supersedes the current sections 4.1.1, 4.1.2, and 4.1.3
		CS9	Coverage of children from conception to birth when mother is not eligible for Medicaid	Supersedes the current sections 4.1.1, 4.1.2, and 4.1.3
Effective/Implementation Date: January 1, 2014		CS13	Cover as deemed newborns children covered by section 1115 demonstration Oklahoma SoonerCare	Supersedes the current section 4.1.3
		CS15	Assurance that state will	Supersedes the

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
			apply MAGI based income methodologies for all separate CHIP covered groups	current section 4.1.3
OK-14-0003 **Effective/Implementation Date: January 1, 2014**	MAGI Eligibility for children covered under title XXI funded Medicaid program	CS3	Converts state's existing income eligibility standards to MAGI-equivalent standards, by age group	Section 4.0 of the current CHIP state plan
OK-14-0004 **Effective/Implementation Date: January 1, 2014**	Establish 2101 (f) Groups	CS14	Eligibility – Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	Incorporate within a separate subsection under section 4.1
OK-14-0005 **Effective/Implementation Date: Oct 1, 2013**	MAGI-based Eligibility Processing	CS24	An alternative single, streamlined application, screening and enrollment process, renewals	Supersedes the current sections 4.3 and 4.4
OK-14-0006 **Effective/Implementation Date: January 1, 2014**	MAGI Eligibility	CS17 CS18 CS19 CS20 CS21 CS23	Non-financial eligibility policies on: Residency Citizenship Social Security Number Substitution of Coverage Non-Payment of Premiums Other Eligibility	Section 4.1.5 Section 4.1.0; 4.1-LR; 4.1.1-LR Section 4.1.9.1 Section 4.4.4 Section 8.7 Section 4.1.9

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
			Standards	

SPA #18-0024 Comply with Parity Regulations
Proposed effective date: 10/02/2017

Proposed implementation date: 10/02/2017

SPA # 18-0001 Implementation of new Health Service Initiatives (HSIs)
Proposed effective date: 10/01/18

Proposed implementation date: 10/01/18

SPA # 18-0016: ~~Purpose of SPA:~~ Implementation of new Health Service Initiative (HSI)
Proposed effective date: 11/01/18

Proposed implementation date: 11/01/18

Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its State plan or amendment. (42 CFR 457.65) The implementation date is defined as the date the State begins to provide services; or, the date on which the State puts into practice the new policy described in the State plan or amendment. For example, in a State that has increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

1.4. Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

SPA #18-0013 Purpose of SPA: Revise CHIP goals and objectives, update tribal consultation requirements, and general clean up
Proposed effective date: 09/01/18

Proposed implementation date: 10/01/18

1.4- TC **Tribal Consultation** (Section 2107(e)(1)(C)) Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

Tribal Consultation took place on 05/16/18 and it included 54 participants;
10 tribes were represented. No comments were received at Tribal consultation.

TN No: 18-0013 Approval Date Effective Date: 09/01/18

2.3-TC **Tribal Consultation Requirements**- (Sections 1902(a)(73) and 2107(e)(1)(C)); (ARRA #2, CHIPRA #3, issued May 28, 2009) 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)(1)(C) 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.

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. Include information about the frequency, inclusiveness and process for seeking such advice.

Tribal Consultation Requirements for All State Plan Changes
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.

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. Per the OHCA Tribal Consultation Policy, executed in

2007, the agency convenes bi-monthly tribal consultation meetings on the first Tuesday of every odd numbered month. These meetings are held at the OHCA building and attendees are also able to attend the meetings via teleconference technology to enable partners to conveniently participate without having to travel from their community. The agenda and summary for the bi-monthly meetings are posted two weeks before the meeting date online at www.okhca.org /tribal relations. The mailing list for bi-monthly meetings has over 100 individuals including elected tribal leaders, I/T/U administrators, tribal community leaders, and key tribal health stakeholders. Additionally, the agency hosts an annual tribal consultation meeting in October. OHCA's annual tribal consultation provides an opportunity for tribal community leaders to receive program updates, as well as give input and ask questions about the SoonerCare and Insure Oklahoma programs. This meeting is designed to receive feedback from tribal partners about the direction of the programs and opportunities for partnerships with tribal entities.

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 via email 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, along with meeting agenda and summary, 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.

The Oklahoma Health Care Authority has staff in the Tribal Government Relations Unit to oversee the communication between the agency, Tribal governments, Indian Health Services, tribal health programs, and tribal communities for state and national level issues including tribal consultation, policy development, legislation, and tribal sovereignty. This includes any consultation regarding program development and policy issues. The goal of the OHCA Tribal Government Relations Unit is to improve services to American Indian SoonerCare members, Indian health care providers, and sovereign tribal governments through effective meaningful communication, and maximizing partnerships.

Section 9. Strategic Objectives and Performance Goals and Plan Administration

The state will report annually using the framework for the annual report of the SCHIP program under Title XXI of the SSA. The state is currently working to revise and update Strategic Objectives and Performance Goals for Oklahoma's Title XXI plan. Revisions as well as updates to Oklahoma's Title XXI plan will be shared accordingly as soon as the information is available. In the interim, the existing framework as found

within the annual report of the SCHIP program under Title XXI of the SSA will continue to be used.

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42 CFR 457.710(b))

1. Reduce the number of uninsured children.

2. Increase CHIP enrollment.

3. Increase Medicaid enrollment.

4. Improve access to care.

5. Improve use of preventive care (immunizations, well baby/child care).

9.2. Specify one or more performance goals for each strategic objective identified: (Section 107(a)(3)) (42 CFR 457.710(c))

1. (a) Decrease the number of uninsured Oklahoma children by 2%, ~~within 5 years beginning 7/1/09,~~during the 10/01/18 through 09/30/23 Insure Oklahoma demonstration renewal period, under 19 years of age, under 186% FPL, converted to the MAGI-equivalent percent of FPL and applicable disregards.

   (b) Increase the number of qualified Oklahoma businesses participating in the Insure Oklahoma program by 2% ~~within 5 years beginning 2/1/10~~, during the 10/01/18 through 09/30/23 Insure Oklahoma demonstration renewal period. Oklahoma businesses participate in the IO program by offering a qualified benefit plan to their workers and families, and by contributing a portion of the monthly premium. Data have shown that for every 5 new lives covered through a subsidized premium, an additional 7 unsubsidized lives are covered incidentally to the program (at no cost to the state or federal government). It is anticipated that as the numbers of participating businesses increase, so will the numbers of covered lives increase for the state as a whole.

2. (a) Increase the number of Soon To Be Sooners (STBS) enrolled Oklahoma pregnant women by 2% within 5 years beginning ~~4/1/08~~10/01/18, under 186% FPL, converted to the MAGI-equivalent percent of FPL and applicable disregards.

   (b) Increase the number of Insure Oklahoma enrolled children by 2% within 5 years beginning ~~2/1/10~~ 10/01/18, under 19 years of age, 186-300% FPL, converted to the MAGI-equivalent percent of FPL and applicable disregards.

3. (a) Increase the number of SoonerCare enrolled Oklahoma children by 2% within 5 years beginning ~~7/1/09~~10/01/18, under 19 years of age, under 186% FPL, converted to the MAGI-equivalent percent of FPL and applicable disregards.

(b) Increase the number of SoonerCare enrolled Oklahoma pregnant women by 2% within 5 years beginning ~~7/1/09~~10/01/18, under 186% FPL, converted to the MAGI-equivalent percent of FPL and applicable disregards.

4. For items 4a and 4b, "capacity" is defined as the total number of SoonerCare or Insure Oklahoma enrollees the PCP's can accommodate.
   (a) Maintain the capacity of contracted SoonerCare primary care providers over a 2 year period beginning ~~7/1/09~~10/01/18.
   (b) Maintain the capacity of contracted Insure Oklahoma primary care providers over a 2 year period beginning ~~2/1/10~~10/01/18.
   (c) Increase the percentage of SoonerCare children, under 19 years of age, under 186% FPL, converted to the MAGI-equivalent percent of FPL and applicable disregards, who have selected a contracted SoonerCare primary care provider by 2% within 5 years beginning ~~1/1/09~~ 10/01/18.
   (d) ~~Increase the percentage of Insure Oklahoma children, under 19 years of age, 186% FPL, who have selected a contracted Insure Oklahoma primary care provider by 2% within 5 years beginning 2/1/10~~.

5. (a) Increase the percentage of SoonerCare well baby/child visits by age of birth through 18 years, by 2% within 5 years beginning ~~7/1/09~~10/01/18. This performance goal tracks the overall increases in visits for the entire child cohort ages birth through 18 years, whereas the CHIP Annual Report tracks visits by age subgroup.
   (b) Participate with the state of Oklahoma to increase the immunization rates of all children, under 19 years of age, under 186% FPL, converted to the MAGI-equivalent percent of FPL and applicable disregards, by 2% within 5 years beginning ~~7/1/09~~ 10/01/18. The overall goal is to participate in statewide activities to increase general immunization rates. The state currently utilizes the Oklahoma State Department of Health's OSIS immunization registry for statewide immunization rates. These data are not specific to or sortable by Medicaid specific populations. However, the state acknowledges Medicaid covers 75 percent of children in the state and 50 percent of all births, and so improvements to statewide immunization rates are worthwhile for Medicaid to monitor.
   (c) Increase the number of SoonerCare pregnant women who sought prenatal care in the first trimester, by 2% within 5 years beginning ~~7/1/09~~10/01/18.
   (d) ~~Increase the percentage of Insure Oklahoma IP well child visits by age, by 2% within 5 years beginning 2/1/10.~~

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the State's performance, taking into account suggested performance indicators as specified below or other indicators the State develops: (Section 2107(a)(4)(A),(B)) (42 CFR 457.710(d))

The State utilizes a number of tools and/or measurement devices to monitor progress toward accomplishing the goals and objectives set forth herein. The State monitors:

- ~~the U.S. Census Bureau (for items related to estimates of coverage);~~
- ~~Current Population Survey (CPS) data, produced and published by the U.S. Census Bureau (for items related to estimates of Medicaid eligibility, numbers and/or~~

~~percentages of uninsured, age/gender demographics, etc.);~~

- ~~PCP alignment and selection rates, tabulated internally by the OHCA;~~

- ~~Medicaid enrollment data related to funding under both Title **XIX** and Title **XXI**, tracked by the Health Care Authority and reported to CMS on the quarterly CMS Form 64 and /or other appropriate reporting mechanism;~~
- ~~MMIS (Medicaid Management Information Systems) data;~~
- ~~OHCA published reports including but not limited to annual reports; strategic plans; service efforts and accomplishments; quality assurance; and fast facts reports;~~
- ~~Medicaid claims data related to services under both T**XIX** and T**XXI**; and~~
- ~~Oklahoma HEDIS data.~~

(1) the U.S. Census Bureau (for items related to estimates of coverage);
(2) American Community Survey (ACS) or Current Population Survey (CPS) data, produced and published by the U.S. Census Bureau (for items related to estimates of Medicaid eligibility, numbers and/or percentages of uninsured, age/gender demographics, etc.);
(3) PCP alignment and selection rates, tabulated internally by the OHCA;
(4) Medicaid enrollment data related to funding under both Title **XIX** and Title **XXI**, tracked by the Health Care Authority and reported to CMS on the quarterly CMS Form 64 and /or other appropriate reporting mechanism;
(5) MMIS (Medicaid Management Information Systems) data;
(6) OHCA published reports including but not limited to annual reports; strategic plans; service efforts and accomplishments; quality assurance; and fast facts reports;
(7) Medicaid claims data related to services under both T**XIX** and T**XXI**; and
(8) Oklahoma HEDIS data.

Check the applicable suggested performance measurements listed below that the State plans to use: (Section 2107(a)(4))

9.3.1. ☒ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
9.3.2. ☒ The reduction in the percentage of uninsured children.
9.3.3. ☒ The increase in the percentage of children with a usual source of care.
9.3.4. ☒ The extent to which outcome measures show progress on one or more of the health problems identified by the state.
9.3.5. ☒ HEDIS Measurement Set relevant to children and adolescents younger than 19.
9.3.6. ~~☒~~ Other child appropriate measurement set. List or describe the set used.

9.3.7. ☐ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
9.3.7.1. ☐ Immunizations
9.3.7.2. ☐ Well childcare
9.3.7.3. ☐ Adolescent well visits

9.3.7.4. ☐ Satisfaction with care
9.3.7.5. ☐ Mental health
9.3.7.6. ☐ Dental care
9.3.7.7. ☐ Other, list:

9.3.8. ☐ Performance measures for special targeted populations.

9.4. ☒ The State assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (42 CFR 457.720)

9.5. ☒ The State assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the State's plan for these annual assessments and reports. (Section 2107(b)(2)) (42 CFR 457.750)

The state will submit the required information for the annual reports and evaluation. It will rely on internal data, surveys of the covered population, national data sources (CPS, etc.) in order to monitor performance and make appropriate changes.

9.6. ☒ The State assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review or audit. (Section 2107(b)(3)) (42 CFR 457.720)

9.7. ☒ The State assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42 CFR 457.710(e))

9.8. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX: (Section 2107(e)) (42 CFR 457.135)

9.8.1. ☒ Section 1902(a)(4)(C) (relating to conflict of interest standards)
9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)
9.8.4. ☒ Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the State to accomplish involvement of the public in the design and implementation of the plan and the method for ensuring ongoing public involvement. (Section 2107(c)) (42 CFR 457.120(a) and (b))

~~In the expansion of a (traditional) Title XIX Medicaid Program, the State does not have a great deal of latitude wherein it can actively seek input from the public.~~ To the extent possible, the Health Care Authority will utilize assistance from other State Agencies, provider organizations, community groups, and others in the development and implementation of outreach programs associated with the expansion. In addition, should the State at some time consider targeting a children's group with special needs for

incorporation into a future Medicaid expansion designed to be funded under Title XXI, it will actively seek input from other (applicable) State Agencies, advocacy groups, and others throughout the process.

The OHCA seeks input on all state plan amendments from Tribal partners. The OHCA also posts the proposed state plan amendments on its public website for public review and feedback. In addition to the web public notice, the OHCA publishes a public notice of the proposed changes in statewide newspapers prior to the effective/implementation date of the state plan amendment request, when the change relates to eligibility and benefits in compliance with 42 CFR 457.65.

~~As it pertains to the Insure Oklahoma (IO) standalone CHIP program:~~

All OHCA programs, including Insure Oklahoma programs, have rules promulgated prior to their implementation. As modifications are made to the programs, rules are revised accordingly, and prior to implementing the change. ~~The cost sharing requirements for Insure Oklahoma are no exception and are included in the OHCA rules.~~ A Notice of Rulemaking Intent is published in the Oklahoma Register, allowing for at least 30 days of public comment. A public hearing is held at which time a summary of each rule to be considered is stated. There is an opportunity for public comment. All proposed rules must also be considered by the Medical Advisory Committee (MAC), comprised of membership representing a variety of areas from the provider community. If necessary, a rates and standards public hearing is also held giving opportunity for public comment. The OHCA Board of Directors meeting is held monthly, as a public meeting, where all proposed rules are considered. Attendees at the monthly Board meetings often include representatives of consumer organizations, as well as a variety of other stakeholders from across the spectrum of health and human services organizations.

~~Pertaining to the Unborn Child and IO (separate SCHIP) programs~~As applicable, the ~~state~~State, likewise, continues to utilize assistance from other state agencies, provider organizations, community groups, and others in the development of ~~this~~ new initiatives. Examples of such groups include the OHCA Board of Directors, Child Health Task Force, Perinatal Advisory Group, Medical Advisory Committee, Medical Advisory Team, and the Tribal Consultation Event, to name a few. The OHCA continues to actively seek input from other groups/individuals throughout the development and refinement process.

~~It is expected that upon federal approval of the IO program these same venues will be used to disseminate education and outreach materials. The educational and outreach material will highlight that the application / enrollment process will not differ from that currently used for SoonerCare, however the coverage will be more limited in scope than SoonerCare.~~

9.9.1. Describe the process used by the State to ensure interaction with Indian Tribes and organizations in the State on the development and implementation of the procedures required in 42 CFR 457.125. States should provide notice and consultation with Tribes on proposed pregnant women expansions. (Section 2107(c)) (42 CFR 457.120(c))

Please refer to Section 2.3-TC for the methodology that the State utilizes to engage Tribal partners regarding any proposed change to the State Plan.

~~Prior to the implementation of SB 639 on December 1, 1997, the Oklahoma Health Care Authority's public information office communicated with the Oklahoma Department of Human Services/TANF Section in order to secure a mechanism to provide relevant~~

~~information on the Medicaid expansion to tribal social services and/or members of the Oklahoma Native Nations Social Services Association (ONSSA). The OHCA developed a press release outlining the newly available services and provided it to the Department of Human Services. DHS, in turn, disseminated the release to representatives of the tribal social services as well as the ONSSA. In terms of the smaller tribes that do not have social services, DHS provided the press release directly to the Chiefs, directors and presidents of their respective tribes.~~

~~In addition to providing the press release to tribal social services located throughout the State, the OHCA secured a tribal mailing list from DHS for use in ongoing communication and dialogue related to Medicaid services. On January 28, 1998, OHCA staff met in Concho, Oklahoma with the Cheyenne and Arapaho tribes to detail the newly expanded health care services available under S.B. 639. The OHCA representatives provided a program overview — emphasizing the tribes' ability to seek healthcare services from any IHS, tribal or urban Indian clinic without a referral or prior authorization from their Sooner Care provider. In addition, the streamlined application was summarized and made available to interested parties. OHCA staff made it a priority to assist in the completion of applications and to provide additional information on eligibility. On April 21, 1998, in collaboration with the Health Care Financing Administration's Dallas Regional Office and the Shawnee Nation, the OHCA met with the representatives of the various American Indian tribes to discuss ways to facilitate the enrollment of American Indians. The OHCA considers it a priority to appropriately communicate the tribe's flexibility in accessing care through the Medicaid program as well as through their tribal, IHS and urban Indian clinics.~~

~~The Oklahoma Health Care Authority has 2 Indian Tribal liaisons who oversee the interaction between the agency, the Indian TribesTribal governments, Indian Health Services, tribal health programs, and tribal communities for state and national level issues including tribal consultation, policy development, legislation, and tribal sovereignty and the IHS. This includes any consultation regarding program development and policy issues. The agency also out stationed Department of Human Services eligibility workers at Tribal facilities who provide onsite eligibility determination. The agency participated in a pilot research program with CMS staff and Tribal community health representatives to do culturally sensitive outreach and education and enrollment.~~

~~The State fully comprehends that for the purposes of eligibility for Title XXI funds, children eligible to receive health care services from IHS or IHS grantees can be covered as targeted low- income children. The State is also fully committed to using SCHIP funds to meet the compelling health care needs of this vulnerable population. The State will make every effort to engage in meaningful consultation with federally recognized American Indian Tribes in order to ensure that the rights of these sovereign Tribal governments are fully respected.~~

~~American Indian and Alaska Native children are eligible for Soon-To-Be-Sooners (separate SCHIP) program on the same basis as any other unborn children in the State, regardless of whether or not they may be eligible for or served by Indian Health Services-funded care. OHCA has continued to keep the tribes updated about the plans for the~~

upcoming STBS program throughout its development. In June 2007, OHCA, in conjunction with tribal leaders across the state, held the first annual Tribal Consultation in Shawnee, Oklahoma. Discussed at this meeting were various programmatic changes to the Oklahoma Medicaid programs, the STBS program being just one. Likewise, in January 2008, an STBS program development update was presented to the Oklahoma City Area Inter-Tribal Health Board, in Oklahoma City. In recent months, bad weather caused the cancellation of a late fall meeting, so OHCA has rescheduled a meeting with all IHS Business Managers on January 23, 2008 at the IHS Area Office in Oklahoma City. An update on STBS is included on the meeting agenda, and time will be included to seek input and responses from all IHS, tribal and urban Indian health facilities. The update will be presented by staff of OHCA's Indian Health Unit and will include information about the status of the CMS review of the SCHIP State Plan Amendment in addition to any OHCA developments.

It is expected that upon federal approval of the STBS program these same venues will be used to disseminate education and outreach materials. The educational and outreach material will highlight that the application / enrollment process will not differ from that currently used for SoonerCare, however the coverage will be more limited in scope than SoonerCare.

As it pertains to the Insure Oklahoma (IO) standalone CHIP program:

American Indian and Alaska Native members are eligible for the IO program on the same basis as any other individual in the State, regardless of whether or not they may be eligible for or served by Indian Health Services-funded care. OHCA has continued to keep the tribes updated about the plans for the upcoming changes to the IO program, throughout its development and implementation. A few examples of the situations where tribes were updated and input sought include the recurring, annual Tribal Consultation held in Shawnee, OK; the quarterly Oklahoma City Area Inter-Tribal Health Board meetings held in Oklahoma City, OK; as well as the monthly Oklahoma Health Care Authority Board meetings (public events) held in various communities throughout the state. In addition, throughout the year ad hoc meetings are arranged between the OHCA's and tribal representative partners (including but not limited to IHS, tribal and urban Indian health facilities) to discuss programmatic topics of interest. A provider letter was directed to all IHS, tribal and urban Indian health facilities on April 16, 2009, to inform these leaders of this proposed new Insure Oklahoma coverage. Comments and questions were invited but none was received by the Indian Health Unit.

9.9.2. For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), describe how and when prior public notice was provided as required in 42 CFR 457.65(b) through (d).

As it pertains to the Insure Oklahoma (IO) standalone CHIP program:

All OHCA programs, including Insure Oklahoma programs, have rules promulgated prior to their implementation. As modifications are made to the programs, rules are revised accordingly, and prior to implementing the change. The cost sharing requirements for

~~Insure Oklahoma are no exception and are included in the OHCA rules. A Notice of Rulemaking Intent is published in the Oklahoma Register, allowing for at least 30 days of public comment. A public hearing is held at which time a summary of each rule to be considered is stated. There is an opportunity for public comment. All proposed rules must also be considered by the Medical Advisory Committee, comprised of membership representing a variety of areas from the provider community. If necessary, a rates and standards public hearing is also held giving opportunity for public comment. The OHCA Board of Directors meeting is held monthly, as a public meeting, where all proposed rules are considered. Attendees at the monthly Board meetings often include representatives of consumer organizations, as well as a variety of other stakeholders from across the spectrum of health and human services organizations.~~

N/A for OK SPA 18-0013; this proposed state plan amendment request is not related to eligibility or benefits.

9.9.3. Describe the State's interaction, consultation, and coordination with any Indian tribes and organizations in the State regarding implementation of the Express Lane eligibility option.

The State does not implement Express Lane Eligibility.

9.10. Provide a 1-year projected budget. A suggested financial form for the budget is below. The budget must describe: (Section 2107(d)) (42 CFR 457.140)

- Planned use of funds, including:
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.
  - Projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc.
  - All cost sharing, benefit, payment, eligibility need to be reflected in the budget.

- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees. (State Appropriation and Tobacco Settlement Funds)
- Include a separate budget line to indicate the cost of providing coverage to pregnant women. (See last page)
- States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children. (See last page)
- Include a separate budget line to indicate the cost of providing dental-only supplemental coverage. (See last page)
- Include a separate budget line to indicate the cost of implementing Express Lane Eligibility. (NA)
- Provide a 1-year projected budget for all targeted low-income children covered under

the state plan using the attached form. Additionally, provide the following:

- Total 1-year cost of adding prenatal coverage (See last page)
- Estimate of unborn children covered in year 1

CHIP Budget

STATE: OKLAHOMA	**FFY 2018 Budget**	**FFY 2019 Budget**
Federal Fiscal Year	**2018**	**2019**
State's enhanced FMAP rate	**94.00%**	**96.67%**
Benefit Costs		
Insurance payments		
Managed care	$199,617,079	$202,810,952
per member/per month rate		
Fee for Service	$25,071,420	$25,472,563
Total Benefit Costs	$224,688,499	$228,283,515
(Offsetting beneficiary cost sharing payments)		
Net Benefit Costs	**$224,688,499**	**$228,283,515**
Cost of Proposed SPA Changes – Benefit		
Administration Costs		
Personnel		
General administration	$10,160,210	$10,322,773
Contractors/Brokers		
Claims Processing		
Outreach/marketing costs		
Health Services Initiatives	$1,358,198	$3,552,165
Other		
Total Administration Costs	**$11,518,408**	**$13,874,938**
10% Administrative Cap	$24,965,389	$25,364,835
Cost of Proposed SPA Changes		$626,122
Federal Share	$222,034,492	$234,094,577
State Share	$14,172,414	$8,063,876
Total Costs of Approved CHIP Plan	**$236,206,907**	**$242,158,453**

Per member/per month rate	FFY'2019	
	# of eligibles	$ PMPM
Managed Care	143,720	$155
Fee for Service	10,624	$244

Other Budget Line items under Title XXI	FFY 19 TOTAL	Federal Share	State share
Yearly cost of providing coverage to pregnant women	**$15,216,376**	14,709,671	506,705
Yearly cost of providing dental Coverage	**$27,881,834**	26,953,369	928,465
Cost of providing coverage to premium assistance children	**$531,259**	513,568	17,691
Yearly cost of prenatal coverage (same as above cost to cover pregnant women -STBS)			
Estimate of unborn children covered in one year	**9,267**		

NOTE: Include the costs associated with the current SPA.

There are no budget costs associated with the current SPA proposal herein. This SPA requests to revise and update the current Title XXI State Plan's Strategic Objectives and Performance Goals. Additionally, Title XXI State Plan will be revised to update language to reflect current practices regarding tribal consultation & public notice processes, remove obsolete processes, and correct grammatical errors in order to comport with the new Title XXI State Plan template format.

The Source of State Share Funds: This SPA request does not have any associated costs; therefore, there are no associated state shares that are applicable.