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

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE 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 State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State 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: Michael Fogarty Position/Title: Chief Executive Officer
Name: Lynn Mitchell Position/Title: State Medicaid Director
Name: Carrie Evans Position/Title: Chief Financial Officer

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 0938-0707. The time required to complete this information collection is estimated to average 160 hours (or minutes) 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, please write to: CMS, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements **(Section 2101)**

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) **(42 CFR 457.70)**:

1.1.1 ☐ Obtaining coverage that meets the requirements for a separate child health program **(Section 2103)**; **OR**

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan **(Title XIX)**; **OR**

1.1.3. X A combination of both of the above.

Oklahoma does not intend to modify any part of its existing Medicaid expansion program, namely SoonerCare, which serves children in families earning up to and including 185 percent of the federal poverty level.

Oklahoma elects to create a standalone SCHIP program (namely Soon-To-Be-Sooners, acronym STBS) for which unborn children of families earning up to and including 185 percent of the federal poverty level. This program allows coverage of pregnancy related services under Title XXI for the benefit of unborn children enrolled through the STBS program through birth. Oklahoma does not intend to include the Insure Oklahoma premium assistance program as an option for members participating in the STBS program.

Oklahoma elects to create a standalone CHIP program (namely Insure Oklahoma, acronym IO) for children in families earning from 185 up to and including 300 percent of the federal poverty level, allowing select groups the ability to receive benefits through either the Premium Assistance Employer Sponsored Insurance (ESI) coverage or state-sponsored direct coverage via Premium Assistance Individual Plan (IP) coverage. ESI is a benefit plan providing premium assistance to qualified children in families employed by an Oklahoma business with access to a private-market, employer sponsored insurance plan. With ESI the cost of health insurance premiums is shared by the employer, the children's family and the Oklahoma Health Care Authority. The state assures that Title XXI funds are used only for the coverage of children. By nature of the enrollment methods established by private, group employer sponsored insurance plans, children participate in subsidized ESI plans as a dependent child on their parents/guardians employment-based private coverage. In areas of this SPA the reader finds mention of employee or family processes and procedures which correspond to their dependent children's private group coverage. The state assures this mention is included only for clarification/explanation of processes and procedures used to gain subsidized coverage for dependent children. IP is a health coverage option which offers comprehensive health services to qualified children in families who may be working for an Oklahoma business are not eligible for ESI, or who may be unemployed.

1.2 Please 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))**

Oklahoma provides 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.

1.3 Please 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. **(42CFR 457.130)**

Oklahoma provides 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.

1.4 Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment **(42 CFR 457.65)**:

Insure Oklahoma coverage for children:
Effective date: 01/01/10

Implementation date: 02/01/10

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

Implementation date: 07/01/09

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination **(Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))**

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). **(42 CFR 457.80(a))**

The State undertook a systematic survey of the available data and developed a methodology to estimate the number of potential new participants in the expansion, the number of current Medicaid eligibles who are not enrolled, the number of "uninsured" eligibles, and the total number of participants in the Medicaid expansion (see Attachment A). The primary data sources for the State's estimates were: the US Census Bureau's Current Population Survey (CPS), Calendar Years 1994-96; the FFY (Federal Fiscal Year) 1997 HCFA 2082 data for Oklahoma (through August 31, 1997); the Urban Institute's State–level Databook on Health Care Access and Financing, published in 1995 (1990-1993 data), which provides valuable information on health systems at the state level; and County-specific focus studies of general population estimates related to the factors of age, sex, and poverty, conducted by the Oklahoma Department of Commerce (1994). Due to the unavailability of reliable data, however, the State is unable to provide information on age breakouts, income brackets, race and ethnicity, and geographic locations. According, to the Oklahoma State Insurance Commissioner's Office, health insurance programs that involve a public-private partnership do not currently exist in the State.

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

The State, on a semi-annual basis, undertakes a systematic review and compilation of the available data and ascertains an estimate of the number of potential new uninsured participants in the IO program. The summary findings are available on a document entitled "Oklahoma Uninsured Fast Facts" located on the Oklahoma Health Care Authority website www.okhca.org. The primary data sources for the State's estimates were: U.S. Census, Current Population Survey 2007 data collected in 2008; Oklahoma Health Care Authority (OHCA) Annual Report SFY 2008, Unduplicated OHCA annual enrollment CY 2007; and U.S. Department of Health and Human Services Medical Expenditure Panel Survey (MEPS), 2006 state-level tables. (See Attachment A.1)

The State, on a monthly basis, undertakes a systematic review and compilation of the available data and ascertains the current number of members in the SoonerCare (i.e. public health coverage program) and IO (i.e. public-private partnerships) programs. The summary findings are available on documents entitled "SoonerCare Fast Facts" and "Insure Oklahoma Fast Facts" located on the OHCA website www.okhca.org. The primary data sources for the State's numbers were the Oklahoma Medicaid Management Information System, accessed monthly; and OHCA Annual Report SFY 2008. (See Attachments A.2, A.3 and A.4)

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: **(Section 2102)(a)(2) (42CFR 457.80(b))**

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e., Medicaid and state-only child health insurance):

Oklahoma did not have an outreach program designed to identify and enroll children who are eligible for, but not participating in Medicaid. Medicaid eligibility in the State was not de-linked from Cash Assistance eligibility until October, 1996 (subsequent to the passage of the Federal TANF legislation). The State did, however, fully commit to an extensive marketing and outreach campaign as a part of its Medicaid expansion under state Senate Bill (S.B.) 639, which became effective 12/01/97 (see Attachment B).

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

The State does not currently cover children through the IO program, therefore no efforts have been made to identify or enroll uncovered children in the IO program.

The State is currently taking the following steps to identify and enroll all uncovered children who are eligible to participate in the SoonerCare program (i.e. public health coverage program):

(1) Working the list of those members eligible for SoonerCare yet falling off the roles at recertification. Working the list means workers at both the OHCA and the Oklahoma Department of Human Services (OKDHS) receive a periodic list of names and contact information for those SoonerCare members who have lost eligibility. The workers make every attempt to contact the member and validate if they are no longer eligible. When members are found to be eligible yet without coverage, workers facilitate the recertification of the member's coverage;

(2) Working the list of those members eligible for SoonerCare yet falling off the roles due to failure to document their citizenship and/or identity. Working the list means workers at both the OHCA and the Oklahoma Department of Human Services (OKDHS) receive a periodic list of names and contact information for those SoonerCare members who have lost eligibility. The workers make every attempt to contact the members and inform them about suitable documentation to establish citizenship and identity. When members are found to be eligible yet without coverage, workers facilitate the recertification of the member's coverage;

(3) Working the list of those members newly born to SoonerCare eligible mothers. Working the list means workers at both the OHCA and the Oklahoma Department of Human Services (OKDHS) receive a periodic list of names and contact information for those SoonerCare members who have had a delivery. The workers make every attempt to contact the member and validate their newborn has gained SoonerCare coverage. When members are found to be eligible yet without coverage, workers

facilitate the certification of the member's coverage. Additionally, the OHCA utilizes an electronic newborn enrollment process at participating hospitals. This enrollment process allows the newly born to receive an eligibility determination , based on their mothers SoonerCare eligibility, and leave the hospital with a SoonerCare identification number alongside a SoonerCare Primary Care Provider (PCP) selection, encouraging timely pediatric follow-up as necessary for newborns. The newborn's eligibility determination is made pursuant to Section 1902 (e)(4) of the Act and 42 CFR 435.117 in the manner as Medicaid newborns are deemed eligible for the program by nature of their mother's Medicaid eligible status;

(4) Outbound calls to uninsured members as identified through the State's uninsured survey. As part of the State's 2008 uninsured survey (conducted by the University of Minnesota's State Health Access Data Assistance Center) a question was asked of all uninsured respondents if they were willing to receive follow-up communication regarding their uninsured status. Respondents who indicated their willingness to participate in follow-up communications were identified. Follow-up communication is being made via telephone to facilitate the respondent's linkage to or enrollment in coverage.;

(5) Partnerships with other state and community organizations to coordinate and grow outreach efforts; and

(6) Ongoing OHCA workgroup efforts to identify and utilize new outreach avenues and methods targeting uninsured members; and

(7) A letter mailed approximately Nov. 19, 2009 to targeted Insure Oklahoma enrollees informing them of the option to enroll their children in the SoonerCare program.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

According, to the State's Insurance Commissioner's Office, children's health insurance programs that involve a public-private partnership do not currently exist in the State.

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

The State does not currently cover children through the IO program (i.e. public-private partnership), therefore no efforts have been made to identify or enroll uncovered children within the select groups in the IO program.

2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. *(Previously 4.4.5.)* **(Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))**

Oklahoma adopted a simplified common Medicaid/SCHIP enrollment application which is available at a wide variety of locations such as the Department of Human Services County offices, the Oklahoma State Department of Health County offices, WIC offices, and public libraries. However, for those applicants needing additional assistance in deciding which Sooner Care program they may be eligible for (Sooner Care Plus/Choice), or for those applicants needing additional assistance in choosing a health plan or provider, there are more detailed enrollment packets available at the county DHS offices. However, applicants do not have to visit the county DHS offices to obtain an enrollment packet-- they can call a toll-free telephone number for additional assistance in enrolling, or request enrollment packets through the mail. The state will continue to outstation eligibility workers at non DHS sites in order to improve access and coordinate efforts of all entities that serve the targeted populations in order to enroll eligible targeted low income children in the SCHIP Medicaid program. The state also explored the effectiveness of expanding the sites for enrolling children in a wider variety of community settings. All of these measures are aimed a significantly reducing barriers to enrollment in Sooner Care. Transportation costs are reduced, the stigma of going to a social services office is removed, parents do not have to miss work and local community groups can assist in distributing applications and information regarding Medicaid and SCHIP.

The State is making every effort to ensure that all entities that serve the targeted populations coordinate their efforts to enroll eligible targeted low income children in the CHIP Medicaid program. The D.H.S. County offices and the Oklahoma State Department of Health County offices will be working in close cooperation with school districts and sending out applications for enrollment in the SCHIP Medicaid program.

The State Health Department will engage in active outreach including assisting applicants in completion of the enrollment application with special emphasis on making an active choice of health plan and a primary care provider. The OHCA also conducts conferences and workshops with entities that serve the targeted populations including representatives from the Department of Human Services Head Start, Community Action Programs, and local youth service organizations and Indian Tribes. In conclusion, while the State will make every attempt to coordinate efforts to ensure that children identified as Medicaid eligible will be promptly enrolled in Medicaid, the eligibility process is designed to incorporate investigation of creditable health coverage in order to ensure that only eligible targeted low income children are covered under SCHIP.

The State has also undertaken several strategies aimed at identifying applicants with current health insurance and monitoring the substitution of SCHIP Coverage for private health insurance coverage.

1) Any child who applies for Sooner Care is first screened for Medicaid eligibility. If the child is found eligible for Medicaid under the standards in effect on March 31, 1997, he/she will be promptly enrolled in the Medicaid program. Under no circumstances will the enhanced FMAP available under SCHIP be claimed for a child who is found eligible for Medicaid under the standards in effect on March 31, 1997.

2) Any child who applies for Sooner Care is also screened for current insurance coverage. If the

child has current insurance coverage, he/she will be enrolled in Sooner Care, and the State will claim FFP at the regular Medicaid rate. Under no circumstances will the enhanced FMAP available under SCHIP be claimed for a child who has current insurance coverage.

3) In order to access the enhanced FMAP available under SCHIP, systems modifications have been implemented which will ensure that eligible targeted children under Title XXI will be separately identified and reported.

Background: Prior to the enactment of the new Children's Health Insurance Program (CHIP) under the Balanced Budget Act of 1997, the Oklahoma Legislature recognized the need to establish a coordinated approach to delivering quality health care services to under-served/uninsured populations (specifically children and pregnant females). Accordingly S.B. 639 was enacted during the State's 1997 Legislative Session. This Bill expanded Medicaid eligibility through the State's successful Medicaid managed care program, **Sooner Care**[1], originally implemented through the State's §1915(b) Program Waiver, subsequently expanded under the State's §1115(a) Research and Demonstration (R & D) Waiver (refer to section 5.1 Outreach and Coordination, for an overview of the §1115(a) R&D Waiver).

S.B. 639 required the Oklahoma Health Care Authority (OHCA) to expand Medicaid eligibility for pregnant females and for children born on or after October 1, 1983, to include those persons with annual incomes up to one-hundred-eighty-five (185%) percent of the Federal Poverty Level (FPL). This expansion became effective December 1, 1997. The bill further directed the OHCA to include in this expansion those children born prior to October 1, 1983, who have not yet reached their eighteenth (18th) birthday, and who are due to be phased-into Oklahoma's Medicaid Program according to existing Federal requirements. Under these requirements, such children would be phased-into Medicaid, one age group each year- starting with the youngest age group – to include children with (family) incomes up to one-hundred (100%) percent of FPL [increased from forty-seven and 74/100 (47.74%) percent of FPL], beginning October 1, 1998. S.B. 639 increases eligibility for these groups as they are phased-in, from one-hundred (100%) percent of FPL to one-hundred-eighty-five (185%) of FPL. On November 1, 1998, Oklahoma accelerated the enrollment of children born prior to October 1, 1983 who have not yet reached their eighteenth birthday (who otherwise would have been phased into the Medicaid program on October 1, 1999 and October 1, 2000 respectively, according to existing Federal requirements).

On September 1, 2001, for children described in 1902(a)(10)(A)(i)(VII), 85% of the Federal Poverty Level as revised annually in the Federal Register, by family size, will be disregarded from income in Oklahoma (for the purposes of determining Medicaid eligibility). Oklahoma will claim Title XXI enhanced funds for all these above mentioned low income uninsured children who did not have Medicaid eligibility on March 31, 1997.

Oklahoma's compliance SPA was approved on February 24, 2003 as a technical SPA only.

Beginning in October 2005, children eligible through the TEFRA (Tax Equity and Fiscal Responsibility Act) program began enrolling. This option allowed Oklahoma to make

SoonerCare benefits available to children under age 10 with physical or mental disabilities who would not ordinarily be eligible for Supplemental Security Income (SSI) benefits because of their parents' income or resources. No amendment was needed.

Oklahoma plans no separate enrollment in its Title XXI State Children's Health Insurance Program (SCHIP) which would be separate and distinct from its Medicaid expansion under S.B. 639. Rather, Oklahoma's Medicaid eligibility and enrollment processes are designed to identify existing "creditable" health coverage and/or other factors which limit the applicability of Title XXI funding, thereby ensuring that Title XXI funds will be used to provide coverage only to eligible, targeted, low-income children.

In order to implement the "outreach" provisions required to support S.B. 639, the OHCA, the Oklahoma Department of Human Services (DHS), the Oklahoma State Department of Health (OSDH), and the Oklahoma Commission on Children and Youth (OCCY) are collaborating to develop and implement a comprehensive marketing and outreach program, including: posters, postcards, public service announcements, fact sheets, press releases, and outdoor advertising.

The State did not rely exclusively on increasing income eligibility thresholds to improve access to health care. In addition to massive outreach campaigns designed to maximize the opportunity for people to apply for Medicaid, the State has also worked to minimize administrative barriers that make it difficult for people to access the Program. The State used multiple strategies to simplify and streamline the application process. Steps to remove administrative barriers include simplification of the Medicaid enrollment application and elimination of the asset test.

In state fiscal year 2006, OHCA paid more than $8.5 million for 2,778 babies who were delivered to undocumented moms without any prenatal care. In an effort to improve the outcomes of these "Soon-To-Be-Sooners" babies at birth, the state has been exploring the provision of coverage limited to the prenatal care needed to appropriately provide for the best possible outcome for the newborn. The state has been engaged in discussion with CMS surrounding Oklahoma's development of an Unborn Child program since 2005. Discussion began following regulation published in 2002 by then Secretary of Health and Human Services (HHS) Tommy G. Thompson. Oklahoma currently operates as an SCHIP expansion state and has been doing so since 1997. Federal approval of Oklahoma's first standalone SCHIP program for Unborn Children will change our operation to that of a combination state. However, Oklahoma will continue to operate the SCHIP expansion program in its current manner, adding the standalone SCHIP option specifically for the Unborn Child program using the existing infrastructure.

Simplified Medicaid Enrollment Application:

In an effort to increase participation in the Program, a simplified Medicaid enrollment application (see attachment C) was developed for the Aid to Families with Dependent Children[2] (AFDC) and AFDC-related applicants. As a result of the coordinated efforts between representatives of the OHCA, the DHS, and the OSDH the original sixteen (16) page application was greatly simplified to a new one page, two-sided form. Included in this new applications are an array of health

related questions designed to assist the primary care physician's assessment of the patients' health care needs it also provided for the actual enrollment into the SoonerCare program. Simplified Medicaid enrollment application readily available at a wide variety of locations such as the DHS county offices, the OSHD county offices, WIC offices and public libraries. A toll-free telephone number is available to provide additional information. In order to reach the Hispanic community, outreach efforts have been suitably modified to more effectively reach this population.

[1]The **SoonerCare** population is defined as the group of Medicaid eligible beneficiaries enrolled into managed care based upon a categorical relationship to the Medicaid program. The State's Medicaid populations will be enrolled into managed care under a multi-year phase-in schedule. The initial enrollment category was the State's Aid to Families with Dependent Children (AFDC) and AFDC-related populations. In phase two, the State intends to enroll the non-institutionalized portion of its Aged, Blind, and Disabled populations. During other phases, the longterm care populations and individuals with chronic mental illnesses will be enrolled into managed care. New population groups of eligibles, resulting from Federal or State mandated categories of eligibles, may be enrolled into managed care during the phase-in schedule.

Also, in order to further simplify the eligibility process and improve access to and participation in the Medicaid Program, face-to-face interviews have been eliminated from the applications process. Local community involvement continues to be actively encouraged at all levels in order to ensure high levels of participation in the expansion

Elimination of The Asset Test- AFDC and AFDC-related:

In order to further improve access for AFDC and AFDC-related recipients, the State amended its Title XIX State Plan (Attachment D) by eliminating the asset test for low-income families and dependent children. The effective date for elimination of this test was December 1, 1997.

The decision to eliminate the asset test not only removed the historical barriers which had prohibited certain children and pregnant females from receiving necessary medical care services, it also proved to be a cost-effective. In comparing the costs which would have been incurred by allowing those individuals to participate in Medicaid whose family "assets" would have otherwise disqualified them from eligibility against the costs the State incurred in "testing" for excess assets, the State estimated that it would save approximately $2,204,000 annually by eliminating the test. The $3,500,000 in annual administrative costs associated with testing for asset would be reduced to $1,296,000 in costs associated with providing Medicaid coverage to pregnant females and children whose assets exceeded the asset limits. The State will use the dollars saved to cover the increased costs of additional applications associated with a larger number of enrollees anticipated due to the expansion.

The State anticipates that its outreach efforts will result in increased participation of current Medicaid eligibles who are not enrolled, as well as a high rate of participation of new eligibles (the "uninsured" as well as those with some form of existing creditable insurance coverage). Individuals who are determined to be currently eligible for Medicaid will be promptly enrolled in the Program. In order to access enhanced funding (available only for eligible targeted low-income children under Title XXI), systems modifications are being implemented (effective as of 12/01/97) which will ensure that eligible targeted low-income children under Title XXI will be separately identified and reported.

[2]"Aid to Families with Dependent Children" is defined as the group of low income families with children, described in Section 1931 of the Social Security Act, who would have qualified for or were receiving financial assistance (AFDC) on July 16, 1996. The Personal Responsibility and Work Opportunity Act of 1996 established a new eligibility group of low income families with children (TANF) and linked that program's eligibility requirements for income/resource eligibility standards and methodologies, and deprivation requirements to the State's plan for AFDC in effect on July 16, 1996. For Medicaid purposes, the AFDC eligibility criteria in effect on July 16, 1996 continues to be the Medicaid eligibility criteria, except Oklahoma has chosen to be less restrictive on its Medicaid, AFDC and AFDC-relate eligibility criteria than the criteria in effect on July 16, 1996.

As a part of the "new" enrollment process, Oklahoma will identify the following:

1. children eligible for (but not necessarily participating in) State employee insurance coverage with incomes at or below 185% of FPL and above the Medicaid AFDC and AFDC-related income levels previously in effect;

2. children eligible for participation in Medicaid under the "old" income levels (those in effect as of 04/15/97 and still in effect as of 11/30/97);

3. children presently covered by "creditable" health insurance coverage;

4. children whose family income is above the old income levels but at or below 185% of FPL (and for whom No. 1 and 3. do not apply); and

5. children whose (family) incomes are between 186% and 200% of FPL, making them ineligible for participation at the present time BUT making them possibly eligible if Oklahoma chose to expand XIX/XX1 to include annual incomes up to 200% FPL.

Federal Financial Participation (FFP) for Medicaid expenditures related to children identified above under Nos. 1., 2., and 3. will be claimed at the regular Title XIX rate, NOT the enhanced Title XXI rate.

FFP for Medicaid expenditures related to children identified above under No. 4. qualify for and will be claimed at the higher Title XXI rate. These expenditures **will** be clearly delineated on the HCFA-64.

"Crowd-Out"

Oklahoma recognizes the potential for "crowd-out"- the substitution of SCHIP coverage for private health insurance coverage. The State will implement several initiatives aimed at identifying instances which could be construed as being "crowd-out". In the short run, the State will develop and implement a statistically-valid survey instrument which it will utilize to survey certain Medicaid beneficiaries in order to determine whether or not they **voluntarily** dropped existing health private health insurance due to the availability of publicly-funded SCHIP coverage. Those beneficiaries the State will survey include children who: (1) have enrolled on-or-after December 1, 1997; (2) were determined to be eligible at the State's new (higher) income eligibility standard; and (3) had no Third Party Liability (TPL) indicator on their (Medicaid) Application. This process will enable the State to assess the existence and or scope of "crowd-out"

In the long-run, the state intends to modify its "Simplified" Medicaid Application Form in order to be able to collect and analyze data specific to any "previous health insurance coverage" which the title XXI beneficiaries may have had prior to their application for Oklahoma Medicaid.

By implementing these steps (the initial survey, followed by an appropriate modification of its Medicaid Application Form), Oklahoma is taking steps it believes are necessary to monitor "crowd-out". If the State determines that the level of "crowd-out" is problematic, it will work in consultation with the Health Care Financing Administration (HCFA) in order to resolve the issue.

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

The IO program allows children in families earning from 185 up to and including 300 percent of the Federal Poverty Level the ability to receive benefits through either the Premium Assistance Employer Sponsored Insurance (ESI) or the Premium Assistance Individual Plan (IP).

IO IP is a health coverage option which offers comprehensive health services to qualified children in families who may either: (1) be working for an Oklahoma business are not eligible for ESI; or (2) be unemployed. The IP program is a state-operated health plan (otherwise referred to as “safety-net” coverage) for those without access to coverage via SoonerCare or ESI, for which members pay a monthly premium. The maximum amount of all cost sharing (co-pays and premiums) cannot exceed five percent of the child’s family’s total income. The benefits available through the IP program largely mirror SoonerCare benefits with some limitations. (See Attachment B.1) Enrollment in the IP program takes place via the Medicaid Management Information System (MMIS), and all children are screened for SoonerCare coverage. If a child is found to be eligible for SoonerCare they may not receive coverage through the IO program. Likewise, if a child is found to be eligible for the ESI program and receiving coverage through a private health plan, the child may not receive coverage through the IP program. Due to this eligibility rule, the coordination of the standalone CHIP program with other public health coverage programs, namely SoonerCare, is always a precursor to the member receiving coverage through the IO program. Coordination with other relevant child health programs (such as those offered through the Oklahoma State Department of Health) occurs as members receive services in a variety of settings, rendered service data are shared among the OHCA and its partners, reports are generated indicating those members who have received appropriate and timely services (i.e. immunizations, child health check up’s, etc), and results are shared periodically with partners. IP covered services for children are provided, arranged and paid for by the state-sponsored direct coverage plan. The state contracts with IP providers directly. The IP Providers receive the Medicaid fee-schedule for allowable rendered services. In our 2010 through 2012 extension request, the state has asked for a change in the primary care delivery system, moving from a flat $3 per member per month care coordination fee, to that of a tiered care coordination fee schedule for those PCP’s that serve as the medical home for children. The state has a dedicated funding source, established through the tobacco tax revenues, to fund the inclusion of children in families earning from 185 up to and including 300 percent of the Federal Poverty Level within Insure Oklahoma.

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 4.

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. **(Section 2102)(a)(4) (42CFR 457.490(a))**

The methods of delivery within the Soon-To-Be-Sooners (separate SCHIP) program will be the same as under Title XIX.

The State assures that the delivery of the child health assistance, i.e. Soon-To-Be-Sooners (STBS) separate SCHIP program, using Title XXI funds will be through selecting State contracted Medicaid providers who gives prenatal care and delivers babies, located in various communities throughout Oklahoma. In both rural and urban areas, services are delivered through Medicaid contracted fee-for-service providers. All STBS members may choose their Medicaid contracted provider. In the event assistance is required to locate a Medicaid contracted provider, a toll free helpline is available. Helpline staff will assist with finding a Medicaid contracted provider in the member's area. Additionally, care management staff are also available via a toll free telephone line to assist with complex health needs. Bilingual staff are available at the SoonerCare HelpLine in Member Services and in Care management.

The combination of Medicaid contracted physicians, hospitals and ancillary service providers deliver medically necessary services described in Section 6.2. The State assures a sufficient number of Medicaid providers are contracted to serve the STBS members. In addition, contracts are offered to Federally Qualified Health Centers (FQHC), Rural Health Centers (RHC), public hospitals and the University of Oklahoma and Oklahoma State University teaching hospitals.

Contracted Medicaid providers are reimbursed in accordance with the Medicaid fee-for-service rate schedule. Payment for STBS covered services is made in one of two ways:
(1) Per Service. Postnatal care is not paid under Title XXI.
(2) Bundled. Postnatal care is included in the bundled payment as defined by the Current Procedural Terminology (CPT) manual.

A Soon-To-Be-Sooners / SoonerCare application for unborn children consists of the Health Benefits application. The application form is signed by the parent, spouse, guardian, or someone else acting on the individual's behalf. An individual does not have to have received a medical service nor expect to receive one to be certified for Health Benefits.

An application may be made in a variety of locations, for example, a physician's office, a hospital or other medical facility, Health Department, or in the county OKDHS office. A face to face interview is not required. Applications may be mailed or faxed to the local county OKDHS office. When an individual indicates a need for health benefits, the physician or facility may forward an application to the OKDHS county office of the patient's residence for processing. Receipt of the Health Benefits application form constitutes an application for the Soon-To-Be-Sooners / SoonerCare program.

The form Notification of Needed Medical Services may be submitted by the physician or facility as notification for a need for medical service. The form also may be accepted as medical verification of the unborn child(ren).

For unborn children, the countable income must be less than the appropriate standard according to the family size, which is 185 percent of the Federal Poverty Level (after exclusions, deductions and disregards). In determining the household size, the unborn child(ren) are included.

When eligibility for the Soon-To-Be-Sooners program is established, the OKDHS county office updates the computer form and the appropriate notice is computer generated to the client and provider. Likewise if denied or closed by the OKDHS county office at any time during the certification period, the case becomes ineligible, and a computer-generated notice is sent to the member and the provider.

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

IP - The State assures that the delivery of the child health assistance, i.e. IP, separate CHIP program, using Title XXI funds is through selecting State contracted IP providers located in various communities throughout Oklahoma. The IP benefit package includes well baby/child exams. These exams include, but are not limited to, age appropriate immunizations as required by State law. In both rural and urban areas, services are delivered through IP contracted fee-for-service providers. All IP members are required to choose their IP contracted primary care provider at the time of application. The PCP is responsible for furnishing primary and preventive services and making medically necessary referrals. In the event assistance is required to locate an IP contracted provider, a toll free helpline is available. Helpline staff assist with finding an appropriate IP contracted provider in the member's geographical area. Information regarding the health care delivery system of IP is shared through brochures, online information accompanying the application, the member handbook, and member services staff via a toll free phone number. IO member services staff are available to provide program orientation and education at any point in the enrollment process and subsequent enrollment period.

The State assures a sufficient number of IP providers are contracted to serve the IP members. In addition, contracts are offered to Federally Qualified Health Centers (FQHC), Rural Health Centers (RHC), public hospitals and the University of Oklahoma and Oklahoma State University teaching hospitals. An IP provider services representative is dedicated to assisting IP network providers.

Contracted IP providers are reimbursed in accordance with the Medicaid fee-for-service rate schedule. The state utilizes a primary care case management system and an additional case management fee paid to IP primary care providers applies. Currently the per-member-per-month funding arrangement includes a monthly case management payment of $3. This payment is for the care coordination of members participating in the IP direct coverage plan. IP providers may collect and retain the approved co-pays, in addition to the fee schedule reimbursement. In our 2010 through 2012 extension request, the state has asked for a change in the primary care delivery system, moving from a flat $3 per member per month care coordination fee, to that of a tiered care coordination fee schedule for those PCP's serving as children's medical home.

In an effort designed to increase PCP accountability, improve access to and continuity of care, reduce fragmented and uncoordinated care, and enhance quality outcomes, the Insure Oklahoma IP program utilizes a patient-centered medical home (PCMH) model utilizing a tier based PCP classification system and payment reform, inclusive of provider incentives. The impetus for this model was generated from the recommendations of the professional membership of the OHCA's Medical Advisory Task Force (MATF).

The Joint Principles of the Patient Centered Medical Home as presented in February 2007 by the American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), and American Osteopathic Association (AOA) are:

- ***Personal physician*** - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

- ***Physician directed medical practice*** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

- ***Whole person orientation*** – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

- ***Care is coordinated and/or integrated*** across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

- ***Quality and safety*** are hallmarks of the medical home.

- ***Enhanced access*** to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

- ***Payment*** appropriately recognizes the added value provided to patients who have a patient-centered medical home.

The patient-centered medical home model utilized by the Insure Oklahoma IP program addresses reimbursement in three components:

1. A monthly care coordination fee that is determined by the provider's self-selection of services available at the medical home
2. Visit-based services are paid fee-for-service at the Medicare allowable
3. A performance based payment to recognize provider excellence and measurable improvement.

Contracted PCPs are responsible for providing or otherwise assuring the provision of medically necessary primary care and case management services and for making specialty care referrals[1]. PCPs are also responsible for providing telephone coverage for their members; this coverage is augmented by an OHCA-contracted Patient Advice Line staffed by registered nurses who utilize nationally established protocols in assisting callers. The Patient Advice Line is available to all members.

The patient-centered medical home concept, including tiered care coordination payments and provider incentive programs known as SoonerExcel, applies to the Insure Oklahoma network. PCPs will receive monthly care coordination fees that vary depending upon whether the practice accepts children, children and adults, or adults. The care coordination fees are determined by the level of medical home expertise offered in the PCP's office. Three tiers have been established – the Entry Level, Advanced and Optimal Medical Homes. A contracted PCP will have to meet certain requirements to qualify for payments in each tier. Care coordination payments will be capitated – paid monthly to the PCP on a per member per month (PMPM) basis according to the enrollment on the day these payments are generated. These PCP providers are responsible for serving as the "medical home" for enrolled members. The patient-centered medical home model ensures that members get the right care at the right time from the right provider.

PCPs must belong to one of the provider types listed in Table II-3 below.

Table II-3: PCP Provider Types

Provider	Required Qualifications
Primary Care Physician	Must be board-certified or –eligible in family medicine,

1 Members may self-refer to the following services: behavioral health, vision, dental, child abuse/sexual abuse examinations, prenatal/obstetrical services and supplies, family planning services and supplies, women's routine and preventive health care services, emergency services and specialty care for members with special health care needs, as defined by OHCA.

	general internal medicine or general pediatrics; engaged in general practice; or meet all Federal employment requirements, be employed by the Federal government and practice primary care in an IHS facility
Specialist Physician	At discretion of OHCA CMO, based on consideration of percentage of primary care services delivered in physician's practice, the availability of primary care physicians in the geographic area, the extent to which the physician has historically served Medicaid and his/her medical education and training
Advanced Practice Nurse	Must be licensed by the state in which s/he practices and have prescriptive authority; or meet all Federal employment requirements, be employed by the Federal government and practice in an IHS facility
Physician's Assistant	Must be licensed by the state in which s/he practices; or meet all Federal employment requirements, be employed by the Federal government and practice primary care in an IHS facility
Medical Resident	Must be at least at the Post Graduate 2 level and may serve as a PCP only within his/her continuity clinic setting. Must work under the supervision of a licensed attending physician
Health Department Clinics	Members would be served by one of 68 county health departments or the two independent city-county health departments in Oklahoma City and Tulsa.

In the patient-centered medical home structure the monthly care coordination payments to Insure Oklahoma IP PCPs are as follows:

CARE COORDINATION FEES

Per Member Per Month	**Tier 1**	**Tier 2**	**Tier 3**
Children Only*	$3.03	$4.65	$6.19
Children & Adults*	$3.78	$5.64	$7.50
Adults Only*	$4.47	$6.53	$8.69

***Note:** Each provider designates acceptance of children only, children and adults, or adults only on their panel. Based on that designation, the provider is paid the corresponding rate for ALL members assigned to the panel, regardless of their age.

The requirements for each tier are as follows:

Tier One - Entry Level Medical Home (current contract requirements will apply)

Mandatory Requirements

1.1 Provides or coordinates all medically necessary primary and preventive services.

1.2 Participates in the Vaccines for Children (VFC) program if serving children, and must meet

all Oklahoma State Immunization Information System (OSIIS) reporting requirements.

1.3 Organizes clinical data in a paper or electronic format as a patient-specific charting system for individual patients.

1.4 Reviews all medications a patient is taking including prescriptions and maintains the patient's medication list in the chart.

1.5 Maintains a system to track tests and provide follow-up on test results, uses a tickler system to remind / notify.

1.6 Maintains a system to track referrals including referral plan and patient report on self referrals, uses a tickler system to remind / notify.

1.7 Provides Care Coordination & Continuity of Care as defined in the current SoonerCare contract and supports family participation in coordinating care. Provides various administrative functions including but not limited to securing referrals for specialty care, and prior authorizations.

1.8 Provides patient education and support, such as patient information handouts, which can be found on the OHCA website.

Add-On Payments

1.9 Coordinates care for children in state custody who are voluntarily enrolled in SoonerCare Choice.

1.10 Accepts electronic communication from OHCA.

1.11 Provides 24/7 Voice to Voice telephone coverage with immediate availability of an on-call medical professional. The OHCA Patient Advice Line (PAL) does not meet this requirement.

Tier Two – Advanced Medical Home

Mandatory Requirements

Tier One Mandatory Requirements plus:

2.1 Obtains mutual agreement on role of medical home between provider and patient.

2.2 Accepts electronic communication from OHCA.

2.3 Provides 24/7 Voice to Voice telephone coverage with immediate availability of an on-call medical professional. The OHCA Patient Advice Line (PAL) does not meet this requirement.

2.4 Makes after hours care available to patients. PCP's must be available to see patients (having established appointment times) during a total of at least 30 hours per week. Of those 30 hours, at least 4 hours must be outside 8am to 5pm, Monday through Friday.

2.5 Uses scheduling processes including open scheduling, work-ins, etc. to promote continuity with clinicians.

2.6 Uses mental health and substance abuse screening and referral procedures.

2.7 Uses data received from OHCA to identify and track medical home patients both inside and outside of the PCP practice

2.8 Coordinates care and follow-up for patients who receive care in inpatient and outpatient facilities, as well as when the patient receives care outside of the PCP's office.

2.9 Implements processes to promote access and communication.

Optional (provider must select two additional components)

2.10 Develops a PCP led practice health care team to provide ongoing support, oversight and

guidance.

2.11 Provides after-visit follow up for the medical home patient.

2.12 Adopts specific evidence-based clinical practice guidelines on preventive and chronic care as defined by the appropriate specialty category, i.e. AAP, AAFP, etc.

2.13 Uses medication reconciliation to avoid interactions or duplications.

2.14 The PCP serves children in state custody who are voluntarily enrolled in SoonerCare Choice as their medical home provider.

2.15 Uses personalized screening, brief intervention and referral to treatment (SBIRT) procedures designed to assess an individual's behavioral health status.

2.16 Participates in Practice Facilitation, uses Health Assessment or documents self management plans as described in tier three.

Tier Three – Optimal Medical Home

Mandatory Requirements

Tier One and Tier Two Mandatory and Optional Requirements plus:

3.1 Organizes and trains staff in roles for care management, creates and maintains a prepared and proactive care team, provides timely call back to patients, adheres to evidence-based clinical practice guidelines on preventive and chronic care.

3.2 Uses health assessment to characterize patient needs and risks.

3.3 Documents patient self-management plan for those with chronic disease.

3.4 Develops a PCP led practice health care team to provide ongoing support, oversight and guidance.

3.5 Provides after-visit follow up for the medical home patient.

3.6 Adopts specific evidence-based clinical practice guidelines on preventive and chronic care as defined by the appropriate specialty category, i.e. AAP, AAFP, etc.

3.7 Uses medication reconciliation to avoid interactions or duplications.

3.8 The PCP serves children in state custody who are voluntarily enrolled in SoonerCare Choice as their medical home provider.

3.9 Uses personalized screening, brief intervention and referral to treatment (SBIRT) procedures designed to assess an individual's behavioral health status.

Optional

3.10 Uses integrated care plan to plan and guide patient care.

3.11 Use of secure systems that provide for patient access for personal health information.

3.12 Reports to OHCA on PCP performance.

3.13 Accepting and engaging a practice facilitator through the SoonerCare Health Management Program.

The link describing the patient-centered medical home model as well as health access networks is as follows: http://www.ohca.state.ok.us/providers.aspx?id=8470&menu=74&parts=8482_10165

A Payment for Excellence program (namely SoonerExcel) has been developed to recognize provider performance. PCPs are eligible for SoonerExcel payments that are made quarterly to recognize

excellence in performance measures. The SoonerExcel payments include the following: 4th DTaP, Breast Cancer, Cervical Cancer, Emergency Department Utilization, EPSDT, Generic Prescription Rate and Physician Inpatient Admitting Visits. The agency furnishes provider profiles in ER use, child health screens, breast and cervical cancer screenings, reports on care of hospitalized members, and generic prescribing. These profiles form the basis for measuring provider performance and awarding financial rewards for excellence. Providers in the lowest quartile on profiles are not eligible for excellence payments.

The Insure Oklahoma IP program has broadened the impact of its PCMH model by the addition of Health Access Networks (HANs) with core components of care management/care coordination, electronic health records, improved access to specialty care, telemedicine and expanded quality improvement strategies. As expressed by members of the OHCA's MATF, the network serves to enhance the capabilities of PCPs, not only with high volume practices, but those with limited access to resources due to location in rural Oklahoma, to fully manage and coordinate care, especially of complex members. The time, human and technology resources and knowledge of social and community supports are usually not available in small PCP offices. As the networks become operational, health and care management initiatives are implemented providing targeted or individualized education and care coordination, implementation of best practice guidelines and evaluation and monitoring of results.

The state has a dedicated funding source, established through the tobacco tax revenues, to fund the inclusion of children in families earning from 185 up to and including 300 percent of the Federal Poverty Level within Insure Oklahoma.

The state, as a requirement of CHIPRA, provides dental services to children who qualify for either ESI or IP. Dental coverage is provided in one of two ways:

(1) Private dental coverage subsidies, namely Dental-ESI. Dental coverage is obtained through private group plans offered by the employer's ESI. Dental-ESI benefits must meet or exceed the covered benefits that are provided by the direct dental coverage, namely Dental-IP. Dental-ESI plans which do not meet minimum requirements are not qualified for participation in the program. The existing cost sharing requirements for ESI qualified children apply. Children obtaining medical coverage through ESI may choose to receive either Dental-ESI coverage (if available to them) or Dental-IP coverage.
(2) Direct dental coverage, namely Dental-IP. Dental coverage is obtained through direct purchase from the state. The existing cost sharing requirements for IP qualified children apply. Children obtaining medical coverage through IP receive Dental-IP coverage. The state contracts with Dental-IP providers directly. The Dental-IP providers receive the Medicaid fee schedule for rendered services.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. **(Section 2102)(a)(4) (42CFR 457.490(b))**

The utilization controls within the Soon-To-Be-Sooners (separate SCHIP) program will be the same as under Title XIX.

Members enrolled in the STBS program receive service coverage from Medicaid contracted providers who must adhere to Medicaid fee-for-service policies and procedures. Utilization review policies and procedures will follow Medicaid Title XIX practices, including protocols for prior approval and denial of services, hospital discharge planning, physician profiling, and retrospective review of both inpatient and ambulatory claims criteria. Utilization review is done cooperatively with Oklahoma Medicaid's Surveillance, Utilization and Review Subsystem (SURS) Unit.

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

IP - Members enrolled in the IP program receive coverage from IP contracted providers who must adhere to IO (Medicaid) fee-for-service policies and procedures. Utilization review policies and procedures follow Medicaid Title XIX practices, including protocols for prior approval and denial of services, hospital discharge planning, physician profiling, and retrospective review of both inpatient and ambulatory claims criteria. Utilization review is done cooperatively with Oklahoma Medicaid's Surveillance, Utilization and Review Subsystem (SURS) Unit as well as the Quality Assurance Division within the OHCA.

Section 4. Eligibility Standards and Methodology. (Section 2102(b))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan,** and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. **(Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))**

Pertaining to the Soon-To-Be-Sooners (separate SCHIP) program:

Pertaining to the Insure Oklahoma (IO) standalone CHIP program:

4.1.1. X Geographic area served by the Plan: STBS - Statewide, IO - Statewide

4.1.2. X Age: STBS - Conception through birth. For unborn children, coverage can begin from the confirmation of pregnancy and certification for the Soon-To-Be-Sooners (separate SCHIP) program, through delivery (birth). The unborn children will not be enrolled with a PCP, nor will they be able to utilize presumptive eligibility.

IO – Children Birth to <19 years of age. The state assures that claiming of Title XXI FFP only occurs for children described herein.

4.1.3. X Income: STBS - Unborn children whose family income is at or below 185 percent of the Federal Poverty Level (after exemptions, deductions and disregards) will be eligible.

For unborn children, the countable income must be less than the appropriate standard according to the family size, which is 185 percent of the Federal Poverty Level (after exemptions, deductions and disregards). In determining the household size, the unborn child(ren) is included.

IO - Children in families whose gross household income is from 185 up to and including 300 percent of the Federal Poverty Level (FPL). No other deductions or disregards apply.

STBS - All available income, except that required to be disregarded by law or OHCA's policy, is taken into consideration in determining need.

STBS - As it relates to individual earned income, exemptions from each individual's earned income include a monthly standard work related expense, child care expenses the individual is responsible for paying, and wages paid by the Census Bureau for temporary employment related to decennial census activities. The standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work, is $240 per each full-time or part-time employed member of the benefit group. Disregard of child care expense is applied after all other income disregards. Child care expenses must be verified and the actual amount per month, as paid, up to a maximum of $200 for a child under the age of two or $175 for a child age two or older may be deducted.

STBS & IO - As it relates to self-employment, if the income results from the individual's activities primarily as a result of the individual's own labor from the operation of a business enterprise, the countable income is the total profit after deducting the business expenses (cost of production).

4.1.4. X Resources (including any standards relating to spend downs and disposition of resources): Same as under Title XIX. All resources are disregarded.

4.1.5. X Residency (so long as residency requirement is not based on length of time in state): Enrollees must be residents of Oklahoma.

4.1.6. X Disability Status (so long as any standard relating to disability status does not restrict eligibility): N/A

4.1.7. X Access to or coverage under other health coverage: STBS - Enrollees cannot be covered under a group health plan, or health insurance coverage and cannot have access to a state health benefits plan.

IO - Enrollees are covered through the ESI program under a private, group health plan offered by their employer, or are covered through the State's IP program. If covered through the IP program, enrollees can not have current coverage under a group health plan.

4.1.8. X Duration of eligibility: STBS - Eligible unborn children receive coverage from confirmation of pregnancy and enrollment in the Soon-To-Be-Sooners (separate SCHIP) program, through delivery (birth)

IO – Eligible ESI and IP members receive coverage for one year from the date of certification.

4.1.9. X Other standards (identify and describe): STBS - The state does not require a social security number or proof of application for a social security number of the unborn children.

IO – Social security numbers are required of all eligible members over the age of one year, for verification purposes such as but not limited to citizenship. In addition, children are not eligible for IO if they are a member of a family eligible for employer-sponsored dependent health insurance coverage under any Oklahoma State Employee Health Insurance Plan (i.e. OSEEGIB).

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: **(Section 2102)(b)(1)(B)) (42CFR 457.320(b))**

4.2.1. X These standards do not discriminate on the basis of diagnosis.

4.2.2. X Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

4.2.3. X These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. **(Section 2102)(b)(2)) (42CFR 457.350)**

The methods of establishing eligibility and continuing enrollment for the Soon-To-Be-

Sooners (separate SCHIP) program will be the same as under Title XIX. A Soon-To-Be-Sooners / SoonerCare application for unborn children consists of the Health Benefits application. The application form is signed by the parent, spouse, guardian, or someone else acting on the individual's behalf. An individual does not have to have received a medical service nor expect to receive one to be certified for Health Benefits.

An application may be made in a variety of locations, for example, a physician's office, a hospital or other medical facility, Health Department, or in the county OKDHS office. A face to face interview is not required. Applications may be mailed or faxed to the local county OKDHS office. When an individual indicates a need for health benefits, the physician or facility may forward an application to the OKDHS county office of the patient's residence for processing. Receipt of the Health Benefits application form constitutes an application for the Soon-To-Be-Sooners / SoonerCare program.

The form Notification of Needed Medical Services may be submitted by the physician or facility as notification for a need for medical service. The form also may be accepted as medical verification of the unborn child(ren).

For unborn children, the countable income must be less than the appropriate standard according to the family size, which is 185 percent of the Federal Poverty Level (after exclusions, deductions and disregards). In determining the household size, the unborn child(ren) are included.

When eligibility for the Soon-To-Be-Sooners program is established, the OKDHS county office updates the computer form and the appropriate notice is computer generated to the client and provider. Likewise if denied or closed by the OKDHS county office at any time during the certification period, the case becomes ineligible, and a computer-generated notice is sent to the member.

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

The primary sources of eligibility, enrollment and benefits information for both ESI and IP programs are:

(1) The Insure Oklahoma website located at www.insureoklahoma.org The website contains detailed descriptions about the programs, instructions on how to apply, as well as additional resources provided to the applicants, members and providers.
(2) The Insure Oklahoma toll-free helpline. The helpline is staffed by knowledgeable representatives who answer questions and assist the applicants and members with various aspects of the program (i.e. enrollment, application status, cost sharing, benefits, network providers, etc.).
(3) The Insure Oklahoma brochures and other printed materials (i.e. handbooks, letters, notices, etc.). The brochures and printed materials are periodically updated and contain information on eligibility criteria, member costs, and covered benefits. Brochures are readily identified as containing information on either the ESI or IP program.

IP – The methods of establishing eligibility and continuing enrollment for the IP program may contain two components, the employer and the child's family. In the event the child's family works for a qualified business, but is not eligible to participate in the employers ESI plan, they may file an application on behalf of the child directly with the OHCA for the IP program. In the event the family's employer is unable or unwilling to provide ESI coverage, for self-employed families, and for unemployed families, children may apply for coverage under the IP program. An application may be made online or mailed or faxed into the Oklahoma Health Care Authority or its agent. The State and its agent verify the information on the application and process it in a timely manner. Eligibility data are shared with the OKDHS system for eligibility certification and results are added to the MMIS. Once an eligibility determination has been made the applicant is notified via letter. The letter indicates the premium amount due from the applicant, which must be remitted to the OHCA's contracted agent prior to services being rendered. Coverage begins on the first day of the month following receipt of the premium. The letter also contains information educating the family that in the event ESI coverage becomes available, they have the option of receiving subsidized ESI coverage in lieu of IP coverage. This transition may be made within 30 days (granted all eligibility criteria are met) and notice is given prior to the effective date of the change.

All members undergo the citizenship and identity verification process whereby data matches are performed on the social security number and/or vital statistics information provided on the application. Successful matches are returned to the OHCA and the eligibility certification process continues. Unsuccessful matches are returned to the OHCA for additional processing via outbound phone call, letter, etc. aiming to result in a successful enrollment. If citizenship and identity are not verified an eligibility denial results.

4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any). **(Section 2106(b)(7)) (42CFR 457.305(b))**

Check here if this section does not apply to your state.

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

The State will impose an enrollment cap at any given time in order to remain within State funding limits. Public notice of the enrollment cap is made through the processes described in Section 9.9.2. The State institutes a separate waiting list for ESI and IP. In the event an enrollment cap is imposed, enrollment in both ESI and IP programs is discontinued at the same time. To insure resources are available statewide, the State is divided into six regions with each region eligible to receive a population density, pro-rata share of funding. Monthly collections from the Tobacco tax are averaged over a six-month period to determine the average amount of funding available per month. The average amount is allocated between IP and ESI and within each program by region. When estimated monthly program expenditures are equal to or greater than the average monthly amount available for the program and region, a waiting list is imposed on new enrollees. When monthly program expenditures drop below the

average amount available, the next wait listed enrollee is allowed to apply on a first-in, first-out basis. Each wait listed enrollee has their application date and time stamped indicating their place on the waiting list. Applications are pulled from the waiting list by their order of receipt of complete application, and by region. Enrollment continues until the estimated cost of all enrollees in the program and region meets or exceeds monthly available funding. The regions are established to ensure statewide distribution of open slots coming available from the waiting list. Children who are already enrolled in the program are not subject to the waiting list upon their renewal. Any currently approved employer or child enrolled in either ESI or IP is not subject to the waiting list when recertification is due.
After receipt of application, new applicants are sent notice that a waiting list has been established and their qualification for the program must wait for the next available opening. They are informed waitlisted applications are processed on a first application in, first application out basis by region. The notice indicates the applicant will receive a letter indicating when their opening becomes available. The applicant is informed they will have 45 days to respond via submitted complete application or phone call, otherwise the opening will move to the next waitlisted applicant. In addition, messages are placed on the Insure Oklahoma website home page as well as at the beginning of the application indicating that a waiting list has been established.

4.4. Describe the procedures that assure that:

4.4.1 Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. **(Sections 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42CFR 457.350(a)(1)) 457.80(c)(3)}**

STBS - At eligibility determination, all applications are reviewed for coverage under a group health plan, or health insurance coverage, for access to a state health benefits plan and Medicaid eligibility prior to enrolling in the Soon-To-Be-Sooners (separate SCHIP) program. The review / screening procedures used at intake for the abovementioned purposes include: (1) a question on the application asking if the member is covered by other health insurance; (2) a question on the application asking if the member is covered by Medicare; (3) a question on the application asking if the member could be eligible for another health insurance program (public or private); (4) all member eligibility is reviewed for the existence of third party liability (TPL). The TPL unit will search for and, if found, update other insurance information onto the Medicaid Management Information System (MMIS). If other, effective insurance coverage is found, eligibility in the STBS program is closed. There is no redetermination of eligibility since eligibility certification for Unborn Children continues through delivery. A new, SoonerCare application is required upon birth to determine eligibility for Title XIX.

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

Upon initial application and enrollment, as well as upon periodic redeterminations of eligibility all children are screened for SoonerCare coverage. If a child is found to be eligible for SoonerCare the child may not receive coverage through the IO program.

Children who already have creditable coverage through another source (i.e. group health plan or state health benefits plan, namely OSEEGIB, whereby the child is eligible for state health benefits on the basis of a family member's employment with a public agency, even if the family declines the coverage) must undergo, or be excepted from, a 6 month uninsured waiting period prior to becoming eligible for either ESI or IP. Exceptions to the waiting period may include:
(1) The cost of covering the family under the ESI plan meets or exceeds 10 percent of the gross household income. The cost of coverage includes premium, deductible co-insurance and copays;
(2) loss of employment by a parent which made coverage available;
(3) affordable ESI is not available; "Affordable" coverage is defined by the OHCA annually using actuarially sound rates established by the Oklahoma State and Education Employee Group Insurance Board (OSEEGIB); or
(4) loss of medical benefits under SoonerCare.
After undergoing the waiting period (if applicable) and becoming eligible, children are allowed to disenroll from ESI coverage and enroll in IP coverage at any time, and vice versa.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XTX. **(Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))**

Screening procedures identify any applicant or enrollee who would be potentially eligible for Medicaid services based on the eligibility of his or her mother under one of the poverty level groups described in section 1902(l)ofthe Act, section 1931 of the Act or a Medicaid demonstration project approved under section 1115 of the Act.

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

Enrollment in the IO program takes place via the Medicaid Management Information System (MMIS), and all children are screened for SoonerCare coverage. If a child is found to be eligible for SoonerCare the child may not receive coverage through the IO program. Children found eligible yet not enrolled in SoonerCare are sent a letter informing them of their opportunity to apply for SoonerCare coverage. When children receive an eligibility denial for IO, due to their eligibility for SoonerCare programs, the letter explains the application sources (i.e. online web addresses, OHCA offices, etc.) and helpline phone number to call for assistance.

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. **(Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))**

STBS - Any applicant or enrollee who is found to be ineligible for comprehensive Medicaid services (based on the eligibility of his or her mother) and appears eligible for the Soon-To-Be-Sooners (separate SCHIP) program is automatically reviewed for the Soon-To-Be-Sooners (separate

SCHIP)program eligibility.

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

When applicants for the SoonerCare program are determined ineligible for the program due to income in excess of 185 percent of the Federal Poverty Level (FPL), a report of individuals is generated using data within the OKDHS and MMIS systems. This report is forwarded to appropriate outreach staff, knowledgeable of Insure Oklahoma enrollment processes. Outreach staff mail program brochures and contact information to the potential members. Outreach staff also contact the applicants and perform follow-up interviews to determine if the applicant may be eligible for an Insure Oklahoma program. Outreach staff assist the potential member (and the employer if applicable) with completing the application and determining eligibility for an Insure Oklahoma program.

4.4.4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. **(Section 2102)(b)(3)(C» (42CFR 457.805) (42 CFR 457.810(a)-(c))**

4.4.4.1. X (STBS Only) Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

STBS - The state does not believe substitution will occur in the Soon-To-Be-Sooners population for the following reasons. Unborn Children will have little or no access to employer sponsored insurance (ESI). The state has found that private insurance carriers require Social Security Numbers (SSN) in order to write policies therefore undocumented individuals (and their unborn children) are not able to be underwritten. As a result employers are not able to provide typical ESI to the undocumented population. In addition to the SSN requirement barrier, the state has found that in the relatively small target population to be served, the very nature of the members being low-income indicates that adequate disposable income to be used on health insurance premiums is not available.

Children who already have creditable coverage through another source (i.e. group health plan or state health benefits plan, namely OSEEGIB, whereby the child is eligible for state health benefits on the basis of a family member's employment with a public agency, even if the family declines the coverage) must undergo, or be excepted from, a 6 month uninsured waiting period prior to becoming eligible for either ESI or IP. Exceptions to the waiting period may include:
(1) The cost of covering the family under the ESI plan meets or exceeds 10 percent of the gross household income. The cost of coverage includes premium, deductible, co-insurance, and copays;
(2) loss of employment by a parent which made coverage available;
(3) affordable ESI is not available; "Affordable" coverage is defined by the OHCA annually using actuarially sound rates established by the Oklahoma State and Education Employee Group Insurance Board (OSEEGIB); or

(4) loss of medical benefits under SoonerCare.
After undergoing the waiting period (if applicable) and becoming eligible, children are allowed to disenroll from ESI coverage and enroll in IP coverage at any time, and vice versa.

When a member is found to have other creditable coverage at the time of application (by responding positively to question(s) asked on the application), and the member does not meet any of the exceptions, the member is denied eligibility for the program. The member responds to questions on the application which indicate if an exception to the "other coverage" eligibility requirement exists. In addition, all members are screened for other third part liability (TPL) coverage through a systematic data match with a state contracted vendor. Member identifying information is shared with the vendor, the vendor searches its databases of past and present effective dates for other sources of creditable coverage, and returns results to the state. The state uses the results to determine the eligibility status of the client based on the "other coverage" eligibility requirements.

The member application collects and tracks the corresponding Federal Poverty Level of all applicants. Regardless of the FPL the member falls within, the same process for other coverage verification occurs. The state maintains and monitors records for children applying for and enrolled in the program per FPL category. Data for these categories are compared among different FPL groups as well as to the children's group as a whole. In addition, the state monitors participation in the employer's health plans through monthly verification of payment of the employer's share of the premium and the continued enrollment of the child in the health plan. If an employer appears to have decreased their equivalent contribution towards coverage, the state may contact the employer to re-establish the eligibility requirements in order for the employer to continue to be qualified to participate in the program.

4.4.4.2. X Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

See response to 4.4.4.1 above. The member application collects and tracks the corresponding Federal Poverty Level of all applicants. Regardless of the FPL the member falls within, the same process for other coverage verification occurs.

4.4.4.3. X Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

See response to 4.4.4.1 above. The member application collects and tracks the corresponding Federal Poverty Level of all applicants. Regardless of the FPL the member falls within, the same process for other coverage verification occurs.

4.4.4.4. ☒ (Insure Oklahoma program only) If the state provides coverage under a

premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The IO program allows children in families earning from 185 up to and including 300 percent of the Federal Poverty Level the ability to receive benefits through either the Premium Assistance Employer Sponsored Insurance (ESI) coverage or the Premium Assistance Individual Plan (IP) coverage.

Before a member is determined eligible for IO, they will have been without health care coverage for a period not less than six months during the first month of operations with the exceptions of:
(1) The cost of covering the family under the ESI plan meets or exceeds 10 percent of the gross household income. The cost of coverage includes premium, deductible, co-insurance, and copays;
(2) loss of employment by a parent which made coverage available;
(3) affordable ESI is not available; "Affordable" coverage is defined by the OHCA annually using actuarially sound rates established by the Oklahoma State and Education Employee Group Insurance Board (OSEEGIB); or
(4) loss of medical benefits under SoonerCare.
After undergoing the waiting period (if applicable) and becoming eligible, children are allowed to disenroll from ESI coverage and enroll in IP coverage at any time, and vice versa.

The minimum employer contribution.

ESI – The employer is required to contribute an equivalent 40 percent of premiums.

IP – Employers are not required to contribute to the monthly premium.

The cost-effectiveness determination.

Within the IO program (both ESI and IP), the State monitors the aggregate costs for the ESI program versus the cost of providing coverage through the IP program as well as through the SoonerCare program. On a quarterly basis, the State compares the State's aggregate, average premium assistance contribution for ESI members to the State's aggregate, average cost for IP members. Likewise, the ESI contribution mentioned above is compared to the State's aggregate, average cost for SoonerCare members. The State ensures that the State's share of premium assistance is less than what would have been paid had the members been enrolled in either the IP program or SoonerCare program.

4.4.5 Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. **(Section 2102)(b)(3)(D)) (42 CFR 457.125(a))**

STBS - 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 child 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.

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: **(Section 2102(c)(1)) (42CFR 457.90)**

Availability:
The OHCA is collaborating closely with the DHS, the OCCY, and the OSDH to develop and implement a comprehensive marketing and outreach plan. The State will utilize a variety of instruments to develop awareness in and educate this new targeted population about the availability of health care coverage. This will be implemented through a combination of written materials (written at the 4th and 6th grade levels) and mass media components. Written materials will consist of flyers, brochures, posters and other materials as deemed necessary. The mass media components are television, newspaper, and radio.

Summarized below is a listing and brief description of the various outreach mechanisms that will be employed by the State:

- **Press Releases** - The OHCA has developed a generic press release (see Attachment E) targeted to local DHS offices statewide. The press releases will allow for individual adaptation by providing blank sections to be completed by each County Administrator. DHS will distribute the releases to all Administrators statewide. Accompanying the press releases will be a letter outlining the Program and the importance of facilitating outreach through local media outlets. Attached to the letter will be a listing of all Oklahoma counties and the estimated number of individuals potentially impacted by the implementation of this Program in each county. A similar letter will accompany all outreach and marketing materials. This letter will be designed to provide background information on the Program as well as give insight into the collaborative effort of the agencies involved.

- **Broadcast Announcements** - The OHCA has secured a contract with the Oklahoma Association of Broadcasters (OAB), see Attachment F, to coordinate the statewide broadcasts of 30~second announcements through television and radio outlets. Announcements (see Attachment G) creating awareness of the Program and directing prospective clients to application sites have been developed and distributed statewide.

In addition to securing the OAB contract, the OHCA will be working to develop bids for statewide outdoor and newspaper advertising.

- **Postcards and Posters** - The OHCA has designed, developed and produced postcards and posters (see Attachment H). The postcards are intended to be used as "hand-outs" and/or mailed to individual households (where databases are available). The posters are similar to the postcards in design but will allow for more detailed information due to the additional space.

- **Spanish Translation of Materials** - In an effort to reach the Hispanic community, the OHCA has contracted with Variety Health Center for the translation of all outreach materials. Also, the OHCA will attempt to contact a member of the Latino Community Development Agency in order to determine the availability of time on the Latino radio show.

- **Toll-free Hotline Number** - A toll-free number is available, through Benova, Inc., (Benova) the State's Enrollment Agent (see Attachment I), for prospective enrollees to ask questions about

and/or request additional information or application materials on the individual programs and enroll in the **SoonerCare** program.

- **Fact Sheets** - A Program "fact sheet" (see Attachment J) has been developed for distribution at community-level meetings anywhere in the State. The content of the fact sheets will be developed in conjunction with a training task force so as to ensure a high level of consistency when addressing the expansion population.

Avenues that will be used to distribute Program information are:

- local DHS County Office networks; databases for direct mail outreach; and through speaking engagements designed to educate local organizations and community leaders;

- develop mechanisms for distributing information through:

  - Food Stamp Program
  - Head Start
  - Health Care Providers Statewide
  - Child Support Programs
  - Immunization (OSIIS)
  - OSU Extension Offices
  - Local United Ways

X "target" printed Program materials toward employers who employ the working poor populace;

X involve local Chambers of Commerce and Units of Local Government;

X empower local coalitions to become actively involved in outreach processes;

X develop partnerships with local churches and the broader religious community (i.e. the Oklahoma Conference of Churches).

Pertaining to the Unborn Child (separate SCHIP) program the state, likewise, continues to utilize assistance from other state agencies, provider organizations, community groups, and others in the development of this new initiative. Examples of such groups includes 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. Also during the development of the Unborn Child program, feedback was received from a variety of Oklahoma health facilities and professionals primarily serving the target population. 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 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:

Insure Oklahoma utilizes a multi-faceted approach to conducting outreach. Due to the nature of the ESI program to incentivize members to enroll with private health plans offered by Oklahoma businesses, outreach efforts have been targeted to insurance agents, businesses, business coalition and economic development organizations and working families. Insure Oklahoma has been conducting periodic "Brown Bag" luncheon seminars as well as continuing education classes for interested agents and businesses in local communities across the state. These seminars include presentations on the program and lengthy question and answer periods where Insure Oklahoma staff can visit, one-on-one, with Oklahomans wanting to learn more about the program. Insure Oklahoma partners with the Oklahoma Insurance Department to staff Agent Partners. Agent Partners are individuals responsible for providing personalized attention to Oklahoma's health insurance agents. The Agent Partner positions were created to be a dedicated resource for agents, both already practicing and those newly established. The Insure Oklahoma program also offers a co-op program to insurance agents that pays half the cost of an approved Insure Oklahoma advertisement (print and/or broadcast) up to $5,000 per month per agent or agency. The advertisement co-op program is funded with tobacco tax revenues and claims administrative federal match. The Insure Oklahoma program sends periodic emails and postal mailings to a distribution list collected from the public website www.insureoklahoma.org The Insure Oklahoma staff continue to respond to requests for presentations to targeted groups, organizations, and communities across the state. Insure Oklahoma also conducts outreach specifically targeted to potential members. An advertising contract was awarded to Griffin Communications in which a marketing strategy and creative development plan was recommended. Griffin created a series of television commercials, print advertisements, billboard displays, and public events where the Insure Oklahoma program was spotlighted as the state's premier health insurance assistance program.

Prior to implementation, the OHCA identified a planning coordinator and project lead and convened an inter-agency workgroup team that oversaw the implementation. Targeted sub-workgroups were formed to address systems issues, enrollment methods, recertification methods, policy, eligibility, member outreach and education, as well as the application process. In addition, the OHCA conducts statewide meetings with consumer, provider, healthcare entities (private and public) and advocacy groups to provide information and receive input about this program. OHCA is developing a comprehensive marketing campaign to conduct outreach to businesses, agents, insurance companies, providers and other stakeholders. In addition, extensive recruitment efforts are devoted to enhancing the IP primary care provider network to ensure access statewide for children served in IP.

Enrollment:

This section describes the processes for statewide enrollment under the Title XIX/XXI expansion. All features of enrollment for the States current SoonerCare Medicaid Managed Care Program, operated under the 1115(a) R&D Waiver, will be included under the Title XXI Medicaid expansion.

Oklahoma's, 1115(a) R&D Waiver was built upon the managed care program implemented in August, 1995 within the State's three major metropolitan areas (Oklahoma, Tulsa, and Lawton) under auspices of the State's 1915(b) Program Waiver. Under the subsuming. 1115(a) R&D Waiver, managed care was extended into all areas of the State, beginning with State Fiscal Year (SFYs) 1996

In areas of the State not served by Health Maintenance Organizations (HMOs)[3] a system of Primary Care Case Management (PCCM) was implemented with services being provided by Primary Care Physicians/Case Managers (PCP/CM). Additionally, HMOs service were expanded into rural counties bordering the metropolitan areas not previously served by health plans. The Program created as a result of these two Waivers is currently known as SoonerCare. This Program includes two major components: an "urban model" (SoonerCare Plus) and a "rural model" (SoonerCare Choice).

[3]For the purposes of the this document a Health Maintenance Organization will also be referred to as: health plans and Managed Care Organizations (MCOs).

Since July 1, 1995, the State has contracted with fully integrated networks comprised of Federally-qualified and State-certified HMOs in order to enroll and serve Title XIX beneficiaries in the urban areas.

The OHCA currently contracts with five HMOs to serve its Title XIX AFDC and AFDC-related beneficiaries. The SoonerCare Choice program has been in operation since April 1, 1996. The OHCA has contracts with over five-hundred (500) PCP/CMs to deliver a defined set of primary care services to rural beneficiaries. Most other services delivered to rural beneficiaries are reimbursed to providers on a fee-for-service basis.

Utilizing these programs, the OHCA has been able to successfully enroll its AFDC and AFDC-related population into managed care and is currently prepared to enroll the targeted low-income children, eligible under Title XXI, in the SoonerCare program.

Medicaid enrollment applications for this expanded group have been simplified and are readily available at a wide variety of locations such as the DHS county offices, OSHD county offices, WIC offices, public libraries, health care providers in the state, local United Way offices, and others. Also, in order to further simplify the eligibility process and improve access to and participation in the Medicaid program, face-to-face interviews and the asset test have been eliminated from the application process.

SoonerCare Plus (Urban) Enrollment Process for MCOs - The State provides information and educational materials to members (recipients) regarding the managed care program and participating MCOs in order to assist them in making a selection. Families are required to select one plan for **all** eligible members. Under the 1115(a) R & D Waiver, individuals/families who select their MCO will be permitted to disenroll from the plan (change plans) in the first month of coverage, during the annual open enrollment period, or at any time for good cause as defined within OHCA guidelines.

The simplified Medicaid application contains a section where beneficiaries can indicate their choice of MCOs. As part of the certification process, the DHS Case Worker will not only certify the beneficiary but will actually complete the enrollment on their behalf

Individuals who do not make a selection at the time of application are given a toll-free "helpline" telephone number to call if and when they are ready to choose. The State has contracted with Benova for this service (see, Attachment T). The "helpline" customer service representatives are trained to answer questions on the **SoonerCare** program and assist beneficiaries in completing the selection process over the phone. Spanish-speaking operators are available for applicants who speak Spanish as a first language, and translation services are available to assist applicants who speak languages other than English and Spanish. A TDD (Telecommunications Device for the Deaf) is available for persons with impaired hearing.

Applicants can also select an MCO by marking their choice on a pre-addressed, postage-paid enrollment card included in the enrollment packet and return it to Benova. The OHCA believes that by offering several methods for health plan selection, it will minimize the number of cases in which individuals do not make a choice.

Regardless of the method used, all individuals are required to select an MCO and inform the State of their choice within fourteen (14) business days of their application for eligibility. Those who do not select will be assigned automatically (autoassigned) to an MCO based on a pre-determined assignment algorithm developed by the State and its consulting actuaries. For those members who do not select an MCO or who are autoassigned, the MCO will assign a PCP. The member can change PCPs if not satisfied with the choice.

The State - by mail - informs beneficiaries of their MCO and effective date when eligibility is granted or re-certified. MCOs are also notified through daily electronic data transmissions. For individuals whose eligibility is determined before the 15th day of the month, their MCO enrollment will become effective at the beginning of the following month. Members whose eligibility is determined the 15th day of the month or later will be enrolled on the first day of the second month after determination. Prior to the MCO effective date, any eligible Medicaid recipient may access covered services through the Fee-for Service Medicaid system.

Upon receiving notification of a new member, the MCO is required to mail out a Member Handbook and inform the member about his or her PCP options and how to make a selection if that member has not already done so. The MCO is also required to issue a permanent identification card (one which meets the standards and specifications of the State) within ten (10)

days of enrollment to all new members.

The OHCA will also mail **SoonerCare Plus** recipients a permanent plastic identification card containing recipient information as well as useful program information - including pertinent telephone numbers.

SoonerCare Choice (Rural) Enrollment Process - The enrollment process is similar to the **SoonerCare Plus** program process. However, the **SoonerCare Choice** beneficiary selects a PCP/CM rather than an MCO. Information about the **SoonerCare Choice** Provider Network is included with the **SoonerCare Choice** enrollment materials.

As with the SoonerCare Plus Program, beneficiaries can indicate their enrollment selection on the simplified application which DHS Staff (refer to section 2.3) will process, or they can telephone the SoonerCare "helpline" to enroll via the telephone. However, when a SoonerCare Choice beneficiary chooses to enroll by mail through the enrollment agent, they can indicate both their first choice and second choice of a PCP/CM on the pre-paid return address enrollment card.

The OHCA will enroll beneficiaries with their first choice whenever possible. However, in the event that a beneficiary's first choice of a PCP/CM has already reached their patient capacity, the beneficiary's second choice of a PCP/CM will be used. The enrollment agent will also answer questions which beneficiaries have prior to choosing a PCP/CM and encourage them to select a PCP/CM within forty-five (45) miles of their residence. If no selection is made, or if the selections made are not available, the beneficiary will be autoassigned[4] to the nearest appropriate provider who has capacity and is within forty-five (45) miles of their residence. Each month PCP/CMs receive a roster which lists their patients for the following month. If no provider is available within forty-five (45) miles, the beneficiary will remain in the Medicaid fee-for-service program until an appropriate provider is available. Beneficiaries will be advised of enrollment via a confirmation letter. Each month, PCP/CMs receive a roster which lists their patients for the following month.

For applicants who are determined eligible before the 15th day of the month, enrollment will become effective the first day of the next month. Those who are determined eligible the 15th of the month or later will be enrolled on the first day of the second month after determination Prior to enrollment with a managed care provider, beneficiaries will be covered for the existing Medicaid fee-for-service benefit package only. Any covered benefits provided to these individuals will be reimbursed by the State.

The provider(s) offered to an individual either by his/her eligibility case worker or by mail will be determined based on his or her place of residence and distance to participating providers. Individuals who need more information prior to making a selection will be given a toll-free "helpline" telephone number to call if and when they are ready to choose. As in the SoonerCare Plus (urban) Program Benova will provide assistance in the rural enrollment process. The telephone lines are manned by customer service representatives trained to assist beneficiaries in completing the selection process over the phone.

Spanish-speaking operators are available for applicants who speak Spanish as a first language. The program will have translation services available to assist applicants who speak languages other

than English or Spanish. A TDD is also available for persons who are hearing impaired.

Applicants will also be able to select a PCP/CM by marking their choice on a pre-addressed and -stamped postcard. The State believes that by offering several methods for provider/network selection, it will minimize the number of cases in which individuals do not make a choice.

Regardless of the method used, all individuals will be required to select a PCP/CM and inform the State of their choice within fourteen (14) business days of their application for eligibility or receipt of the enrollment materials. Those who do not select will be autoassigned to a provider or network from the pool of providers with existing capacity. Currently, beneficiaries can change their PCP/CM at any time. The State will inform beneficiaries of their PCP/CM by mail. The provider will also be notified once per month via special delivery mail.

Once an individual has enrolled with a PCP/CM, the State will mail the "Member Handbook" which explains how to access services in the PCP/CM system. The OHCA will also mail **SoonerCare Choice** recipients a permanent plastic identification card containing recipient information as well as useful program information - including pertinent telephone numbers.

[4] The Slate is currently contracted with GEO Access, a Kansas City based software and consulting company. GEO handles the autoassignment algorithm for the SoonerCare Choice program. Eligibility files as well as new member files are sent to GEO Access's corporate office monthly for autoassignment processing.

Prior to January 1, 2004 OHCA operated two separate forms of managed care – SoonerCare Plus and SoonerCare Choice. Under the SoonerCare Plus program OHCA contracted directly with Health Maintenance Organizations (HMOs) to provide medically necessary services to beneficiaries residing in Oklahoma's urban counties. In November of 2003, news of increased health care costs and a decision by a health maintenance organization (HMO) to pull out of the state Medicaid program prompted the Oklahoma Health Care Authority board to approve a proposal to end its health maintenance organization (HMO) contracts and expand the state's other managed care system, SoonerCare Choice.

Now OHCA only has one managed care program – SoonerCare Choice. After the transition of all beneficiaries from SoonerCare Plus into SoonerCare Choice in April 2004, OHCA dropped the word "Choice" from the name of the program. We now refer to the entire managed care program as SoonerCare.

SoonerCare is a primary care case management (PCCM) program in which the state contracts directly with primary care providers throughout the state to provide basic health care services. The SoonerCare program is partially capitated, in that providers are paid a monthly capitated rate for a fixed set of services with noncapitated services remaining compensable on a fee-for-services basis. Some beneficiary groups are not eligible to participate in the SoonerCare program. Persons eligible for Oklahoma Medicaid who are institutionalized, dual eligibles, in state or tribal custody or enrolled under a Home and Community-Based Waiver are not included in the

SoonerCare program at this time.

Beneficiaries enrolled in SoonerCare are not "locked in" with a primary care provider/case manager (PCP/CM) and can change health care providers up to four times per year. This important facet to the program allows SoonerCare beneficiaries the opportunity to select a provider that has been added to the program. Providers contracting in this program include physicians, nurse practitioners and physician assistants.

Identifying the need to coordinate care for SoonerCare members with complex medical needs, the SoonerCare division created a Care Management department. This department contains nurse exceptional needs coordinators (ENCs) who support the Oklahoma Medicaid provider networks in both the SoonerCare program and fee-for-service areas through research, collaboration and problem resolution as related to members' care.

In November 2003, the Oklahoma Health Care Authority began activities to transition members enrolled under the SoonerCare Plus program to SoonerCare Choice. Below are some highlights of those activities.
~ SoonerCare Choice total enrollment as of June 2004 was 359,682 members compared to January enrollment of 161,759.
~ SoonerCare Choice rollout for the SoonerCare Plus areas had an average of 83 percent beneficiary selected primary care provider (PCP) or an average of 17 percent PCP autoassignment rate.
~ 17 on-site SoonerCare training sessions for Oklahoma Department of Human Services (OKDHS) county staff were held. OKDHS is the agency contracted with the OHCA to perform the determination of Medicaid eligibility. This means that all applications for Oklahoma Medicaid enrollment are processed and approved or denied by OKDHS.
~ The transition was successfully completed by April 1, 2004.
~ OHCA conducted an outbound Plus member calling campaign from November 17, 2003 through March 12, 2004; OHCA staff attempted to call 156,539 TANF members and members categorized as ABD.
~ OHCA held forty-seven enrollment fairs from December 17, 2003 through March 13, 2004. These fairs were attended by 3,046 beneficiaries and resulted in 3,993 PCP selections.
~ OHCA conducted a targeted post-transition calling campaign to 3,842 individuals during April..
~ 103,560 open enrollment packets and 115,429 enrollment fair flyers were mailed. More than 400 enrollment fair posters were distributed.
~ PCP preselections were manually or electronically entered for about 159,000 individuals.
~ OHCA conducted 17 on-site visits to homeless shelters / low-income housing.
~ OHCA conducted an outbound calling campaign to 593 former Plus physicians.
~ OHCA held on-site meetings with 275 individual and group providers.
~ Contracted with 40 of 43 HIS/Tribal/Urban Indian Clinics resulting in a 20 percent increase in Native American enrollees with these sites.
~ OHCA held large provider training sessions for the Tulsa and Oklahoma City areas.
~ Recruitment letters were sent to 405 Plus physicians without Choice contracts.
~ There was a targeted campaign to 480 specialty physicians.

~ OHCA held multiple calling campaigns to 354 individuals with Special Behavioral Health Needs and 271 individuals identified with special needs to educate about the transition, facilitate PCP selection and notify the members of their designated care manager.
~ Initial home visits to 80 children receiving skilled nursing services were performed.
~ On-site meetings were conducted with Eight in-state Neonatal Intensive Care Units.

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

Partnerships with various community organizations, across the state, have been formed and strengthened in anticipation of increased enrollment efforts within the Insure Oklahoma program. Coupled with the outreach and marketing campaigns, business, economic development and consumer organizations have been approached to assist members to learn about and facilitate their enrollment in the program.

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 7.

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) **(42CFR 457.410(a))**

6.1.1. ☐ Benchmark coverage; **(Section 2103(a)(1) and 42 CFR 457.420)**

6.1.1.1. ☐ FEHBP-equivalent coverage; **(Section 2103(b)(1))** (If checked, attach copy of the plan.)

6.1.1.2. ☐ State employee coverage; **(Section 2103(b)(2))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3. ☐ HMO with largest insured commercial enrollment **(Section 2103(b)(3))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2. ☐ Benchmark-equivalent coverage; **(Section 2103(a)(2) and 42 CFR 457.430)** Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431**. See instructions.**

6.1.3. ☐ Existing Comprehensive State-Based Coverage; **(Section 2103(a)(3) and 42 CFR 457.440)** [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of

8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

6.1.4. X Secretary-Approved Coverage. **(Section 2103(a)(4)) (42 CFR 457.450)**

6.1.4.1. ☐ Coverage the same as Medicaid State plan

6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration project

6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population

6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage

6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage

6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit-by-benefit comparison (Please provide a sample of how the comparison will be done)

6.1.4.7. X Other (Describe)

No alterations are being made to Oklahoma's current ability to provide expanded eligibility under the state's Medicaid plan to SoonerCare children.

Pertaining to the Soon-To-Be-Sooners (separate SCHIP) program: The state elects to provide pregnancy related benefits covered under Title XXI through the STBS (separate SCHIP) program. Professional services, ante partum care and delivery services (including associated tests and procedures such as ultrasounds, non stress tests, amniocentesis and other pregnancy specific tests, procedures and services as covered under Title XIX) are provided as medically necessary to support optimal pregnancy outcomes, and are billed using the appropriate CPT/HCPC codes. In addition, two visits per month with specialists and subspecialists and the related tests and procedures will be covered to provide evaluation and management of maternal or fetal conditions, diseases and disorders that may impact the pregnancy, and/or maternal/fetal outcomes. Examples of these visits would be an outpatient office or clinic visit with an endocrinologist regarding a maternal (pre) diabetic condition, or a visit with a cardiologist regarding a preexisting maternal heart defect and potential care and treatment during pregnancy needed in order to maximize fetal well-being. Services to treat maternal conditions that bear no relationship to fetal well-being and outcomes will not be covered. Examples of non-covered care are evaluation and treatment of maternal cataracts, evaluation and treatment of maternal

hearing loss or outpatient psychosocial rehabilitation services for mental illness.

Pertaining to the Insure Oklahoma (IO) standalone CHIP program:
IP Coverage follows state defined services as listed below in Section 6.2

6.2. The state elects to provide the following forms of coverage to children:
(Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) **(Section 2110(a)) (42CFR 457.490)**

No alterations are being made to Oklahoma's current ability to provide expanded eligibility under the state's Medicaid plan to SoonerCare children.

Pertaining to the Insure Oklahoma (IO) standalone CHIP program:
All elected / checked services are covered as medically necessary.
See attachment B.1 for the IO IP Schedule of Benefits for children.

6.2.1. X Inpatient services (Section 2110(a)(1))

Inpatient services coverage for SoonerCare children will be the same as under Title XIX.

Inpatient services coverage for eligible Unborn Children enrolled in the Soon-To-Be-Sooners (separate SCHIP) program will be covered as medically necessary and only when services benefit the unborn child throughout the pregnancy and birth.

IP program covered as medically necessary and includes a $50 per admission co-pay.

6.2.2. X Outpatient services (Section 2110(a)(2))

Outpatient services coverage for SoonerCare children will be the same as under Title XIX.

Outpatient services coverage for eligible Unborn Children enrolled in the Soon-To-Be-Sooners (separate SCHIP) program will be covered as medically necessary and only when services benefit the unborn child throughout the pregnancy and birth.

IP program covered as medically necessary. Ambulatory surgical centers include a $25 per visit co-pay. Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for persons with proven malignancies or opportunistic infections, includes a $10 per visit co-pay.

6.2.3. X Physician services (Section 2110(a)(3))

Physician services coverage for SoonerCare children will be the same as under Title XIX.

Physician services coverage for eligible Unborn Children enrolled in the Soon-To-Be-Sooners (separate SCHIP) program will be covered as medically necessary and only when services benefit the unborn child throughout the pregnancy and birth. Professional services, ante partum care and delivery services (including associated tests and procedures such as ultrasounds, non stress tests, amniocentesis and other pregnancy specific tests, procedures and services as covered under Title XIX) are provided as medically necessary to support optimal pregnancy outcomes, and are billed using the appropriate CPT/HCPC codes. In addition, two visits per month with specialists and subspecialists and the related tests and procedures will be covered to provide evaluation and management of maternal or fetal conditions, diseases and disorders that may impact the pregnancy, and/or maternal/fetal outcomes. Examples of these visits would be an outpatient office or clinic visit with an endocrinologist regarding a maternal (pre) diabetic condition, or a visit with a cardiologist regarding a preexisting maternal heart defect and potential care and treatment during pregnancy needed in order to maximize fetal well-being. Services to treat maternal conditions that bear no relationship to fetal well-being and outcomes will not be covered. Examples of non-covered care are evaluation and treatment of maternal cataracts, evaluation and treatment of maternal hearing loss or outpatient psychosocial rehabilitation services for mental illness.

IP program covered as medically necessary and includes a $10 per visit co-pay, no co-pay for well baby/child visit following recommended schedule, no co-pay for preventive visits, primary care provider referral needed for specialist visits. Blood lead screen covered as medically necessary. Hearing services limited to one outpatient newborn screening.

6.2.4. X Surgical services (Section 2110(a)(4))

Surgical services coverage for SoonerCare children will be the same as under Title XIX.

Surgical services coverage for eligible Unborn Children enrolled in the Soon-To-Be-Sooners (separate SCHIP) program will be covered as medically necessary and only when services benefit the unborn child throughout the pregnancy and birth.

IP program covered as medically necessary and includes a $25 outpatient facility co-pay, or $50 inpatient facility co-pay.

6.2.5. X Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))

Clinic services coverage for SoonerCare children will be the same as under Title XIX.

Clinic services coverage for eligible Unborn Children enrolled in the Soon-To-Be-Sooners (separate SCHIP) program will be covered as medically necessary and only when services benefit the unborn child throughout the pregnancy and birth.

IP program covered as medically necessary and includes a $10 per visit co-pay, waived if a dialysis visit. Clinics that provide appropriate primary care services are eligible to be primary care providers.

6.2.6. X Prescription drugs (Section 2110(a)(6))

Prescription drug coverage for SoonerCare children will be the same as under Title XIX.

Prescription drug coverage for eligible Unborn Children enrolled in the Soon-To-Be-Sooners (separate SCHIP) program will be covered as medically necessary and only when services benefit the unborn child throughout the pregnancy and birth.

IP program includes a $5 per generic prescription co-pay, $10 per brand name prescription, limited to a total of six prescriptions per month, generic preferred. Prenatal vitamins and smoking cessation products do not count toward the six prescription limit.

6.2.7. ☐ Over-the-counter medications **(Section 2110(a)(7))**

6.2.8. X Laboratory and radiological services (Section 2110(a)(8))

Laboratory and radiological services coverage for SoonerCare children will be the same as under Title XIX.

Laboratory and radiological services coverage for eligible Unborn Children enrolled in the Soon-To-Be-Sooners (separate SCHIP) program will be covered as medically necessary and only when services benefit the unborn child throughout the pregnancy and birth.

IP program covered as medically necessary and includes no co-pay.

6.2.9. X Prenatal care and prepregnancy family services and supplies (Section 2110(a)(9))

Prenatal care and prepregnancy family services and supplies coverage for SoonerCare children will be the same as under Title XIX.

Prepregnancy family services are not covered for eligible Unborn Children.

Prenatal care services and supplies coverage for eligible Unborn Children enrolled in the Soon-To-Be-Sooners (separate SCHIP) program will be covered as medically necessary and only when services benefit the unborn child throughout the pregnancy and birth. Professional services, ante partum care and delivery services (including associated tests and procedures such as ultrasounds, non stress tests, amniocentesis and other pregnancy specific tests, procedures and services as covered under Title XIX) are provided as medically necessary to support optimal pregnancy outcomes, and are billed using the appropriate CPT/HCPC codes. In addition, two visits per month with specialists and subspecialists and the related tests and procedures will be covered to provide evaluation and management of maternal or fetal conditions, diseases and disorders that may impact the pregnancy, and/or maternal/fetal outcomes. Examples of these visits would be an outpatient office or clinic visit with an endocrinologist regarding a maternal (pre) diabetic condition, or a visit with a cardiologist regarding a preexisting maternal heart defect and potential care and treatment during pregnancy needed in order to maximize fetal well-being. Services to treat maternal conditions that bear no relationship to fetal well-being and outcomes will not be covered. Examples of non-covered care are evaluation and treatment of maternal cataracts, evaluation and treatment of maternal hearing loss or outpatient psychosocial rehabilitation services for mental illness. Eligible Unborn Children will receive the services described in 6.1.4.7 and 6.2 with fee-for-service reimbursement, and will not be enrolled with a PCP.

IP program covered as medically necessary and includes no co-pay for office visits for family planning; $0 co-pay for pregnancy visits; $50 per admission co-pay for delivery.

6.2.10. X Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services **(Section 2110(a)(10))**

IP program includes inpatient acute detox, partial and residential treatment centers with 30 days for children per State Fiscal Year, 2 days of partial or residential treatment centers service equals 1 day accruing to maximum. Inpatient mental health services day limits are separate from outpatient mental health services day limits, and are separate from Inpatient substance abuse treatment services and residential substance abuse treatment services. Prior authorization required, $50 per admission co-pay.

6.2.11. X Outpatient mental health services, other than services described in 6.2.19, but

including services furnished in a state-operated mental hospital and including community-based services **(Section 2110(a)(11)**

IP program includes an array of outpatient services, including but not limited to case management and crisis stabilization, limited to 48 visits per calendar year. Licensed Behavioral Health Practitioners (LBHP) services are limited to 8 therapy services per month and 8 testing units per calendar year. Outpatient mental health services day limits are separate from inpatient mental health services day limits, and are separate from Outpatient substance abuse treatment services and residential substance abuse treatment services. All services require prior authorization, $10 per visit co-pay.

6.2.12. X Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(0))

DME coverage for SoonerCare children will be the same as under Title XIX.

DME coverage for eligible Unborn Children enrolled in the Soon-To-Be-Sooners (separate SCHIP) program will be covered as medically necessary and only when services benefit the unborn child throughout the pregnancy and birth.

IP program includes coverage as medically necessary up to $15,000 annual maximum, $5 per item co-pay for durable/non-durable supplies, $25 per item co-pay for DME.

6.2.13. X Disposable medical supplies (Section 2110(a)(i3))

Disposable medical supplies coverage for SoonerCare children will be the same as under Title XIX.

Disposable medical supplies coverage for eligible Unborn Children enrolled in the Soon-To-Be-Sooners (separate SCHIP) program will be covered as medically necessary and only when services benefit the unborn child throughout the pregnancy and birth.

IP program includes coverage of diabetic supplies, the cost of which are not included in the $15,000 annual DME maximum, one glucometer per year, one spring-loaded lancet device per year, three replacement batteries per year, 100 glucose strips and lancets per month, Additional supplies require prior authorization, $5 co-pay per billable service.

6.2.14. ☐ Home and community-based health care services (See instructions) **(Section**

2110(a)(14))

6.2.15. X Nursing care services (See instructions) (Section 21 I©(a)(l5))

Nursing care services coverage for SoonerCare children will be the same as under Title XIX.

Nursing care services coverage for eligible Unborn Children enrolled in the Soon-To-Be-Sooners (separate SCHIP) program will be covered as medically necessary and only when services benefit the unborn child throughout the pregnancy and birth.

IP program includes no co-pay for medically necessary nursing care services, nurse midwife services are covered as medically necessary for pregnancy-related services only, $0 co-pay. Private Duty Nursing services are not a covered service.

6.2.16. X Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest **(Section 2110(a)(16)**

6.2.17. X Dental services **(Section 2110(a)(17))**

Dental-IP program covered as medically necessary and includes coverage for Class A, B, C, and orthodontia services. All coverage provided as necessary to prevent disease, promote and restore oral health, and treat emergency conditions. Dental services follow the AAPD periodicity schedule which can be found online at http://www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf and also attachment D.1. Prior authorization required. Class A covered as medically necessary and includes preventive, diagnostic care such as cleanings, check-ups, X-rays, and fluoride treatments, no co-pay; Class B covered as medically necessary and includes basic, restorative, endodontic, periodontic, oral and maxillofacial surgery care such as fillings, extractions, periodontal care, and some root canal, $10 co-pay; Class C covered as medically necessary and includes major, prosthodontic care such as crowns, bridges and dentures, $25 co-pay; Class D covered as medically necessary and includes orthodontic care, orthodontics is not covered for cosmetic and purposes not medical in nature, $25 co-pay; Emergency Dental Services covered as medically necessary, no co-pay. (See attachment C.1)

6.2.18. X Inpatient substance abuse treatment services and residential substance abuse treatment services **(Section 2110(a)(18))**

IP program includes inpatient acute detox, partial and residential treatment

centers with 30 days for children per State Fiscal Year, 2 days of partial or residential treatment centers service equals 1 day accruing to maximum, prior authorization required, $50 per admission co-pay.

6.2.19. X Outpatient substance abuse treatment services **(Section 2110(a)(19))**

IP program includes an array of outpatient services, including but not limited to case management and crisis stabilization, limited to 48 visits per calendar year. Licensed Behavioral Health Practitioners (LBHP) services are limited to 8 therapy services per month and 8 testing units per calendar year. All services require prior authorization, $10 per visit co-pay.

6.2.20. ☐ Case management services **(Section 2110(a)(20))**

6.2.21. X Care coordination services **(Section 2110(a)(21))**

IP program includes the patient-centered medical home (PCMH) model (previously described in Section 3.1) which provides monthly care coordination fees paid to primary care providers for each enrolled member. The PCP is responsible for providing or otherwise assuring the provision of medically necessary primary care services and for making specialty care referrals. The Insure Oklahoma IP program has broadened the impact of its PCMH model by the addition of Health Access Networks (HANs) with core components of care management/care coordination, electronic health records, improved access to specialty care, telemedicine and expanded quality improvement strategies. The HAN serves to enhance the capabilities of PCPs, not only with high volume practices, but those with limited access to resources due to location in rural Oklahoma, to fully manage and coordinate care, especially of complex members. The time, human and technology resources and knowledge of social and community supports are usually not available in small PCP offices. As the networks become operational, health and care management initiatives are implemented providing targeted or individualized education and care coordination, implementation of best practice guidelines and evaluation and monitoring of results.

6.2.22. X Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders **(Section 2110(a)(22))**

IP program includes coverage as medically necessary, prior authorization required, $10 per visit co-pay.

6.2.23. X Hospice care **(Section 2110(a)(23))**

IP program includes coverage as medically necessary, prior authorization required, $10 per visit co-pay.

6.2.24. X Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 21iO(a)(24))

Other services coverage for SoonerCare children will be the same as under Title XIX.

Other services coverage for eligible Unborn Children enrolled in the Soon-To-Be-Sooners (separate SCHIP) program will be covered as medically necessary and only when services benefit the unborn child throughout the pregnancy and birth.

IP program includes coverage as medically necessary except as indicated in the limitations (see attachment B.1).

6.2.25. X Premiums for private health care insurance coverage **(Section 2110(a)(25))**

Premiums for private group health care insurance coverage is covered as outlined in 6.4.2 "Additional State Option for Providing Premium Assistance as authorized under CHIPRA".

6.2.26. X Medical transportation **(Section 2110(a)(26))**

IP program includes coverage as medically necessary for emergency medical transportation, $50 copay per occurrence, waived if admitted. Non-emergency transportation not a covered service.

6.2.27. ☐ Enabling services (such as transportation, translation, and outreach services (See instructions) **(Section 2110(a)(27))**

6.2.28. X Any other health care services or items specified by the Secretary and not included under this section **(Section 2110(a)(28)**

IP program includes coverage as medically necessary for emergency services defined at 42CFR457.10.

6.2.-D The State will provide dental coverage to children through one of the following. Dental services provided to children eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5)):

6.2.1.-D X **State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT) codes are included in the dental benefits:**

1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)
2. Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1000-D1999) (must follow periodicity schedule)
3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)
4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999)
5. Periodontic (treatment of gum disease) (CDT codes: D4000-D4999)
6. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999)
7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999)
8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)
9. Emergency Dental Services

The Dental-IP program includes coverage for all categories listed above and attached to this SPA are the dental periodicity schedule found online at http://www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf (Attachment D.1) and Dental-IP for Children Schedule of Benefits (Attachment C.1).

6.2.1.2-D ~ Periodicity Schedule. The State has adopted the following periodicity schedule:

☐ State-developed **Medicaid-specific**
X **American Academy of Pediatric Dentistry** (See Attachment D.1)
☐ **Other Nationally recognized periodicity schedule**
☐ **Other (description attached)**

6.2.2-D ☐ **Benchmark coverage; (Section 2103(c)(5), 42 CFR 457.410, and 42 CFR 457.420)**

6.2.2.1.-D ☐ **FEHBP-equivalent coverage; (Section 2103**(c)(5)(C)(i)) **(If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, please also attach a description of the services and applicable CDT codes)**

6.2.2.2-D ☐ **State employee coverage; (Section 2103**(c)(**5**)(C)(ii)) **(If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, please also attach a description of the services and**

applicable CDT codes)

6.2.2.3.-D☐ HMO with largest insured commercial enrollment (Section 2103(c)(5)(C)(iii)) **(If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, please also attach a description of the services and applicable CDT codes)**

6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: **(42CFR 457.480)**

6.3.1. X The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services **(Section 2102(b)(J)(B)(ii))**; OR

Item 6.3.1 applies to the IP program (i.e. state administered safety-net plan). No pre-existing medical condition exclusion is permitted.

6.3.2. X The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Please describe: Previously 8.6

Item 6.3.2 applies to the ESI program (i.e. subsidized private health plan). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA.

6.4 **Additional Purchase Options.** If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: **(Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)**

6.4.1. ☐ **Cost Effective Coverage.** Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following **(42CFR 457.1005(a))**:

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; **Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR**

457.1005(b))

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above. **Describe the cost of such coverage on an average per child basis**. **(Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))**

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. **Describe the community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))**

6.4.2. ☐ **Purchase of Family Coverage.** Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: **(Section 2105(c)(3)) (42CFR 457.1010)**

6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.) (Section 2105(c)(3)(A)) (42CFR 457.1010(a))**

6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. **(Section 2105(c)(3)(B)) (42CFR 457.1010(b))**

6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. **(42CFR 457.1010(c))**

"**6.4.2.** ☒ **Additional State Option for Providing Premium Assistance as authorized under CHIPRA,"** (Note: Section 301(a)(1) of CHIPRA provides States with an additional premium assistance option under CHIP by adding 2105(c)(10) to the Social Security Act). Please provide the details of your premium assistance program only in this section, including a description of the programmatic features specified in CHIRPA related to optional enrollment, benefits provided (including wrap around), cost sharing, period of uninsurance, minimum employer contribution level, qualified to employer sponsored insurance (ESI), cost effectiveness, notice of availability (states are required to include information about premium assistance on the CHIP application and establish other procedures to ensure that parents are fully informed of the choices for child health assistance or through the receipt of premium assistance subsidies) and a description of intended outreach, education and enrollment efforts related to

premium assistance subsidies. There is no need to reference the premium assistance program in any other areas of the CHIP state plan.

Optional Enrollment

Enrollment in the ESI program takes place via the Medicaid Management Information System (MMIS), and all children are screened for SoonerCare coverage. If a child is found to be eligible for SoonerCare they may not receive coverage through the IO program. Due to this eligibility rule, the coordination of the standalone CHIP program with other public health coverage programs, namely SoonerCare, is always a precursor to the member receiving coverage through the IO program. Due to the overall nature of the ESI program which incentivizes and makes private health coverage affordable for low income children in families, the coordination of the standalone CHIP program with other private health insurance programs is essential to the program's success.

An application for the ESI program may be made in a variety of locations, for example, online from a home or office personal computer, on a paper form at a physician's office, a hospital or other medical facility, Health Department, or in the county OKDHS office. Frequently an insurance agent/producer/broker facilitates both the private group health plan and IO applications. A face to face interview is not required. ESI members select a qualified health plan at the time of application, based upon the private health plans offered to them through the business the family works for. The application includes all instructions needed for completing the application and providing all information necessary to determine the member's eligibility.

The methods of establishing eligibility and continuing enrollment for the ESI program contains two parts, the employer and the child's family. Employers who wish to participate in the program file an application form documenting their total number of employees and the qualified health plan they offer. In order for an employer to be eligible to participate in the Insure Oklahoma/O-EPIC program the employer must have a business that is physically located in Oklahoma; be currently offering, or at the contracting stage to offer a QHP; offer QHP coverage to working families; and contribute an equivalent 40 percent of premiums. An application may be made online or mailed or faxed into the Oklahoma Health Care Authority (OHCA) or its contractor. The State and its contracted agent verify the information on the application and process it in a timely manner, and results are added to the MMIS. Once an eligibility determination has been made the employer is notified via letter. After the employer is enrolled in the program the child's family completes a separate member application documenting their household income and number of children to be enrolled. The member application may be made online or mailed or faxed into the Oklahoma Health Care Authority or its contractor. In a manner similar to the employer process, the State and its contracted agent verify the information on the application and process it in a timely manner. Eligibility data are shared with the OKDHS system for eligibility certification and results are added to the MMIS. Once an eligibility determination has been made the child's family is notified via letter.

Benefits Provided

Members enrolled under ESI receive coverage through qualified, private health plan benefits offered through their eligible employer. Private health plans which do not meet minimum

requirements are not qualified for participation in the program. ESI members utilize the health care delivery system and network available to them through the private, qualified health plan. Providers are contracted directly with the private health plan and utilize the private health plan's health care delivery system and associated payment structure. Each individual private health plan oversees the utilization monitoring of their covered lives and contracted providers. Likewise, the private health plans make decisions as to the appropriateness and medical necessity of covered services. The private health plans must submit to the OHCA their schedule of benefits, including information on their protocols for prior approval and denial of services, prior to becoming qualified for participation in the ESI program. The OHCA reviews the submitted information and makes a determination as to whether the private health plan meets all established requirements.

The state, as a requirement of CHIPRA, provides dental services to children qualified for either ESI or IP. Dental coverage is provided in one of two ways:

(1) Private dental coverage subsidies, namely Dental-ESI. Dental coverage is obtained through private group plans offered by the employer's ESI. Dental-ESI benefits must meet or exceed covered benefits provided by the direct dental coverage, namely Dental-IP. Dental-ESI plans which do not meet minimum requirements are not qualified for participation in the program. The existing cost sharing requirements for ESI qualified children apply. Children obtaining medical coverage through ESI may choose to receive either Dental-ESI coverage (if available to them) or Dental-IP coverage.

(2) Direct dental coverage, namely Dental-IP. Dental coverage is obtained through direct purchase from the state. The existing cost sharing requirements for IP qualified children apply. Children obtaining medical coverage through IP receive Dental-IP coverage. The state contracts with Dental-IP providers directly. The Dental-IP providers receive the Medicaid fee schedule for rendered services.

Wrap Around Services

In order for a private health plan to become qualified for participation in the ESI program to provide coverage for children, the ESI plan must meet or exceed the coverage for items or services that are offered through direct coverage via Individual Plan (IP). Private health plans which do not meet minimum requirements are not qualified for participation in the program.

Cost Sharing

With ESI the cost of health insurance premiums is shared by the employer an equivalent 40 percent employer contribution of premiums, the child's family (maximum of 15 percent, ultimately capped at 5 percent of household income) and state/federal sources. Due to the contractual relationship between the employer and the private insurance carrier per the health coverage policy, and to decrease burden on the members, premium subsidy payments are made to the employer, who in turn remits full payment to the private insurance carrier. Private health plan deductibles must meet certain requirements which include:

a, An annual out-of-pocket maximum not to exceed $3,000 per individual, excluding copays and pharmacy deductibles.

Premiums: Members enrolled in the ESI program are required to pay up to 15 percent of their monthly health plan premium, not to exceed 3 percent out of the 5 percent annual gross household

income cap. (See ESI Maximum Monthly Premium chart at attachment B.4) Premium expenses, as well as co-payments, deductibles and coinsurance for covered family members shall not exceed 5 percent of the child's family's gross household income. Once this 5 percent maximum has been reached the State continues to provide reimbursement for allowable out of pocket expenses. A medical expense must be for an allowed and covered service by the health plan to be eligible for reimbursement.

Deductibles: Premium expenses, as well as co-payments, deductibles and coinsurance for covered family members shall not exceed 5 percent of the family's gross household income. Once this 5 percent maximum has been reached the State continues to provide reimbursement for allowable out of pocket expenses. A medical expense must be for an allowed and covered service by the health plan to be eligible for reimbursement. Deductibles for qualified, private health plans participating in the ESI program are established by the private insurance carrier, but must meet all IO program requirements (listed below). Private health plan deductibles must meet certain requirements which include:

a. Annual pharmacy deductibles cannot exceed $500 per individual; and

b, An annual out-of-pocket maximum cannot exceed $3,000 per individual, excluding copays and pharmacy deductibles.

Coinsurance or Copayments: Premium expenses, as well as co-payments, deductibles and coinsurance for covered children shall not exceed 5 percent of the family's gross household income. Once this 5 percent maximum has been reached the State continues to provide reimbursement for allowable out of pocket expenses. A medical expense must be for an allowed and covered service by the health plan to be eligible for reimbursement. Coinsurance or co-payments for qualified, private health plans participating in the Insure Oklahoma program are established by the private insurance carrier, but must meet all IO program requirements (listed below). Private health plan co-payments must meet certain requirements which include:

a. Office visits cannot require a co-pay exceeding $50 per visit; and

b. An annual out-of-pocket maximum cannot exceed $3,000 per individual, excluding copays and pharmacy deductibles.

Waiting Period

Upon initial application and enrollment, as well as upon periodic redeterminations of eligibility, all children are screened for SoonerCare coverage. If a child is found to be eligible for SoonerCare the child may not receive coverage through the Insure Oklahoma program.

Children who already have creditable coverage through another source (i.e. group health plan or state health benefits plan, namely OSEEGIB) must undergo, or be excepted from, a 6 month uninsured waiting period prior to becoming eligible for either ESI or IP. The State assures the policies governing waiting period application and exception are consistent for both ESI and IP programs. Exceptions to the waiting period may include:

(1) The cost of covering the family under the ESI plan meets or exceeds 10 percent of the gross household income. The cost of coverage includes premium, deductible co-insurance and copays;

(2) loss of employment by a parent which made coverage available;

(3) affordable ESI is not available; "Affordable" coverage is defined by the OHCA annually

using actuarially sound rates established by the Oklahoma State and Education Employee Group Insurance Board (OSEEGIB); and
(4) loss of medical benefits under SoonerCare.
After undergoing the waiting period (if applicable) and becoming eligible, children are allowed to disenroll from ESI coverage and enroll in IP coverage at any time, and vice versa.

Minimum Employer Contributions

The employer is required to contribute an equivalent 40 percent of premiums.

Qualified ESI Plans

Private health plans must meet certain requirements in order to participate in the program which include hospital services, physician services, clinical laboratory and radiology, pharmacy and office visits. Private health plans which do not meet minimum requirements are not qualified for participation in the program. ESI covered services for children are provided, arranged, and paid for by the private health plan. The state makes a monthly payment to the Oklahoma business for the subsidized premium amount. Coverage for children must also be available in order for a private health plan to participate in the program. Additionally, private health plan co-payments and deductibles must meet certain requirements which include:

b. Office visits cannot require a co-pay exceeding $50 per visit;
c. Annual pharmacy deductibles cannot exceed $500 per individual;
d. An annual out-of-pocket maximum cannot exceed $3,000 per individual, excluding copays and pharmacy deductibles; and
e. The maximum amount of all cost sharing (co-pays, deductibles and premiums) cannot exceed five percent of the child's family's total income. Cost sharing incurred by the family in excess of 5 percent is reimbursed by the Insure Oklahoma program.

Members enrolled under ESI receive coverage through qualified, private health plan benefits offered through their family's eligible employer. In addition to current requirements, qualified health plans must include well baby/well child exams including, but not limited to age appropriate immunizations as required by State law. Qualified health plans must also include coverage as medically necessary for emergency services defined at 42CFR457.10, and under state and federal law must comply with all provisions of EMTALA. ESI members utilize the health care delivery system and network available to them through the private, qualified health plan. Providers are contracted directly with the private health plan and utilize the private health plan's health care delivery system and associated payment structure.

Notice of Availability

All children are provided with information for both ESI and IP programs at the time of application through the Insure Oklahoma website. Families of children make an informed choice upon initial enrollment between either ESI or IP programs. The welcome letter (i.e. eligibility decision letter) to the child's family contains information educating the family that coverage for children via ESI is voluntary. The letter explains that children of the family may choose to utilize the option to "opt-out" of ESI coverage at any time, receiving instead direct coverage through the Premium Assistance Individual Plan (IP). This same information is shared with families at their time of recertification via letter / renewal notice. A letter is also sent to the employer indicating the working family is now qualified for the ESI program, and the employer begins receiving subsidy payments on behalf of the child's family. In the

event a member disenrolls from the ESI program, the member is provided a 30-day opportunity to enroll in the IP program without any gap in coverage. In these instances the member must notify the OHCA or its contracted agent of their intent to change programs prior to the effective date of the change. The OHCA or its contracted agent facilitates the member's enrollment, granted that all eligibility criteria continue to be met otherwise.

Outreach, Education, Enrollment

Insure Oklahoma utilizes a multi-faceted approach to conducting outreach. Due to the nature of the ESI program to incentivize members to enroll with private health plans offered by Oklahoma businesses, outreach efforts have been targeted to insurance agents, businesses, business coalition and economic development organizations and working families. Insure Oklahoma has been conducting periodic "Brown Bag" luncheon seminars as well as continuing education classes for interested agents and businesses in local communities across the state. These seminars include presentations on the program and lengthy question and answer periods where Insure Oklahoma staff can visit, one-on-one, with Oklahomans wanting to learn more about the program. Insure Oklahoma partners with the Oklahoma Insurance Department to staff Agent Partners. Agent Partners are individuals responsible for providing personalized attention to Oklahoma's health insurance agents. The Agent Partner positions were created to be a dedicated resource for agents, both already practicing and those newly established. The Insure Oklahoma program also offers a co-op program to insurance agents that pays half the cost of an approved Insure Oklahoma advertisement (print and/or broadcast) up to $5,000 per month per agent or agency. The advertisement co-op program is funded by tobacco tax revenues and claims administrative federal match. The Insure Oklahoma program sends periodic emails and postal mailings to a distribution list collected from the public website www.insureoklahoma.org The Insure Oklahoma staff continue to respond to requests for presentations to targeted groups, organizations, and communities across the state. Insure Oklahoma also conducts outreach specifically targeted to potential members. An advertising contract was awarded to Griffin Communications in which a marketing strategy and creative development recommendations were developed. Griffin created a series of television commercials, print advertisements, billboard displays, and public events where the Insure Oklahoma program was spotlighted as the state's premier health insurance assistance program.

Section 7. Quality and Appropriateness of Care

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. **(2102(a)(7)(A)) (42CFR 457.495(a))**

The methods used for the Soon-To-Be-Sooners (separate SCHIP) program will be the same as under Title XIX. 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.

Pertaining to 7.1.1 through 7.1.4 below. The state will also continue to use existing methods to assure the quality and appropriateness of care as have been established through the HEDIS monitoring tools. The state acknowledges these established tools do not appear to include special performance measurements specific to the unborn children and that the limited eligibility period and time on the program greatly inhibits the use of established monitoring tools. The state will work to include such (as the data allow) in the revisions and updates to the Strategic Objectives and Performance Goals for Oklahoma's Title XXI plan.

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

IP - Members enrolled in the IP program receive coverage from IP contracted providers who must adhere to IO (Medicaid) fee-for-service policies and procedures. Utilization review policies and procedures will follow Medicaid Title XIX practices, including protocols for prior approval and denial of services, hospital discharge planning, physician profiling, and retrospective review of both inpatient and ambulatory claims criteria. Utilization review is done cooperatively with Oklahoma Medicaid's Surveillance, Utilization and Review Subsystem (SURS) Unit as well as the Quality Assurance Division within the OHCA.

The methods used for IP program will be the same as under Title XIX, to the extent applicable. The state will report annually using the framework for the annual report of the CHIP program under Title XXI of the SSA. The OHCA puts forth an annual performance and quality report entitled "Minding our P's and Q's". In this report are research results pertaining to child health checkups, prenatal care and outcomes, comprehensive diabetes care, medical management of depression, and emergency room utilization study. Additionally this report includes performance trends as established by an independent review of the approved quality assessment tool (four primary domains) and HEDIS (Healthcare Effectiveness Data and Information Set) studies, as well as reports on the CAHPS (Consumer Assessment of Healthcare Providers and Systems)and ECHO (Experience of Care and Health Outcomes) surveys. This report can be found on the agency website at www.okhca.org Findings from this report are used to guide policy decisions impacting new areas to be targeted for improvement or demonstrate the effect of completed quality improvement activities.

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

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

Pertaining to 7.1.1 through 7.1.4 below. The state uses existing methods to assure the quality and appropriateness of care as have been established through the various monitoring tools listed below.

7.1.1. X Quality standards

The OHCA utilizes quality measures to determine whether a standard has been met during a certain time frame, as well as measures increases or decreases in rates over time. The quality standards used to measure performance come largely from nationally recognized health care measures. The primary sets of standards come from the national Medicaid mean of HEDIS measures, as well as agency-developed annual benchmarks aimed at improving quality performance by raising benchmarks from year to year.

7.1.2. X Performance measurement

The standard set of measures used by the OHCA mirror that of most American health plans by tracking performance on several important dimensions of care and services. The set of measures is the HEDIS group. HEDIS measures are used to identify areas for improvement and monitor effectiveness of performance improvement initiatives. The HEDIS measures tracked and included in the agency's annual quality report are dental care; breast cancer screening; cervical cancer screening; child health checkups; accessing care; comprehensive diabetes care; and appropriate medications for asthma. Likewise, annually the OHCA undergoes an external quality review which provides an independent assessment of the degree to which the agency has met our obligations under state and federal laws and regulations. The current quality assessment tool used for this review contains 122 measures and 4 domains in the areas of quality assurance; articulation of member rights; aspects of health care service delivery; and accountability of delegated functions.

7.1.3. X Information strategies

Assessing member satisfaction with OHCA programs and the health care they receive from contracted providers is performed primarily through two surveys. The CAHPS and ECHO surveys both ask questions related to members' experiences with providers and the health care system provided by OHCA programs. Findings from these surveys are used to inform policy and operational decisions surrounding ways the agency can improve service to members. Likewise, the OHCA conducts various provider reviews throughout the year. These reviews are used to inform contracted providers of potential quality issues while also allowing the agency to monitor the quality of services provided to members. The types of reviews include on-site provider reviews; dental provider audits; medical record review; and quality of care review.

7.1.4. X Quality improvement strategies

The OHCA acknowledges that in order to effectively administer the programs offered by the agency, input from external stakeholders is critical. The OHCA has created five primary advisory groups for the purpose of monitoring quality and providing guidance to the agency on strategies to achieve continuous quality improvement. These four groups are:
(1) Child Health Advisory Task Force – In collaboration with the Oklahoma State Department of

Health and a number of other organizations, the OHCA is participating in the Task Force which has set a priority list for issues to be tackled in the coming year.
(2) Medical Advisory Task Force – The Task Force consists of 12 physician members and is advising the OHCA on medical issues and recommending program and policy changes.
(3) Tribal Consultation – The OHCA has launched a formal program of consulting Native American tribes on program issues, such as program development, strategic planning, and legislation.
(4) Perinatal Advisory Task Force – The Task Force focuses specifically on perinatal issues and has come up with a set of recommendations largely leading to expanded benefits for pregnant members. Among the expanded benefits are the Perinatal Dental Access Program, Lactation Consultant services, Maternal and Infant Health Social Work services, Genetic Counseling, and Prenatal Risk Assessment.
(5) Behavioral Health Advisory Council – The Advisory Council has been in existence since 1999, focusing on the mental health and substance abuse needs, benefits, policies, and quality of services for our members. The 35 member council is made up of behavioral health providers (both pubic and private), consumers, advocacy groups, state agency reps, and professional organizations.

7.2. Describe the methods used, including monitoring, to assure: **(2102(a)(7)(B)) (42CFR 457.495)**

The methods used for the Soon-To-Be-Sooners (separate SCHIP) program will be the same as under Title XIX.

7.2.1 X Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. **(Section 2102(a)(7)) (42CFR 457.495(a))**

IO ESI utilizes private health plans which must be qualified by the OHCA prior to participation in the program. IP utilizes a state-administered “safety-net” plan which contains a provision for no-cost preventive services. Both ESI and IP plans are required to provide well baby/child care including immunizations as a condition of qualification for the program. IO staff routinely review compliance with the plan requirements and operating systems supporting the plans.

7.2.2 X Access to covered services, including emergency services as defined in 42 CFR. 457.10. **(Section 2102(a)(7)) 42CFR 457.495(b))**

Access to emergency services is monitored as part of the emergency room utilization study, which includes reviewing claims, diagnosis, member PCP alignment, PCP visits and member surveys.

7.2.3 X Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollees medical condition. **(Section 2102(a)(7)) (42CFR 457.495(c))**

The state monitors and facilitate treatment of enrollees with chronic, complex or serious medical conditions. One way this occurs is through the Health Management Program(HMP). The

program is designed to target members at high risk for health problems that may be improved through the HMP intervention. Interventions are conducted by care management nurses and a variety of education programs, aimed at conditions or diagnoses seen frequently among members, are offered to members.

7.2.4 X Decisions related to the prior authorization of health services are completed in accordance with state law **or,** in accordance with the medical needs of the patient, within 34 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d))

The state assures that prior authorization of health services are completed in a timely manner and in accordance with state law. The OHCA takes into consideration the urgency of care in responding to prior authorization requests.

Section 8. Cost Sharing and Payment **(Section 2103(e))**

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 9.

8.1. Is cost sharing imposed on any of the children covered under the plan? **(42CFR 457.505)**

8.1.1. X YES (Insure Oklahoma (IO) standalone CHIP program only.)

8.1.2. ☐ NO**, skip to question 8.8.**

8.2. Describe the amount of cost sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate. **(Section 2103(e)(1)(A))** **(42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))**

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

8.2.1. Premiums:

IP - IP is a health coverage option which offers comprehensive health services to qualified children in families who may either: (1) be employed by an Oklahoma business but are not eligible for ESI; or (2) be unemployed. The IP program is a state-operated health plan (otherwise referred to as "safety-net" coverage) for those without access to coverage via SoonerCare or ESI, for which members pay a monthly premium and co-payments for some services. The maximum amount of all cost sharing (co-pays and premiums) cannot exceed five percent of the child's family's gross total income. Once this 5 percent maximum has been reached the State continues to provide reimbursement for allowable out of pocket expenses. A medical expense must be for an allowed and covered service by the health plan to be eligible for reimbursement. The average IP premium is set annually based on claims experience projections for the child's eligibility group. For each State fiscal year, the State establishes age/gender premium bands for IP. The monthly premium for a child is set

at 20 percent of the age/gender band. The household contribution is capped, not to exceed 4 percent of the monthly gross household income. See IP Maximum Monthly Premiums chart at attachment B.3.

f. 8.2.2. Deductibles:

IP – No Deductibles.

g. 8.2.3. Coinsurance or copayments:

IP – No coinsurance. Co-payments for covered children shall not exceed 5 percent of the family's gross household income. Once this 5 percent maximum has been reached the State continues to provide reimbursement for allowable out of pocket expenses. A medical expense must be for an allowed and covered service by the health plan to be eligible for reimbursement. Co-payments for covered services in the Insure Oklahoma IP program are established by the Oklahoma Health Care Authority. A full listing of the benefits with associated co-payments can be found below as well as within attachment B.2. Well baby/child exams and age appropriate immunizations are not subject to co-payments.

Service	Cost Sharing per Service
Ambulance	*$50.00 co-pay per occurrence, waived if admitted*
Blood and Blood Products	$0 co
	$0 co
Chelation Therapy	$0 co
Chemotherapy and Radiation Therapy	*$10.00 co-pay per visit*
Clinic Services including renal dialysis services	*$0.00 co-pay for dialysis services; $10.00 co-pay per office visit*
Dental Services (Dental IP)	*Class A $0 co-pay*
	Class B $10 co-pay
	Class C $25 co-pay
	Class D $25 co-pay
Diabetic Supplies	*$5.00 co-pay billable service*
Diagnostic X-ray services	*$25.00 co-pay per scan for MRI, MRA, PET, CAT sans only*
Dialysis	$0 co-pay

Service	Cost Sharing per Service
Durable Medical Equipment and supplies	*$5.00 per item co-pay for durable/non-durable supplies; $25.00 co-pay per item for DME, $15,000 annual maximum*
Emergency Department	*$30.00 co-pay per occurrence, waived if admitted*
Family Planning services and supplies	$0 co-pay
Home Health services	*Copay $10 per visit, Appropriate Pharmacy and DME co-pay will apply*
Hospice services	*Copay $10 per visit*
Immunizations	*$0 co-pay per immunization*
Inpatient Hospital services (Acute Care only)	*$50.00 co-pay per admission*
Laboratory	$0 co-pay
Psychological Testing	$0 co-pay
Mental Health/ Substance Abuse Treatment-Outpatient	*$10.00 per outpatient visit*
Mental Health/Substance AbuseTreatment- Inpatient	*$50.00 co-pay per admission*
Nurse Midwife services	*$0 co-pay*
Nutrition Services	$10 co-pay per visit
Nutritional Support	*$25.00 co-pay per month, not subject to $15,000 annual DME limit*
Oral Surgery	*$25.00/outpatient facility -$50.00 inpatient hospital co-pay*
Other medically necessary services not otherwise specified	$0 co-pay
Outpatient Hospital services	*$25.00 co-pay per visit; Therapeutic radioogy or chemotherapy $10.00 co-pay per visit*
Oxygen	*$5.00 co-pay per month;*
PCP visits	*$10.00 co-pay per visit*
Physical, Occupational and Speech Therapy	*$10.00 co-pay per visit*

Service	Cost Sharing per Service
Physician services, including preventive services	*$10.00 co-pay per visit*
Prenatal, delivery and postpartum services	*$0.00 co-pay for office visits; $50.00 co-pay for delivery*
Prescription Drugs and insulin	*$5.00/$10.00 co-pay per prescription*
Smoking Cessation Products	*$5.00/$10.00 co-pay per product*
Specialty Clinic visits	*$10.00 co-pay per visit*
Surgery	*$25.00/outpatient facility -$50.00 inpatient hospital co-pay*
Tuberculosis services	*$10.00 co-pay per visit*
Ultraviolet Treatment-Actinotherapy	$5 co-pay per visit

8.2.4. Other: None

8.3. Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. **(Section 2103(e)((1)(B)) (42CFR 457.505(b))**

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.

General reference to the cost-sharing requirements is included in all printed materials and

website information concerning the IO program. The specific requirements are detailed in all pamphlets and brochures developed for outreach purposes, on the materials supporting the application for participation, and within the member's handbook. The letter that confirms eligibility and enrollment in the program also addresses the cost-sharing requirements and indicate the family cap (in both percentage and dollar amounts) that applies based on reported income. All staff who deal directly with the public concerning the program are trained on the cost-sharing requirement alongside all programmatic information.

8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: **(Section 2103(e))**

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

8.4.1. X Cost sharing does not favor children from higher income families over lower income families. **(Section 2103(e)(1)(B)) (42CFR 457.530)**

8.4.2. X No cost sharing applies to well-baby and well-child care, including age-appropriate immunizations. **(Section 2103(e)(2)) (42CFR 457.520)**

8.4.3 X No additional cost sharing applies to the costs of emergency medical services delivered outside the network. **(Section 2103(e)(1)(A)) (42CFR 457.515(f))**

8.5. Describe how the state will ensure that the annual aggregate cost sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: **(Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))**

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

ESI - Children enrolled in the ESI program are required to pay a portion of their monthly health plan premium, up to 15 percent of the health insurance premium not to exceed 3 percent out of the 5 percent annual gross household income cap. Premium expenses, as well as co-payments, deductibles and coinsurance for covered family members shall not exceed 5 percent of the family's gross household income. Once this 5 percent maximum has been reached the State continues to provide reimbursement for allowable out of pocket expenses. A medical expense must be for an allowed and covered service by the health plan to be eligible for reimbursement. In an effort to prevent members from relying primarily on a refund given by the State, the ESI program captures the premium amount due from the member with the initial application, identifies the 3 percent of household income cap, and based upon the cap, calculates the monthly premium amount due from the member for the remainder of the year. This process guarantees that the member is not required to be reimbursed for any premium expenses.

IP - For children enrolled in the IP program the maximum amount of all cost sharing (co-pays

and premiums) cannot exceed five percent of a family's total income. Once this 5 percent maximum has been reached the State continues to provide reimbursement for allowable out of pocket expenses. A medical expense must be for an allowed and covered service by the health plan to be eligible for reimbursement. The household contribution is capped, not to exceed 4 percent of the monthly gross household income. In an effort to prevent members from relying primarily on a refund given by the State, the IP program captures the premium amount due from the member with the initial application, identifies the 4 percent of household income cap, and based upon the cap, calculates the monthly premium amount due from the member for the remainder of the year. This process guarantees that the member is not required to be reimbursed for any premium expenses.

8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost sharing. **(Section 2103(b)(3)(D)) (42CFR 457.535)**

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

The state ensures that American Indian and Alaska Native children are excluded from cost-sharing, by collecting information on the application and at the time of redetermination of eligibility regarding a child's status as an American Indian or Alaska Native. The applicant is asked to indicate their tribal membership by stating this on the application and the State receiving appropriate tribal documentation. If an applicant is found to be in the AI/AN category, the family is notified of the exemption. For AI/AN children the systematic cost sharing limits are set to 0 percent which prevents the assessment of a premium. In addition, the requirement that no AI/AN child be charged a copayment is contained in two places: (1) the provider contract; and (2) the provider manual each new IO provider receives. All providers are required to verify eligibility by checking the eligibility card, which contains a notation regarding AI/AN status. For the ESI program AI/AN children have systematic cost sharing limits set to 0 percent of household income. This results in AI/AN children's cost sharing limit equaling 0 percent, rather than the 5 percent limit incurred by non-AI/AN children. The 0 percent limit allows immediate issue of payment for all cost sharing amounts entered into the system (i.e. premium, deductible, copay, and co-insurance).

8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. **(42CFR 457.570 and 457.505(c))**

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

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

X State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. **(42CFR 457.570(a))**

IP Premiums are required from the member before the first of the month to which coverage applies. IP premium payment is due on the 5th of each month prior to the month of coverage. If the State has billed a member for a premium payment, and the member does not pay the amount due within 60 days of the date on the bill, then the member's eligibility for benefits is terminated. By allowing members 60 days to remit payment, the State assures all members are provided the minimum 30 day grace period for premium payment. The member receives an additional written notice of termination at least 10 days prior to the date of the termination.

X The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. **(42CFR 457.570(b))**

The IP member's eligibility is not terminated if the member, prior to the date of termination, pays all amounts which have been billed 60 days or establishes a payment plan acceptable to the State. After such a payment plan has been established, the State bills the member for (a) payments in accordance with the payment plan, and (b) monthly premiums due subsequent to the establishment of the payment plan. If the member does not make payments in accordance with the payment plan within 30 days of the date on the bill, the member's eligibility is terminated. The State sends written notice of termination within 7 days from the beginning of the 30 day period. If the State determines that the requirement to pay a premium results in an extreme financial hardship for an enrollee, the State may, in its sole discretion, waive payment of the premium or reduce the amount of the premiums assessed to a family.

All IO members are advised at enrollment that in the event their household situation changes (i.e. family size, employment, income, etc.) they may initiate a new IO application. This new application collects new information from the household and is submitted to the OHCA or its contracted agent. The new applications are processed and if appropriate, trigger re-calculation of the 5 percent household income cap and monthly premiums.

X In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. **(42CFR 457.570(b))**

In the event the IO family demonstrates, through a hardship waiver, a change in income (an income loss), the family is assisted with determining if the family (or certain members of the family) are now eligible for the SoonerCare program, at no cost. The eligibility determination is facilitated by staff who assist the member completing the information necessary for enrollment in to the program.

X The state provides the enrollee with an opportunity for an impartial review to

address disenrollment from the program. **(42CFR 457.570(c))**

All OHCA programs, including Insure Oklahoma programs, are governed by administrative rules which include member grievance and appeals procedures. These procedures are available to all members and allow for an impartial review of the facts of their case.

8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: **(Section 2103(e))**

8.8.1. X No Federal funds will be used toward state matching requirements. **(Section 2105(c)(4)) (42CFR 457.220)**

8.8.2. X No cost sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. **(Section 2105(c)(5) (42CFR 457.224)** (*Previously 8.4.5)*

8.8.3. X No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. **(Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))**

8.8.4. X Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. **(Section 2105(d)(1)) (42CFR 457.622(b)(5))**

8.8.5. X No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. **(Section 2105)(c)(7)(B)) (42CFR 457.475)**

8.8.6. X No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). **(Section 2105)(c)(7)(A)) (42CFR 457.475)**

Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

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)) (42CFR 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 2107(a)(3)) (42CFR 457.710(c))**

1. (a) Decrease the number of uninsured Oklahoma children by 2% within 5 years beginning 7/1/09, under 19 years of age, under 186% FPL.
(b) Decrease the number of uninsured Oklahoma children by 2% within 5 years beginning 2/1/10, under 19 years of age, 186-300% FPL.
(c) Increase the number of qualified Oklahoma businesses participating in the Insure Oklahoma program by 2% within 5 years beginning 2/1/10. Oklahoma businesses participate in the IO program by offering a qualified health 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, under 186% FPL.
(b) Increase the number of Insure Oklahoma enrolled children by 2% within 5 years beginning 2/1/10, under 19 years of age, 186-300% FPL.

3. (a) Increase the number of SoonerCare enrolled Oklahoma children by 2% within 5 years beginning 7/1/09, under 19 years of age, under 186% FPL.
(b) Increase the number of SoonerCare enrolled Oklahoma pregnant women by 2% within 5 years beginning 7/1/09, under 186% FPL.

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.
(b) Maintain the capacity of contracted Insure Oklahoma primary care providers over a 2 year period beginning 2/1/10.

(c) Increase the percentage of SoonerCare children, under 19 years of age, under 186% FPL, who have selected a contracted SoonerCare primary care provider by 2% within 5 years beginning 1/1/09.

(d) Increase the percentage of Insure Oklahoma children, under 19 years of age, 186-300% 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. 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, by 2% within 5 years beginning 7/1/09. 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.

(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)) (42CFR 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 (C.P.S.) 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 TXIX and TXXI; and
- Oklahoma HEDIS data.

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

9.3.1. X The increase in the percentage of Medicaid-eligihle children enrolled in Medicaid.

9.3.2. X The reduction in the percentage of uninsured children.

9.3.3. X The increase in the percentage of children with a usual source of care.

9.3.4. X The extent to which outcome measures show progress on one or more of the health problems identified by the state.

9.3.5. X HEDIS Measurement Set relevant to children and adolescents younger than 19.

9.3.6. X 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-child care

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, please list:

9.3.8. ☐ Performance measures for special targeted populations.

9.4. X 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)) (42CFR 457.720)**

9.5. X The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the states plan for these annual assessments and reports. **(Section 2107(b)(2)) (42CFR 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. X The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. **(Section 2107(b)(3)) (42CFR 457.720)**

9.7. X The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. **(42CFR 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)) (42CFR 457.135)**

9.8.1. X Section 1902(a)(4)(C) (relating to conflict of interest standards)

9.8.2. X Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)

9.8.3. X Section 1903(w) (relating to limitations on provider donations and taxes)

9.8.4. X Section 1132 (relating to periods within which claims must he 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 insuring ongoing public involvement. **(Section 2107(c)) (42CFR 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.

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.

Pertaining to the Unborn Child and IO (separate SCHIP) programs the state, likewise, continues to utilize assistance from other state agencies, provider organizations, community groups, and others in the development of this new initiative. 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. (Section 2107(c)) (42CFR 457.120(c))**

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 OIJCA 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 20-2 i, 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 Tribes, 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), please describe how and when prior public notice was provided as required in §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.

9.10. Provide a 1-year projected budget. A suggested financial form for the budget is attached. The budget must describe: **(Section 2107(d)) (42CFR 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 sources of non-Federal plan expenditures, including any requirements for cost sharing by enrollees.

DECEMBER 30, 2008 SCHIP ANNUAL REPORT EXCERPT

Below are the actual SCHIP expenditures for 2008 along with revised estimates of expenditures for 2009 and 2010. These estimates were included in the SCHIP Annual Report which was submitted to CMS last week.

Several issues to note about how these estimates were developed:

1. Overall enrollment and average per participant costs are the drivers.
2. I projected an overall 1% increase in the base SCHIP enrollment and a 3% increase in the average cost per participant per year and then added my projections to the estimates for the Soon to be Sooners and the All Kids Act programs (estimates are broken out below).
3. Overall SCHIP enrollment would have declined by ~3,250 between 2007 and 2008 had it not been for the Soon to be Sooners program.
4. Between December 2007 and October 2008 5,380 SCHIP beneficiaries lost benefits due to citizenship documentation issues. Of that amount, 3,247 were reopened.
5. I anticipated the All Kids Act issue to be resolved and went back to the original estimates of kids covered up to 300% FPL with a 20% annual uptake each year and put the program into effect for 3 quarters of 2009.
6. There was a substantial increase in the Fee for Service expenditure line between 2007 ($6.1 million) and 2008 ($14.3 million). A review of this line indicates an increase in inpatient hospital and inpatient mental health expenditures.

COST OF APPROVED SCHIP PLAN

Benefit Costs	**2008**	**2009**	**2010**
Insurance payments	0	6,550,410	17,829,612
Managed Care	108,688,345	110,438,227	113,751,374

Fee for Service	14,379,110	17,552,906	20,079,833
Total Benefit Costs	123,067,455	134,541,543	151,660,820
(Offsetting beneficiary cost sharing payments)			
Net Benefit Costs	123,067,455	134,541,543	151,660,820

Administration Costs

Personnel			
General Administration	**3,033,105**	3,775,515	4,809,659
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/Marketing costs			
Other (e.g., indirect costs)			
Health Services Initiatives			
Total Administration Costs	**3,033,105**	**3,775,515**	**4,809,659**
10% Administrative Cap (net benefit costs ÷ 9)	**13,674,162**	**14,949,060**	**16,851,202**

Federal Title XXI Share	**95,059,601**	**105,300,776**	**117,509,329**
State Share	**29,040,959**	**33,016,282**	**38,961,149**

TOTAL COSTS OF APPROVED SCHIP PLAN	**126,100,560**	**138,317,058**	**156,470,479**

2. What were the sources of non-Federal funding used for State match during the reporting period?

- ☒ State appropriations
- ☐ County/local funds
- ☐ Employer contributions
- ☐ Foundation grants
- ☐ Private donations
- ☐ Tobacco settlement
- ☒ Other (specify) **For 2009 and beyond the state match for the insurance program will be from an allocation of state tobacco taxes which are collected by the state tax commission and deposited into a separate continuing fund administered by OHCA. Per Oklahoma state statute, $8M has been set aside within the Tobacco Tax revenues specifically for coverage of children in families earning from 185 up to and including 300 percent of the federal poverty level through the Insure Oklahoma program.**

3. Did you experience a short fall in SCHIP funds this year? If so, what is your analysis for why there were not enough Federal SCHIP funds for your program? **No**

4. In the table below, enter 1) number of eligible used to determine per member per month costs for the current year and estimates for the next two years; and, 2) per member per month cost rounded to a whole number. If you have SCHIP enrollees in a fee for service program, per member per month cost will be the average cost per month to provide services to these enrollees.

	2008		2009		2010	
	# of eligible Per Month	$ PMPM	# of eligible Per Month	$ PMPM	# of eligible Per Month	$ PMPM
Insurance Premiums			3,478	$156.64	9,275	$160.19
Managed Care	60,467	$149.79	61,072	$150.70	61,682	$153.66
Fee for Service	4,410	$346.43	6,498	$225.10	6,600	$253.54
Program Totals	64,876	$160.02	71,048	$157.81	77,557	$162.96

Enter any Narrative text below. **Data include Soon to be Sooners and three quarters of the year for 2009 of premium assistance program for children up to 300% of FPL.**

Soon to be Sooners Break Out Section Included in Estimates

	FFY 2009	FFY 2010	FFY 2011
Estimated # of Enrolled STBS	6,710	6,844	7,000
Estimated Cost Per Enrolled for the Year Based on MAR Report Oct 2007 to November 2008	$714	$728	$728
Estimated Annual	$4,790,626	$4,984,167	$5,096,000
Administrative Expenses 2.44% of Program Cost	$116,891	$121,614	$124,342
Total Annual	$4,907,517	$5,105,781	$5,220,342
55% in Any Month	3,691	3,764	3,850
Member Months	44,286	45,170	46,200

All Kids up to 300% Break Out Section Included in Estimates

All Kids to 300%

	2009 Partial Year	2010 Year	2011 Year	2012 Year	2013 Year
Overall Total	42,159				
20% enrollment 1st Year for three quarters	6,323.85	16,863.60	25,295.40	33,727.20	42,159.00
55% enrolled any given month	3,478	9,275	13,912	18,550	23,187
Cost Per Eligible	$1,103.06	1,140.55	1,163.36	1,163.36	1,163.36
Total Computable	$6,975,580	$19,233,800	$29,427,714	$39,236,953	$49,046,191
E-FMAP	76.13%	75.10%	75.10%	75.10%	75.10%
Federal	$5,310,509	$14,444,584	$22,100,214	$29,466,951	$36,833,689
State	$1,665,071	$4,789,216	$7,327,501	$9,770,001	$12,212,501

Annual Unduplicated SCHIP Enrollment in Oklahoma
Data Source: MARS Reports

Federal Fiscal Year	*Enrollment*	*Annual Change*	*Percent Change*	*Total Computable Cost Per Participant*
FFY 2004	92,798			$628
FFY 2005	108,231	15,433	16.63%	$742
FFY 2006	116,112	7,881	7.28%	$901
FFY 2007	117,392	1,280	1.10%	$1,054
FFY 2008	117,892	500	0.43%	$1,070
Estimate for 2009	125,395	7,503	6.36%	$1,103
Estimate for 2010	137,188	11,794	9.41%	$1,141
Estimate for 2011	146,992	9,804	7.15%	$1,163

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: **(Section 2108(a)(1),(2)) (42CFR 457.750)**

10.1.1. X The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on

the result of the assessment, and

10.2. X The state assures it will comply with future reporting requirements as they are developed. **(42CFR 457.710(e))**

10.3. X The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

Section 10.3-D X Specify that the State agrees to submit yearly the approved dental benefit package and to submit quarterly the required information on dental providers in the State to the Health Resources and Services Administration for posting on the Insure Kids Now! Website.

Section 11. Program Integrity (Section 2101(a))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue to Section 12.

11.1 X 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. **(Section 2101(a)) (42CFR 457.940(b))**

11.2. 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)) (42CFR 457.935(b))** The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)

11.2.1. X 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)

11.2.2. X Section 1124 (relating to disclosure of ownership and related information)

11.2.3. X Section 1126 (relating to disclosure of information about certain convicted individuals)

11.2.4. X Section 1128A (relating to civil monetary penalties)

11.2.5. X Section 1128B (relating to criminal penalties for certain additional charges)

11.2.6. X Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and enrollee protections (Sections 2101(a))

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan.

Eligibility and Enrollment Matters

12.1 X Please describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120.

The review process for eligibility and enrollment matters will be the same as the Medicaid Fair Hearing Process.

Health Services Matters

12.2 X Please describe the review process for health services matters that complies with 42 CFR 457.1120.

The review process for health service matters will be the same as the Medicaid Fair Hearing Process.

Premium Assistance Programs

12.3 X If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

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

The State assures that all private-market group health plans participating in the ESI program meet all requirements currently in effect for all health insurance issuers (as defined in section 2791 of the Public Health Service Act). The Oklahoma Insurance Department currently oversees the licensing of all Oklahoma health plans, the requirements for which must meet all state and federal laws in effect pertaining to health insurance issuers.