
Table of Contents

State/Territory Name: Oklahoma

State Plan Amendments (SPA) #: OK-18-0024

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) State Plan Pages

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



Children and Adults Health Programs Group

Melody Anthony
Medicaid Director
Oklahoma Health Care Authority
4345 N. Lincoln Boulevard
Oklahoma City, OK 73105

NOV 01 2019

Dear Ms. Anthony:

I am pleased to inform you that your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA) OK-18-0024 has been approved. Effective September 1, 2019, Oklahoma elected to provide behavioral health coverage and to add non-emergency medical transportation for its separate CHIP population in order to provide Early Periodic Screening Diagnostic and Treatment (EPSDT) that is consistent with Medicaid.

Section 2103(c)(7)(B) of the Social Security Act (the Act), as implemented through regulations at 42 CFR 457.496(b), provides that if CHIP coverage includes the EPSDT benefit as defined in section 1905(r) of the Act and provided in accordance with section 1902(a)(43) of the Act, the state plan will be deemed to satisfy parity requirements. Effective the date of this letter, the state has removed all visit limits in order to receive EPSDT deemed compliance. The state has also provided the necessary assurances and supporting documentation to demonstrate that EPSDT is provided in accordance with sections 1905(r) and 1902(a)(43) of the Act. This SPA approval relates only to benefits provided under the CHIP state plan; Medicaid benefits will be analyzed separately.

Your title XXI project officer is Jasmine Aplin. She is available to answer questions concerning these amendments. Ms. Aplin's contact information is as follows:

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

Official communications regarding program matters should be sent simultaneously to Ms. Jasmine Aplin and to Mr. Bill Brooks, Director, Division of Medicaid Field Operations South. Mr. Brooks' address is:

Page 2- Ms. Anthony

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

If you have additional questions or concerns, please contact Ms. Amy Lutzky, Director, Division of State Coverage Programs, at (410) 786-0721. We look forward to continuing to work with you and your staff.

Sincerely,



/signed Anne Marie Costello/

Anne Marie Costello
Director

cc: Mr. Bill Brooks, Director, Division of Medicaid Field Operations South

**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: Kevin Corbett	Position/Title: Chief Executive Officer
Name: Melody Anthony	Position/Title: Chief Operations Officer
Name: Maria Maule	Position/Title: Interim Chief of Legal Services

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. A combination of both of the above.

Oklahoma provides medically necessary services under its expansion program to children up to, and including, 185 percent of the Federal Poverty Level (FPL), converted to the MAGI-equivalent percent of FPL and applicable disregards. In Oklahoma, this expansion program is called SoonerCare.

Oklahoma also provides medically necessary services under two distinct programs that operate under the separate child health program authority. The separate child health programs are called Soon-to-be-Sooners (STBS) and Insure Oklahoma (IO).

In Oklahoma, Soon-to-be-Sooners (STBS) is the unborn child program, while Insure Oklahoma (IO) is the program that offers premium assistance to eligible and enrolled families and children.

Oklahoma operates a combination program.

SoonerCare (Medicaid Expansion)

The state operates a Medicaid expansion program, namely SoonerCare, which serves children in families earning up to and including 185 percent of the federal poverty level, converted to the MAGI-equivalent percent of FPL and applicable disregards.

Oklahoma also operates a standalone SCHIP program with two components: 1) children covered from conception to birth under Soon-To-Be Sooners, and 2) a premium assistance program referred to as Insure Oklahoma.

Soon-To-Be-Sooners (STBS/Separate CHIP)

Under this program unborn children of families earning up to and including 185 percent of the federal poverty level, converted to the MAGI-equivalent percent of FPL and applicable disregards, are covered. 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.

Insure Oklahoma (IO/Separate CHIP):

Oklahoma manages a standalone CHIP program, IO for children in families earning up to and including 225 percent of the federal poverty level, allowing select groups the ability to receive benefits through the Premium Assistance Employer Sponsored Insurance (ESI) 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.

- 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):

Original Plan:
 Effective Date: 12/01/97

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

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

Disregard 85% of the FPL from income:
 Effective date: 09/01/01

Technical SPA:

Date: 02/24/03

Separate SCHIP program for unborn children:

Effective date: 01/01/08

Implementation Date: 04/01/08

STBS:

Effective date: 01/01/08

Implementation date: 04/01/08

Census Income Disregard:

Effective date: 07/01/09

Implementation date: 07/01/09

OK-CHIPSPA#6: To cover children above 185 to 300% of FPL with two options:

1) direct coverage or 2) premium assistance.

Date Submitted; June 22, 2009

Date Approved: December 18, 2009

Effective Date: December 1, 2009

Insure Oklahoma coverage for children:

Effective date: 01/01/10

Implementation date: 02/01/10

Implementation date: 08/01/10 (Expanded ESI)

Implementation date: 09/01/10 (Expanded IP)

Remove Insure Oklahoma coverage for IP children & update waiting period:

Implementation date: 01/01/14

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

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

OK-16-0007: Establishing multiple new Health Services Initiatives (HSIs). 1) Provide LARC devices to a target population, 2) to provide education to provider’s about those devices, 3) Naloxone kits, 4) services for foster care children, and 5) Academic Detailing.
 Date Submitted; March 11, 2016
 Date Approved: May 26, 2016
 Effective Date: July 1, 2016

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

SPA # 18-0013 Revise and Update CHIP Goals & Objectives
Proposed effective date: 09/01/2018
Proposed implementation date: 09/01/2018

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

SPA #18-0024: Demonstrates compliance with MHAEA requirements
Proposed effective date: 11/01/2019
Implementation date for adding benefits: 09/01/2019
Implementation date for all other changes: 11/01/2019

SPA #19-0041: This SPA changes the premium assistance authority, clarifies that beginning on 01.01.2014 the State discontinued premium assistance in the individual market, and provides updates to outdated language in the CHIP state plan.
Proposed effective date: 07/01/19
Proposed implementation date: 01/01/2014

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 eligible individuals who are not enrolled, the number of "uninsured" eligible individuals 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.

2.3-TC Tribal Consultation Requirements- (Sections 1902(a)(73) and 2107(e)(1)(C)); (ARRA #2, CHIPRA #3, issued May 28, 2009) Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(1)(C) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

Describe the process the State uses to seek advice on a regular, ongoing basis from federally-recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Include information about the frequency, inclusiveness and process for seeking such advice.

Tribal Consultation Requirements for All State Plan Changes

Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

Oklahoma has three different tribal provider types including 638 tribal facilities, facilities operated by the Indian Health Service, and Urban Indian clinics (This collective group is referred to as Indian Tribal Units I/T/Us). The agency has quarterly meetings with all of the Indian Health Service business office managers, and meets on an as needed basis with any of the three tribal provider types, as well as conducts site visits and trainings as needed. Per the OHCA Tribal Consultation Policy, executed in 2007, the agency convenes bi-monthly tribal consultation meetings on the first Tuesday of every odd numbered month. These meetings are held at the OHCA building and attendees are also able to attend the meetings via teleconference technology to enable partners to conveniently participate without having to travel from their community. The agenda and summary for the bi-monthly meetings are posted two weeks before the meeting date online at www.okhca.org/tribalrelations. The mailing list for bi-monthly meetings has over 100 individuals including elected tribal leaders, I/T/U administrators, tribal community leaders, and key tribal health stakeholders. Additionally, the agency hosts an annual tribal consultation meeting in October. OHCA's annual tribal consultation provides an opportunity for tribal community leaders to receive program updates, as well as give input and ask questions about the SoonerCare and Insure Oklahoma programs. This meeting is designed to receive feedback from tribal partners about the direction of the programs and opportunities for partnerships with tribal entities.

In regard to rule, waiver implementations or renewals, state plan changes, and demonstrations projects, the agency issues an I/T/U Public Notice provider letter via email to each I/T/U provider(s) advising them of all proposed rule, waiver implementations or renewals, state plan changes, and demonstrations projects, and/or state plan changes. The I/T/Us are encouraged to offer feedback on proposed changes. The letter, along with meeting agenda and summary, is also posted to our public website under I/T/U Public Notification which is a designated place for I/T/Us updates and information. The agency also has a proposed rule change page on our public website that allows public comment on proposed rule changes and offers web alerts for future updates and comment opportunities. Notification to tribes for consultation under normal circumstances is provided at least 60 days prior to a rule change or waiver/SPA submission. In the event of abnormal circumstances (such as, but not exclusive to Federal Regulatory changes, judgments from lawsuits, etc.), I/T/Us are given as much notice for consultation as possible; if such an abnormal process has been identified, notification to tribes for consultation could be as short as 14 days prior to submission of the waiver implementations or renewals, state plan changes, and/or demonstrations projects, in conjunction with email notification to the I/T/Us of the proposed changes.

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

- 2.2** Health Services Initiatives- Describe if the State will use the health services initiative option as allowed at 42 CFR 457.10. If so, describe what services or programs the State is proposing to cover with administrative funds, including the cost of each program, and how it is currently funded (if applicable), also update the budget accordingly. (Section 2105(a)(1)(D)(ii)); (42 CFR 457.10)

Health Service Initiative Request #1:

The Long Acting Reversible Contraceptive (LARC) devices Health Service Initiative (HSI) will address a state-wide effort to promote education to the 18 and younger targeted age group. The initiative will align strategies across agencies as well as private and public payers in order to promote efficient utilization. This effort will increase the target population's access and utilization of LARC devices leading to a decrease in unwanted pregnancies as well as decrease costs to the Medicaid program. The estimated total budget impact for FFY 2016 for this program is \$30,000; the federal share for FFY 16 is \$28,707 and state share is \$1,293. The estimated total budget impact for FFY 2017 for this program is \$120,000; the federal share for FFY 17 is \$113,952 and the state share is \$6,048. The budget has been updated accordingly. This strategy will be part of a larger project already underway and funded by Tulsa Community Foundation and the OHCA; however, the specific strategy mentioned herein is not currently funded.

Health Service Initiative Request #2:

The Long Acting Reversible Contraceptive (LARC) devices Health Service Initiative (HSI) will formulate a concerted effort to address the problem of unwanted pregnancy and promote LARC

devices. The State proposes to spearhead a state-wide effort to promote provider education and training regarding LARC devices and align strategies across agencies as well as private and public payers in order to support efficient utilization. The State will contract with an entity to provide training and education for other payers, medical schools, health departments, and stakeholders in order to increase availability and usage of LARC devices while decreasing the barriers of LARC device usage in female Oklahomans under the age of 19. The estimated total budget impact for FFY 2016 for this program is \$400,000; the federal share for FFY 16 is \$382,760 and the state share is \$17,240. The estimated total budget impact for FFY 2017 for this program is \$1,600,000; the federal share for FFY 17 is \$1,519,360 and the state share is \$80,640. The budget has been updated accordingly. This strategy is new and it is not currently funded.

Health Service Initiative Request #3:

Oklahoma leads the nation in non-medical use of prescription painkillers, with more than 8% of the population aged 12 and older abusing/misusing painkillers. It is also one of the leading states in prescription painkiller sales per capita. Both behaviors have resulted in a large number of hospitalizations and overdose deaths among the States' residents. An increasingly popular medication that can prevent the hospitalizations and deaths is Naloxone, which reverses the effects of an opioid overdose and is completely safe to use. However, the State does not currently have a comprehensive, centralized overdose prevention program to pay for and distribute it. The State has identified 13 high-risk, high-need counties where Naloxone rescue kits will be distributed to at-risk individuals 19 years of age and younger. The rescue kits will be distributed by Comprehensive Community Addiction Recovery Centers (CCARCs) and Opioid Treatment Programs (OTPs) within the identified communities. These two entities will contract with the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) which will provide the funding and training. Monitoring will be provided jointly by the Oklahoma Health Care Authority and ODMHSAS. The estimated total budget impact for FFY 2016 for this program is \$294,900; the federal share FFY 16 is \$282,190 and the state share is \$12,710. The estimated total budget impact for FFY 2017 for this program is \$730,700; the federal share for FFY 17 is \$693,873 and the state share is \$36,827. The budget has been updated accordingly. This strategy is new and it is not currently funded.

Health Service Initiative Request #4:

The Oklahoma Health Care Authority (OHCA) and the Oklahoma Department of Human Services (OKDHS) would like to implement an informed and coordinated approach to ensuring quality of care for children in the foster care system that are prescribed psychotropic medications. The methods for achieving this include additional improvements to our current health portal, the creation of an advisory committee of community experts to identify best practices; identification of barriers and improving current data matching; and the development of training and outreach for foster parents, health care providers, and child welfare workers in order to improve services to all children in the foster care system under the age of 19. The estimated total budget impact for FFY 2016 for this program is \$115,816; the federal share for FFY 16 is \$110,824 and the state share is \$4,992. The estimated total budget impact for FFY 2017 for this program is \$463,258; the federal share for FFY 17 is \$439,910 and the state share is \$23,348. The budget has been updated accordingly. This strategy is new and it is not currently funded.

Health Service Initiative Request #5:

The State Medicaid agency is responsible for controlling costs of state purchased health care while assuring that standards of care are met as part of a progressive system. Combining standards of care with current evidence and presenting these in a nonbiased manner is known as Academic

Detailing (AD). It is anticipated that the AD program will result in measurable cost savings to OHCA through improved prescribing according to existing evidence and a decrease in the number of prior authorizations submitted. Over the long term, it is expected that improved prescribing will result in improved patient outcome and decreased burden on the healthcare system. The 15-18 month pilot phase of the AD program will be a targeted intervention aimed at improving evidence-based prescribing of Attention Deficit Hyperactivity Disorder (ADHD) medications and atypical antipsychotic medications for Medicaid members under 18 years of age. Counties which have high utilization of the initial target medications will be selected for the intervention. Prescribers within those counties will be chosen from non-specialists. A specially trained pharmacist will make an appointment with the selected prescriber to go over the guidelines for appropriate prescribing within the targeted therapeutic category and provide resources as needed. The estimated total budget impact for FFY 2016 for this program is \$72,523; the federal share for FFY 16 is \$69,397 and the state share is \$3,126. The estimated total budget impact for FFY 2017 for this program is \$290,090; the federal share for FFY 17 is \$275,469 and the state share is \$14,621. The budget has been updated accordingly. This strategy is new and it is not currently funded.

Health Service Initiative Request #6

Individuals with Sickle Cell disease (SCD) experience lifelong complications including anemia, infections, stroke, tissue damage, organ failure, intense painful episodes, and premature death. These debilitating symptoms and the complex treatment needs of people living with SCD often limit their education, career opportunities, and quality of life. In Oklahoma, approximately 1,500 individuals enrolled in Sooner Care are impacted by SCD and its inherited disorders. Individuals living with SCD face a highly-fragmented system of care and health disparities in access and health outcomes. In this project, a newborn kit is designed to help new moms integrate into the sickle cell community, make connections with other parents/caregivers, ask the right questions and begin the lifelong journey of self-education, self-care management and knowing that they are not alone. A separate care kit is developed for children ages 6 to 18 to address isolation and depression for the child/youth and provide parents/caregivers with information that will assist them in identifying symptoms that their child/youth may be experiencing. The total estimated budget impact for FFY19 is \$50,250; the federal share for FFY19 is \$48,577, and the state share is \$1,673. The budget has been updated accordingly in Section 9.10 of the Plan.

Health Service Initiative Request #7

In 2015, there were 88 infants in Oklahoma that died before their first birthday due to Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Infant Death (SUID); this was an increase from 67 deaths the previous year. This project seeks to increase the number of vulnerable infants that use a safe sleep environment during their first year of life. OHCA will work in partnership with the Oklahoma State Department of Health to expand a current effort working with delivery hospitals on safe sleep for newborns. Newborns assessed with a need will be eligible to receive a safe sleep kit to increase access to a safe sleep environment during their first year. The HSI funding will be used to cover the costs of the crib kits for newborns and a vendor for hospital recruitment and follow-up surveys. The total estimated budget impact for FFY19 is \$61,000; the federal share for FFY19 is \$58,969, and the state share is \$2,031. The budget has been updated accordingly in Section 9.10 of the Plan.

Health Service Initiative Request #8

Nearly half (45.7%) of all pregnancies in Oklahoma are unintended. In teens the number of

unintended pregnancies is around 82%. Oklahoma experiences the 2nd highest teen birth rate in 15-19 year olds, and 1 in every 5 teen births is a subsequent birth. Pregnant and parenting teens are less likely to finish school, and more likely to live in poverty. Additionally, Medicaid is the principal source of payment for 9 of 10 subsequent births to teens in Oklahoma. Around 40% of unintended pregnancies are estimated to be the result of no use or misuse of contraception. Therefore, increasing access to highly effective forms of contraception such as long-acting reversible contraceptives (LARC) is a strategy that has shown promise in reducing unintended pregnancies. Through the use of HSI funding and the collaborative effort between the Oklahoma Health Care Authority (OHCA) and the Oklahoma State Department of Health (OSDH), long-acting reversible contraceptives (LARC) will be purchased for health department locations statewide to increase access to low maintenance highly effective contraceptive methods and to decrease the number of unintended pregnancies in Oklahoma for uninsured individuals. The total estimated budget impact for FFY19 is \$413,472; the federal share for FFY19 is \$399,703, and the state share is \$13,769. The budget has been updated accordingly in Section 9.10 of the Plan.

Health Service Initiative Request #9

The 2016 SoonerCare Program Quality of Care report indicated that in 2015 only 56.7% of children ages 3-6 in the SoonerCare Program received well-child visits as compared to the national average of 71.3%, and that only 15.7% received a developmental screening during their first three years of life. The Oklahoma Health Care Authority (OHCA) seeks to improve these rates by working in collaboration with the University of Oklahoma (OU) College of Medicine, Department of Pediatrics to train pediatric and primary care practices to implement the Reach Out and Read (ROR) early literacy program and use standardized developmental screening tools during health visits with young children. Federal Early and Periodic Screening Diagnosis and Treatment (EPSDT) policy and the ROR mission overlap in that they share common goals of ensuring timely and quality developmental surveillance by primary care providers in an effort to identify needed interventions or supports to improve health outcomes. The implementation of ROR into health care practices will improve both the quality of the child's preventive health visit and developmental screening processes. Providers will receive standardized developmental screening tools and training to incorporate them into practice. The total estimated budget for FFY19 is \$101,400; the federal share is \$98,024 and the state share is \$3,377. The budget has been updated accordingly in Section 9.10 of the Plan.

The State assures that the HSI projects will target only children/youth under the age of 19 and that the HSI programs will not supplant or match CHIP federal funds with other federal funds nor allow other federal funds to supplant or match CHIP federal funds.

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))

Unborn child health benefits are provided through the same provider network that provides

prenatal and delivery care to pregnant women under Title **XIX**.

Fee-for-Service (FFS) reimbursement is provided for services provided under the unborn child option.

- 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))

Members enrolled in the CHIP 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 and Review is done cooperatively with Oklahoma Medicaid's Program Integrity unit.

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))

4.1.0 Describe how the State meets the citizenship verification requirements. Include whether or not State has opted to use SSA verification option. Please refer to template CS18 located at the end of the CHIP State Plan.

4.1.1. Geographic area served by the Plan: Please refer to templates CS7, CS9, and located at the end of the CHIP State Plan.

4.1.2. Age: Please refer to templates CS7 and CS9, located at the end of the CHIP State Plan.

4.1.3. Income: Please refer to templates CS7 for income standards for children in the premium assistance program (Insure Oklahoma). Please refer to CS9 for income standards for the unborn child populations, and CS15 for additional income related information located at the end of the CHIP State Plan.

4.1.4. Resources (including any standards relating to spend downs and disposition of resources): N/A.

4.1.5. Residency: Please refer to template CS17 located at the end of the CHIP State Plan.

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

4.1.7. 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 cannot have current coverage under a group health plan.

4.1.8. 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. Other). Please refer to template CS23 located at the end of the CHIP State Plan.

4.1.10. Children Ineligible for Medicaid as a Result of the Elimination of Income Disregard: Please refer to templates CS 14 at the end of the CHIP State Plan.

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

4.2.2. 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. 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)

Please refer to template CS24 located at the end of the CHIP State Plan.

The methods of establishing eligibility and continuing enrollment for the Soon-To-Be-Sooners (separate SCHIP/unborn child) program is the same as under Title XIX. A Soon-To-Be-Sooners / SoonerCare application for unborn children may be made online at www.mysooner.org.

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 205 percent of the Federal Poverty Level (after exclusions, deductions and disregards). In determining the household size, the unborn child(ren) are included.

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

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

- 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))

Please refer to template CS24 located at the end of the CHIP State Plan.

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))

Please refer to template CS24 located at the end of the CHIP State Plan.

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) and2102(c)(2))(42CFR 431.636(b)(4))

Please refer to template CS24 located at the end of the CHIP State Plan.

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))

Please refer to template CS20 located at the end of the CHIP State Plan.

4.4.5 X 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))

Section 5. Outreach and Coordination (Section 2102(c))

- 5.1 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))

Guidance: The information below may include whether the state elects express lane eligibility a description of the State's outreach efforts through Medicaid and state-only programs.

- 5.1.1. 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):

The Oklahoma Health Care Authority constantly monitors uninsured figures. Generally, the official source is the U.S. Census Bureau's American Community Survey; however, other sources that provide alternate information to help the agency identify potential uncovered children, such as the State Health Access Data Assistance Center, which provides Oklahoma specific/county level data on uninsurance.

The State will utilize a variety of instruments to develop awareness in and educate this 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, radio and social media.

In addition, the State works with various statewide community partners to assist potential members fill out a Medicaid application. Community partners assist potential members with the online enrollment process and answer questions or they allow an OHCA employee to come to their facilities and assist potential members with enrollment and/or enrollment questions. Further, the State has an agreement with Tribal partners to increase outreach and enrollment of uninsured members, it is called the Oklahoma Tribal Medicaid Administrative Match (OK TMAM). Through OK TMAM, tribal partners receive reimbursement for accepting and processing new and renewed applications for the SoonerCare program.

- 5.1.2. 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:

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

- a) Community Forums - information is presented at OHCA community forums that are held in various state regions.
- b) Newsletters –information is included in most OHCA newsletters, including those for community partners, providers, and SoonerCare members.
- c) Community health fairs and events – information is available at OHCA booths at community events.
- d) Government partnerships – partnerships with other state agencies to promote the program through the agencies' communications channels.
- e) Target" printed program materials
- f) Utilize local coalitions to become actively involved in outreach processes.
- g) Regional provider trainings.

- 5.2 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. 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 by visiting mysoonerhealth.org to enroll online.

5.3. **Strategies** 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)

Soon-to-be Sooners

Pertaining to the Unborn Child (separate CHIP) 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.

Insure Oklahoma

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 also capitalizes on statewide earned media opportunities, such as promoting the program on various local television news programs and getting coverage in daily and weekly newspapers. The Insure Oklahoma program sends periodic emails to a distribution list collected from the public website www.insureoklahoma.org The Insure Oklahoma staff continue to respond to requests and initiate opportunities for presentations to targeted groups, organizations, and communities across the state. Insure Oklahoma also conducts outreach specifically targeted to potential members through social media. An advertising contract was awarded to STAPLEGUN Design, Inc. on April 16, 2015 in which a marketing strategy and creative development plan were proposed and executed throughout the contract period. STAPLEGUN Design, Inc. is tasked with creating a series of broadcast commercials, print advertisements, and other advertising tactics to promote Insure Oklahoma as the state's premier health insurance assistance program. STAPLEGUN Design, Inc. also will administer an advertising co-op program for insurance agents that pays a percentage of

the cost of an approved Insure Oklahoma advertisement. The advertisement co-op program is funded with tobacco tax revenues and claims administrative federal match.

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

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 proceed to Section 7 since children covered under a Medicaid expansion program will receive all Medicaid covered services including EPSDT.

6.1. The State elects to provide the following forms of coverage to children: (Check all that apply.) (Section 2103(c)); (42 CFR 457.410(a))

Guidance: Benchmark coverage is substantially equal to the benefits coverage in a benchmark benefit package (FEHBP-equivalent coverage, State employee coverage, and/or the HMO coverage plan that has the largest insured commercial, non-Medicaid enrollment in the state). If box below is checked, either 6.1.1.1., 6.1.1.2., or 6.1.1.3. must also be checked. (Section 2103(a)(1))

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

Guidance: Check box below if the benchmark benefit package to be offered by the State is the standard Blue Cross/Blue Shield preferred provider option service benefit plan, as described in and offered under Section 8903(1) of Title 5, United States Code. (Section 2103(b)(1) (42 CFR 457.420(b))

6.1.1.1. FEHBP-equivalent coverage; (Section 2103(b)(1) (42 CFR 457.420(a)) (If checked, attach copy of the plan.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is State employee coverage, meaning a coverage plan that is offered and generally available to State employees in the state. (Section 2103(b)(2))

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

Guidance: Check box below if the benchmark benefit package to be offered by the State is offered by a health maintenance organization (as defined in Section 2791(b)(3) of the Public Health Services Act) and has the largest insured commercial, non-Medicaid enrollment of covered lives of such coverage plans offered by an HMO in the state. (Section 2103(b)(3) (42 CFR 457.420(c)))

- 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.)

Guidance: States choosing Benchmark-equivalent coverage must check the box below and ensure that the coverage meets the following requirements:

- the coverage includes benefits for items and services within each of the categories of basic services described in 42 CFR 457.430:
 - dental services
 - inpatient and outpatient hospital services,
 - physicians' services,
 - surgical and medical services,
 - laboratory and x-ray services,
 - well-baby and well-child care, including age-appropriate immunizations, and
 - emergency services;
- the coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages (FEHBP-equivalent coverage, State employee coverage, or coverage offered through an HMO coverage plan that has the largest insured commercial enrollment in the state); and
- the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the additional categories in such package, if offered, as described in 42 CFR 457.430:
 - coverage of prescription drugs,
 - mental health services,
 - vision services and
 - hearing services.

If 6.1.2. is checked, a signed actuarial memorandum must be attached. The actuary who prepares the opinion must select and specify the standardized set and population to be used under paragraphs (b)(3) and (b)(4) of 42 CFR 457.431. The State must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by CMS, to replicate the State results.

The actuarial report must be prepared by an individual who is a member of the American Academy of Actuaries. This report must be prepared in accordance with the principles and standards of the American Academy of Actuaries. In preparing the report, the actuary must use generally accepted actuarial principles and methodologies, use a standardized set of utilization and price factors, use a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan, apply the same principles and factors in comparing the value of different coverage (or categories of services), without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used, and take into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing

under such coverage. (Section 2103(a)(2))

- 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. Attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431.

Guidance: A State approved under the provision below, may modify its program from time to time so long as it continues to provide coverage at least equal to the lower of the actuarial value of the coverage under the program as of August 5, 1997, or one of the benchmark programs. If "existing comprehensive state-based coverage" is modified, an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997, or one of the benchmark plans must be attached. Also, the fiscal year 1996 State expenditures for "existing comprehensive state-based coverage" must be described in the space provided for all states. (Section 2103(a)(3))

- 6.1.3. Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) This option is only applicable to New York, Florida, and Pennsylvania. Attach a description of the benefits package, administration, and date of enactment. If existing comprehensive State-based coverage is modified, provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997 or one of the benchmark plans. Describe the fiscal year 1996 State expenditures for existing comprehensive state-based coverage.

Guidance: Secretary-approved coverage refers to any other health benefits coverage deemed appropriate and acceptable by the Secretary upon application by a state. (Section 2103(a)(4)) (42 CFR 457.250)

- 6.1.4. Secretary-approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)

Guidance: Section 1905(r) of the Act defines EPSDT to require coverage of (1) any medically necessary screening, and diagnostic services, including vision, hearing, and dental screening and diagnostic services, consistent with a periodicity schedule based on current and reasonable medical practice standards or the health needs of an individual child to determine if a suspected condition or illness exists; and (2) all services listed in section 1905(a) of the Act that are necessary to correct or ameliorate any defects and mental and physical illnesses or conditions discovered by the screening services, whether or not those services are covered under the Medicaid state plan. Section 1902(a)(43) of the Act requires that the State (1) provide and arrange for all necessary services, including supportive services, such as transportation, needed to receive medical care included within the scope of the EPSDT benefit and (2) inform eligible beneficiaries about the services available under the EPSDT benefit.

If the coverage provided does not meet all of the statutory requirements for EPSDT contained in sections 1902(a)(43) and 1905(r) of the Act, do not check this box.

6.1.4.1. Coverage of all benefits that are provided to children that is the same as the benefits provided under the Medicaid State plan, including Early Periodic Screening, Diagnostic, and Treatment (EPSDT).

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

6.1.4.3. Coverage that the State has extended to the entire Medicaid population.

Guidance: Check below if the coverage offered includes benchmark coverage, as specified in §457.420, plus additional coverage. Under this option, the State must clearly demonstrate that the coverage it provides includes the same coverage as the benchmark package, and also describes the services that are being added to the benchmark package.

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 applicable only in New York, Pennsylvania or Florida. (under 42 CFR 457.440)

Guidance: Check below if the State is purchasing coverage through a group health plan, and intends to demonstrate that the group health plan is substantially equivalent to or greater than coverage under one of the benchmark plans specified in 457.420, through the use of a benefit-by-benefit comparison of the coverage. Provide a sample of the comparison format that will be used. Under this option, if coverage for any benefit does not meet or exceed the coverage for that benefit under the benchmark, the State must provide an actuarial analysis as described in 457.431 to determine actuarial equivalence.

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 (Provide a sample of how the comparison will be done).

Guidance: Check below if the State elects to provide a source of coverage that is not described above. Describe the coverage that will be offered, including any benefit limitations or exclusions.

6.1.4.7. Other. (Describe)

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

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

known as the Unborn Child 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, visits 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.

Guidance: All forms of coverage that the State elects to provide to children in its plan must be checked. The State should also describe the scope, amount and duration of services covered under its plan, as well as any exclusions or limitations. States that choose to cover unborn children under the State plan should include a separate section 6.2 that specifies benefits for the unborn child population. (Section 2110(a)) (42 CFR, 457.490)

If the state elects to cover the new option of targeted low income pregnant women, but chooses to provide a different benefit package for these pregnant women under the CHIP plan, the state must include a separate section 6.2 describing the benefit package for pregnant women. (Section 2112)

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)) (42 CFR 457.490)

6.2.1. Inpatient services (Section 2110(a)(1))
 Inpatient services coverage for CHIP 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.

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

Outpatient services coverage for CHIP 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.

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

Physician services coverage for CHIP 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, visits 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.

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

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

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

Clinic services coverage for CHIP 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.

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

Prescription drug coverage for CHIP 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.

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

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

Laboratory and radiological services coverage for CHIP 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.

6.2.9. Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))

Prenatal care and prepregnancy family services and supplies coverage for CHIP 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, visits 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. 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.

6.2.10. 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))

Inpatient mental health services coverage for CHIP SoonerCare children is the same as under Title XIX.

Inpatient mental health 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.

- 6.2.11.** 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))

Outpatient mental health services coverage for CHIP SoonerCare children is the same as under Title XIX.

Outpatient mental health 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.

- 6.2.12.** 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)(12))
DME coverage for CHIP 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.

- 6.2.13.** Disposable medical supplies (Section 2110(a)(13))

Disposable medical supplies coverage for CHIP 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.

Guidance: Home and community based services may include supportive services such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home.

- 6.2.14.** Home and community-based health care services (Section 2110(a)(14))
CHIP SoonerCare children eligible for services HCBS receive TXIX services and any additional HCBS services covered under the waiver.

Individuals under the Unborn Child category do not qualify for HCBS services.

Guidance: Nursing services may include nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services in a home, school or other setting.

6.2.15. Nursing care services (Section 2110(a)(15))

Nursing care services coverage for CHIP 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.

6.2.16. 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. Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)

Dental services coverage for CHIP SoonerCare children is the same as under Title XIX.

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

ESI-Dental 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

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.

6.2.18. Vision screenings and services (Section 2110(a)(24))

^Vision screening and services coverage for CHIP SoonerCare children is the same as under Title XIX.

Vision screening and 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.

6.2.19. Hearing screenings and services (Section 2110(a)(24))

Hearing screening and services coverage for CHIP SoonerCare children is the same as under Title XIX.

Hearing screening and 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.

6.2.20. Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))

Inpatient substance abuse treatment services coverage for CHIP SoonerCare children is the same as under Title XIX.

Inpatient substance abuse treatment 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.

6.2.21. Outpatient substance abuse treatment services (Section 2110(a)(19))

Outpatient substance abuse treatment services coverage for CHIP SoonerCare children is the same as under Title XIX.

Outpatient substance abuse treatment 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.

6.2.22. Case management services (Section 2110(a)(20))

Case management services coverage for CHIP SoonerCare children is the same as under Title XIX.

Case management 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.

6.2.23. Care coordination services (Section 2110(a)(21))

Care coordination services coverage for CHIP SoonerCare children is the same as under Title XIX.

Care coordination 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.

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

Physical therapy, occupational therapy, and services coverage for CHIP SoonerCare children is the same as under Title XIX.

Physical therapy, occupational therapy, and 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.

- 6.2.25.** Hospice care (Section 2110(a)(23))
Hospice care coverage for CHIP SoonerCare children is the same as under Title XIX.

Hospice care 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.

Guidance: See guidance for Section 6.1.4.1 for guidance on the statutory requirements for EPSDT under sections 1905(r) and 1902(a)(43) of the Act. If the benefit being provided does not meet the EPSDT statutory requirements, do not check the box below.

- 6.2.26.** EPSDT consistent with requirements of sections 1905(r) and 1902(a)(43) of the Act

Guidance: Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative service may be provided, whether in a facility, home, school, or other setting, if recognized by State law and only if the service is: 1) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as prescribed by State law; 2) performed under the general supervision or at the direction of a physician; or 3) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

- 6.2.27.** Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (Section 2110(a)(24))
Other services coverage for CHIP 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.

6.2.28. 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”.

6.2.29. Medical transportation (Section 2110(a)(26))
 Medical transportation coverage for CHIP SoonerCare children is the same as under Title XIX.

Medical transportation 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.

Guidance: Enabling services, such as transportation, translation, and outreach services, may be offered only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

6.2.30. Enabling services (such as transportation, translation, and outreach services) (Section 2110(a)(27))

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

6.2-DC **Dental Coverage** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) The State will provide dental coverage to children through one of the following. Please update Sections 9.10 and 10.3-DC when electing this option. 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-DC State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT¹) 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

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6.2.1.1-DC Periodicity Schedule. The State has adopted the following periodicity schedule:

- State-developed Medicaid-specific
- American Academy of Pediatric Dentistry
- Other Nationally recognized periodicity schedule
- Other (description attached)

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

6.2.2.1-DC FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT² codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2.2.2-DC 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, also attach a description of the services and applicable CDT codes)

6.2.2.3-DC 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, also attach a description of the services and applicable CDT codes)

6.2-DS **Supplemental Dental Coverage-** The State will provide dental coverage to children eligible for dental-only supplemental services. Children eligible for this option must receive the same dental services as provided to otherwise eligible CHIP children (Section 2110(b)(5)(C)(ii)). Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, and 9.10 when electing this option.

Guidance: Under Title XXI, pre-existing condition exclusions are not allowed, with the only exception being in relation to another law in existence (HIPAA/ERISA). Indicate that the plan adheres to this requirement by checking the applicable description.

In the event that the State provides benefits through a group health plan or group health coverage, or provides family coverage through a group health plan under a waiver (see Section 6.4.2.), pre-existing condition limits are allowed to the extent permitted by HIPAA/ERISA. If the State is contracting with a group health plan or provides benefits through group health coverage, describe briefly any limitations on pre-existing conditions. (Formerly 8.6.)

6.2- MHPAEA Section 2103(c)(6)(A) of the Social Security Act requires that, to the extent that it provides both medical/surgical benefits and mental health or substance use disorder benefits, a State

child health plan ensures that financial requirements and treatment limitations applicable to mental health and substance use disorder benefits comply with the mental health parity requirements of section 2705(a) of the Public Health Service Act in the same manner that such requirements apply to a group health plan. If the state child health plan provides for delivery of services through a managed care arrangement, this requirement applies to both the state and managed care plans. These requirements are also applicable to any additional benefits provided voluntarily to the child health plan population by managed care entities and will be considered as part of CMS’s contract review process at 42 CFR 457.1201(i).

6.2.1- MHPAEA Before completing a parity analysis, the State must determine whether each covered benefit is a medical/surgical, mental health, or substance use disorder benefit based on a standard that is consistent with state and federal law and generally recognized independent standards of medical practice. (42 CFR 457.496(f)(1)(i))

6.2.1.1- MHPAEA Please choose the standard(s) the state uses to determine whether a covered benefit is a medical/surgical benefit, mental health benefit, or substance use disorder benefit. The most current version of the standard elected must be used. If different standards are used for different benefit types, please specify the benefit type(s) to which each standard is applied. If “Other” is selected, please provide a description of that standard.

- International Classification of Disease (ICD)
- Diagnostic and Statistical Manual of Mental Disorders (DSM)
- State guidelines (Describe: _____)
- Other (Describe: _____)

6.2.1.2- MHPAEA Does the State provide mental health and/or substance use disorder benefits?

- Yes
- No

Guidance: If the State does not provide any mental health or substance use disorder benefits, the mental health parity requirements do not apply ((42 CFR 457.496(f)(1)). Continue on to Section 6.3.

6.2.2- MHPAEA Section 2103(c)(6)(B) of the Social Security Act (the Act) provides that to the extent a State child health plan includes coverage of early and periodic screening, diagnostic, and treatment services (EPSDT) defined in section 1905(r) of the Act and provided in accordance with section 1902(a)(43) of the Act, the plan shall be deemed to satisfy the parity requirements of section 2103(c)(6)(A) of the Act.

6.2.2.1- MHPAEA Does the State child health plan provide coverage of EPSDT? The State must provide for coverage of EPSDT benefits, consistent with Medicaid statutory requirements, as indicated in section 6.2.26 of the State child health plan in order to answer “yes.”

- Yes

No

Guidance: If the State child health plan *does not* provide EPSDT consistent with Medicaid statutory requirements at sections 1902(a)(43) and 1905(r) of the Act, please go to Section 6.2.3- MHPAEA to complete the required parity analysis of the State child health plan.

If the state *does* provide EPSDT benefits consistent with Medicaid requirements, please continue this section to demonstrate compliance with the statutory requirements of section 2103(c)(6)(B) of the Act and the mental health parity regulations of 42 CFR 457.496(b) related to deemed compliance. Please provide supporting documentation, such as contract language, provider manuals, and/or member handbooks describing the state's provision of EPSDT.

6.2.2.2- MHPAEA EPSDT benefits are provided to the following:

All children covered under the State child health plan.

A subset of children covered under the State child health plan.

Please describe the different populations (if applicable) covered under the State child health plan that are provided EPSDT benefits consistent with Medicaid statutory requirements.

Guidance: If only a subset of children are provided EPSDT benefits under the State child health plan, 42 CFR 457.496(b)(3) limits deemed compliance to those children only and Section 6.2.3- MHPAEA must be completed as well as the required parity analysis for the other children.

6.2.2.3- MHPAEA To be deemed compliant with the MHPAEA parity requirements, States must provide EPSDT in accordance with sections 1902(a)(43) and 1905(r) of the Act (42 CFR 457.496(b)). The State assures each of the following for children eligible for EPSDT under the separate State child health plan:

All screening services, including screenings for mental health and substance use disorder conditions, are provided at intervals that align with a periodicity schedule that meets reasonable standards of medical or dental practice as well as when medically necessary to determine the existence of suspected illness or conditions. (Section 1905(r))

All diagnostic services described in 1905(a) of the Act are provided as needed to diagnose suspected conditions or illnesses discovered through screening services, whether or not those services are covered under the Medicaid state plan. (Section 1905(r))

All items and services described in section 1905(a) of the Act are provided when needed to correct or ameliorate a defect or any physical or mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid State plan. (Section 1905(r)(5))

Treatment limitations applied to services provided under the EPSDT benefit are not limited based on a monetary cap or budgetary constraints and may be exceeded as medically necessary to correct or ameliorate a medical or physical condition or illness. (Section 1905(r)(5))

Non-quantitative treatment limitations, such as definitions of medical necessity or criteria for medical necessity, are applied in an individualized manner that does not preclude coverage of any items or services necessary to correct or ameliorate any medical or physical condition or illness. (Section 1905(r)(5))

EPSDT benefits are not excluded on the basis of any condition, disorder, or diagnosis. (Section 1905(r)(5))

The provision of all requested EPSDT screening services, as well as any corrective treatments needed based on those screening services, are provided or arranged for as necessary. (Section 1902(a)(43))

All families with children eligible for the EPSDT benefit under the separate State child health plan are provided information and informed about the full range of services available to them. (Section 1902(a)(43)(A))

Guidance: For states seeking deemed compliance for their entire State child health plan population, please continue to Section 6.3. If not all of the covered populations are offered EPSDT, the State must conduct a parity analysis of the benefit packages provided to those populations. Please continue to 6.2.3-MHPAEA.

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

6.3.1. The State shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR

6.3.2. 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 6.6.2. (formerly 6.4.2) of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA. (Formerly 8.6.) (Section 2103(f)) Describe:

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)

The methods of establishing eligibility and continuing enrollment for the ESI program contains two parts, the employer and the employee. Employers who wish to participate in the program complete an application documenting their total number of employees and the qualified benefit plan they offer. In order for an employer to be eligible to participate in the Insure Oklahoma program, the employer must have a business that is physically located in Oklahoma; be currently offering or at the contracting stage to offer a Qualified Benefit Plan (QBP); and contribute an equivalent 40 percent of premiums. An application may be made online, mailed, or faxed to the Oklahoma Health Care Authority (OHCA). OHCA verifies the information on the application and processes it in a timely manner and the decision to approve or deny is added to

the system. Once an eligibility determination has been made the employer is notified. After the employer is enrolled in the program the employee completes a separate member application documenting their household income and number of children to be enrolled. The member application may be made online, mailed, or faxed to OHCA. In a manner similar to the employer process, OHCA verifies the information on the application and processes it in a timely manner. Eligibility data are shared with the OKDHS system for eligibility certification and results are added to the OHCA MMIS system. Once an eligibility determination about the family has been made, the employee is notified.

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.

The primary sources of eligibility, enrollment and benefits information for the ESI program 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.

The State will impose an enrollment cap at any given time in order to remain within State funding limits. The State institutes a waiting list for ESI. In the event an enrollment cap is imposed, enrollment in ESI is discontinued. To ensure 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. 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 ESI 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.

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.

Participating qualified benefit plans must offer, at a minimum, benefits that include hospital services, physician services, clinical laboratory and radiology, pharmacy, office visits, well baby/well child exams, age appropriate immunizations as required by law and emergency services as required by law.

The health plan, if required, must be approved by the Oklahoma Insurance Department for participation in the Oklahoma market. All health plans must share in the cost of covered services and pharmacy products in addition to any negotiated discounts with network providers, pharmacies, or pharmaceutical manufacturers.

ESI members utilize the health care delivery system and network available to them through the private, qualified benefit 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 ESI. Dental coverage is provided through 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. 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.

ESI-Dental 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.

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.

Authority for the Insure Oklahoma program (IO) is granted to the State by an approved Section 1115 Demonstration Waiver.

- 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))

In Oklahoma, the annual average cost of providing health care to a child under the SoonerCare program (Oklahoma Medicaid) in State Fiscal Year (SFY) 2018 was \$2,994. In comparison, the annual average health care premium cost for a child in the Insure Oklahoma (IO) program employer-sponsored program (ESI) for SFY 2018 was \$2,978.

The Oklahoma Health Care Authority (OHCA) provides premium assistance to qualified businesses for approved applicants and contracts with group health service carriers (private insurance carriers) to provide the actual health services to enrolled participants. Arrangement for the provision of all medical services is the responsibility of the contracted group health service carrier. However, the OHCA utilizes the SoonerCare provider network to provide dental services to children enrolled as dependents in the IO ESI program, as this is not a benefit provided through the contracted group health service carriers. The total cost for wrap around dental services in SFY 2018 for all enrolled children in the IO ESI program was \$5,348.09, approximately \$11.68 per child a year. The dental expenditures are incorporated in the total ESI child cost noted above.

Premium/Subsidy Assistance

Eligible IO ESI members (adults) are responsible for up to fifteen percent (15%) of their benefit plan premium as well as fifteen percent (15%) of their dependent's benefit plan premium; however, the combined portion of the overall cost sharing for

benefit plan premiums cannot exceed three percent (3%) of their annual gross household income. The Insure Oklahoma program takes on the premium expenses above the three percent threshold.

Out of pocket expenses for all approved and eligible IO ESI members, including dependent children, is limited to five percent (5%) of their annual gross household income. The OHCA will provide reimbursement for out-of-pocket expenses in excess of the 5% annual gross household income. Out of pocket reimbursement is also noted in the cumulated ESI figure noted above. Native American/Alaskan Native children are exempt from all cost-sharing requirements.

Administrative cost/staffing

The IO program is administered by the OHCA and the funding for positions which directly work with the IO program are budgeted as permanent positions through the OHCA's budget request process. The administration cost for the Insure Oklahoma program is \$3,145,711; the figure accounts for administration costs for all IO programs (ESI, ESI college students, and the IO Individual plan (IP)). The administration cost for the IO program is approximately 3.5 percent (3.5%) of the total OHCA expenses for the Insure Oklahoma program in particular, and approximately .06 percent (.06%) of total OHCA expenses. As this figure is so nominal, it is not included in the cumulative costs listed above.

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

Financial Responsibilities:

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 reimburses approved and eligible members for allowable out of pocket medical expenses above the 5 percent threshold. A medical expense must be for an allowed and covered service by the health plan to be eligible for reimbursement. An allowed and covered service is defined as an in-network service covered in accordance with a qualified health plan's benefit summary and policies. 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 (OHCA does not qualify a health plan if their co-pays exceed \$50); and
- b. An annual out-of-pocket maximum cannot exceed \$3,000 per individual, excluding copays and pharmacy deductibles.

In the past 12 months, out of 17,330 IO ESI members, 151 have been reimbursed for out of pocket expenses that exceeded the 5% cap.

SoonerCare Screening

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.

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.

If the health plan requires co-payments or deductibles, the co-payments or deductibles cannot exceed the limits below:

- (1) An annual in-network out-of-pocket maximum cannot exceed \$3,000 per individual, excluding separate pharmacy deductibles.
- (2) Office visits cannot require a co-payment exceeding \$50 per visit.
- (3) Annual in-network pharmacy deductibles cannot exceed \$500 per individual.

Qualified benefit plans will provide an EOB, an expense summary, or required documentation for paid and/or denied claims subject to member co-insurance or member deductible calculations. The required documentation must contain, at a minimum, the:

- 5.1.2.1. provider's name;
- 5.1.2.2. patient's name;
- 5.1.2.3. date(s) of service;
- 5.1.2.4. code(s) and/or description(s) indicating the service(s) rendered, the amount(s) paid or the denied status of the claim(s);
- 5.1.2.5. reason code(s) and description(s) for any denied service(s);
- 5.1.2.6. amount due and/or paid from the patient or responsible party; and
- 5.1.2.7. provider network status (in-network or out-of-network provider).

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 benefit plans must include dental services, well baby/well child exams including, but not limited to age appropriate immunizations as required by State law. Qualified benefit 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 benefit 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 the ESI program at the time of application through the Insure Oklahoma website. 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, and no other coverage is available under the CHIP or Medicaid state plan. 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.

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.

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. 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. 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. 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. 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 five 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 public and private), consumers, advocacy groups, state agency reps, and professional organizations.

7.2. Describe the methods used, including monitoring, to assure: (Section 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 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42.CFR 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 Access to covered services, including emergency services as defined in 42 CFR. 457.10. (Section 2102(a)(7)) (42 CFR 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 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)) (42 CFR 457.495(c))

The state monitors and facilitates 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 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)) (42 CFR 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

- 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) Indicate if this also applies for pregnant women. (CHIPRA #2, SHO # 09-006, issued May 11, 2009)

- 8.1.1. Yes
 8.1.2. No, skip to question 8.8.
 8.1.1-PW Yes

8.1.2-PW No, skip to question 8.8.

Guidance: It is important to note that for families below 150 percent of poverty, the same limitations on cost sharing that are under the Medicaid program apply. (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as implemented by regulations at 42 CFR 447.50 - 447.59). For families with incomes of 150 percent of poverty and above, cost sharing for all children in the family cannot exceed 5 percent of a family's income per year. Include a statement that no cost sharing will be charged for pregnancy-related services. (CHIPRA #2, SHO # 09-006, issued May 11, 2009) (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

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 by age and income (if applicable) 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) and (c), 457.515(a) and (c))

8.2.1. Premiums:

8.2.2. Deductibles:

8.2.3. Coinsurance or copayments:

8.2.4. Other:

8.2-DS **Supplemental Dental** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) For children enrolled in the dental-only supplemental coverage, describe the amount of cost-sharing, specifying any sliding scale based on income. Also describe how the State will track that the cost sharing does not exceed 5 percent of gross family income. The 5 percent of income calculation shall include all cost-sharing for health insurance and dental insurance. (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b), and (c), 457.515(a) and (c), and 457.560(a)) Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, 6.2-DS, and 9.10 when electing this option.

8.2.1-DS Premiums:

8.2.2-DS Deductibles:

8.2.3-DS Coinsurance or copayments:

8.2.4-DS Other:

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)(A)) (42CFR 457.505(b))

Guidance: The State should be able to demonstrate upon request its rationale and justification regarding these assurances. This section also addresses limitations on payments for

certain expenditures and requirements for maintenance of effort.

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

- 8.4.1.** 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.** 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** 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))

8.4.1- MHPAEA There is no separate accumulation of cumulative financial requirements, as defined in §457.496(a), for mental health and substance abuse disorder benefits compared to medical/surgical benefits (§457.496(d)(3)(iii)).

8.4.2- MHPAEA If applicable, any different levels of financial requirements that are applied to different tiers of prescription drugs are determined based on reasonable factors, regardless of whether a drug is generally prescribed for medical/surgical benefits or mental health/substance use disorder benefits (§457.496(d)(3)(ii)(A)).

8.4.3- MHPAEA Cost sharing applied to benefits provided under the State child health plan will remain capped at five percent of the beneficiary's income as required §457.560 (§457.496(d)(i)(D)).

8.4.4- MHPAEA Does the State apply financial requirements to any mental health or substance use disorder benefits? If yes, specify the classification(s) of benefits in which the State applies financial requirements on any mental health or substance use disorder benefits.

Yes (Specify: _____)

No

Guidance: If the state does not apply financial requirements on any mental health or substance use disorder benefits, the state meets parity requirements for financial requirements. If the state does apply financial requirements to mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue below.

8.4.5- MHPAEA Does the State apply any type of financial requirements on any medical/surgical benefits?

Yes

No

Guidance: If the State does not apply financial requirements on any medical/surgical benefits, the State may not impose financial requirements on mental health or substance use disorder benefits.

8.4.6- MHPAEA Within each classification of benefits in which the State applies a type of financial requirement on any mental health or substance use disorder benefits, the State must determine the proportion of medical and surgical benefits in the class which are subject to the limitation.

The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above (Section 6.2.5.2) for each classification or within which the State applies financial requirements to mental health or substance use disorder benefits (§457.496(d)(3)(i)(E)).

Guidance: Please include the state's methodology as an attachment to the State child health plan.

8.4.7- MHPAEA For each type of financial requirement applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of financial requirement to at least two-thirds ("substantially all") of all the medical/surgical benefits within the same classification? (§457.496(d)(3)(i)(A))

Yes

No

Guidance: If the State does not apply a type of financial requirement to substantially all medical/surgical benefits in a given classification of benefits, the State may *not* impose financial requirements on mental health or substance use disorder benefits in that classification. (§457.496(d)(3)(i)(A))

8.4.8- MHPAEA For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State must determine the predominant level (as defined in §457.496(d)(3)(i)(B)(1)) of that type which is applied to medical/surgical benefits in the classification. For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State assures:

The same reasonable methodology applied in determining the dollar amounts used in determining whether substantially all medical/surgical benefits within a classification are subject to a type of financial requirement also is applied in determining the dollar amounts used to determine the predominant level of a type of financial requirement applied to medical/surgical benefits within a classification. (§457.496(d)(3)(i)(E))

The level of each type of financial requirement applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominate level of that type which is applied by the State to medical/surgical benefits within the same classification. (§457.496(d)(2)(i))

Guidance: If there is no single level of a type of financial requirement that exceeds the one-half threshold, the State may combine levels within a type of financial requirement such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominate level is the least

restrictive level of the levels combined to meet the one-half threshold (§457.496(d)(3)(i)(B)(2)).

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

Guidance: Section 8.7.1 is based on Section 2101(a) of the Act provides that the purpose of title XXI is to provide 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 that is coordinated with other sources of health benefits coverage for children.

8.7.1. Provide an assurance that the following disenrollment protections are being applied:

Guidance: Provide a description below of the State's premium grace period process and how the State notifies families of their rights and responsibilities with respect to payment of premiums. (Section 2103(e)(3)(C))

- 8.7.1.1.** 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))
- 8.7.1.2.** 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))
- 8.7.1.3.** 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))
- 8.7.1.4** The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

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.** No Federal funds will be used toward State matching requirements. (Section 2105(c)(4)) (42CFR 457.220)
- 8.8.2.** No cost-sharing (including premiums, deductibles, copayments, 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. 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. 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. 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. 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%, during the 10/01/18 through 09/30/23 Insure Oklahoma demonstration renewal period, under 19 years of age, under 186% FPL, converted to the MAGI-equivalent percent of FPL and applicable disregards.
 - (b) Increase the number of qualified Oklahoma businesses participating in the Insure Oklahoma program by 2%, during the 10/01/18 through 09/30/23 Insure Oklahoma demonstration renewal period. Oklahoma businesses participate in the IO program by offering

a qualified benefit plan to their workers and families, and by contributing a portion of the monthly premium. Data have shown that for every 5 new lives covered through a subsidized premium, an additional 7 unsubsidized lives are covered incidentally to the program (at no cost to the state or federal government). It is anticipated that as the numbers of participating businesses increase, so will the numbers of covered lives increase for the state as a whole.

2. (a) Increase the number of Soon To Be Sooners (STBS) enrolled Oklahoma pregnant women by 2% within 5 years beginning 10/01/18, under 186% FPL, converted to the MAGI-equivalent percent of FPL and applicable disregards.
 - (b) Increase the number of Insure Oklahoma enrolled children by 2% within 5 years beginning 10/01/18, under 19 years of age, 186-300% FPL, converted to the MAGI-equivalent percent of FPL and applicable disregards.

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

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

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

trimester, by 2% within 5 years beginning 10/01/18.

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

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

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

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

- 9.3.1. The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
- 9.3.2. The reduction in the percentage of uninsured children.
- 9.3.3. The increase in the percentage of children with a usual source of care.
- 9.3.4. The extent to which outcome measures show progress on one or more of the health problems identified by the state.
- 9.3.5. HEDIS Measurement Set relevant to children and adolescents younger than 19.
- 9.3.6. Other child appropriate measurement set. List or describe the set used.
- 9.3.7. If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
- 9.3.7.1. Immunizations
 - 9.3.7.2. Well childcare
 - 9.3.7.3. Adolescent well visits
 - 9.3.7.4. Satisfaction with care
 - 9.3.7.5. Mental health
 - 9.3.7.6. Dental care
 - 9.3.7.7. Other, list:
- 9.3.8. Performance measures for special targeted populations.

- 9.4. The State assures it will collect all data, maintain records and furnish reports to the

Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (42 CFR 457.720)

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

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

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

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

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

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

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

To the extent possible, the Health Care Authority will utilize assistance from other State Agencies, provider organizations, community groups, and others in the development and implementation of outreach programs associated with the expansion. In addition, should the State at some time consider targeting a children's group with special needs for incorporation into a future Medicaid expansion designed to be funded under Title XXI, it will actively seek input from other (applicable) State Agencies, advocacy groups, and others throughout the process.

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

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. A Notice of Rulemaking Intent is published in the Oklahoma Register, allowing for at least 30 days of public comment. A public hearing is held at which time a summary of each rule to be considered is stated. There is an opportunity for public comment. All proposed rules must also be considered by the Medical Advisory Committee (MAC), comprised of membership representing a variety of areas from the provider community. If necessary, a rates and standards public hearing is also held giving opportunity for public comment. The OHCA Board of Directors meeting is held monthly, as a public meeting, where all proposed rules are considered. Attendees at the monthly Board meetings often include representatives of consumer organizations, as well as a variety of other stakeholders from across the spectrum of health and human services organizations.

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

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))

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

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).

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

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

The State does not implement Express Lane Eligibility.

9.10. Provide a 1-year projected budget. A suggested financial form for the budget is 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.

CHIP Budget

STATE: OKLAHOMA	FFY 2019 Budget
Federal Fiscal Year	2019
State's enhanced FMAP rate	96.67%
Benefit Costs	
Insurance payments	
Managed care	\$202,860,952
per member/per month rate (See below)	
Fee for Service	\$25,472,563
Total Benefit Costs	\$228,333,515
(Offsetting beneficiary cost sharing payments)	-
Net Benefit Costs	\$228,333,515
Cost of Proposed SPA Changes – Benefit	
Administration Costs	
Personnel	
General administration	\$10,322,773
Contractors/Brokers	
Claims Processing	
Outreach/marketing costs	
Health Services Initiatives	\$3,552,165
Other	
Total Administration Costs	\$13,874,938
10% Administrative Cap	\$25,370,391
Cost of Proposed SPA Changes	\$676,122
Federal Share	\$234,142,912
State Share	\$8,065,541
Total Costs of Approved CHIP Plan	\$242,208,453

<u>Per member/per month rate</u>	FFY'2019	
	<u># of eligibles</u>	<u>\$ PMPM</u>
<u>Managed Care</u>	<u>143.720</u>	<u>\$155</u>
<u>Fee for Service</u>	<u>10.624</u>	<u>\$244</u>

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) **The state match for the insurance program is 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, the Tobacco Tax revenues are 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.

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

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

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

10.3. 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 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 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. 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
- 11.2.2. Section 1124 (relating to disclosure of ownership and related information)
- 11.2.3. Section 1126 (relating to disclosure of information about certain convicted individuals)
- 11.2.4. Section 1128A (relating to civil monetary penalties)
- 11.2.5. Section 1128B (relating to criminal penalties for certain additional charges)
- 11.2.6. 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 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 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 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.

Superseded section 4.0. (CS3)



CHIP Eligibility

OMB Control Number: 0938-1148
 Expiration date: 10/31/2014

Eligibility for Medicaid Expansion Program					CS3
42 CFR 457.320(a)(2) and (3)					
Income eligibility for children under the Medicaid Expansion is determined in accordance with the following income standards: There should be no overlaps or gaps for the ages entered.					
Age and Household Income Ranges					
	From Age	To Age	Above (% FPL)	Up to & including (% FPL)	
+	0	1	169	205	X
+	1	6	151	205	X
+	6	14	115	205	X
+	14	19	65	205	X

PRA Disclosure Statement

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Page 1 of 1

Superseded section 4.1.0., 4.1-LR, 4.1.1 – LR (CS 14, CS18)



CHIP Eligibility

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

**Child Health Insurance Program
Eligibility - Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards CS14**

Section 2101(f) of the ACA and 42 CFR 457.310(d)

Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards

The CHIP agency provides coverage for this group of children as follows:

- The state has received approval from CMS to maintain Medicaid eligibility for children who would otherwise be subject to Section 2101(f) such that no child in the state will be subject to this provision.

- The state assures that separate CHIP coverage will be provided for children ineligible for Medicaid due to the elimination of income disregards in accordance with 42 CFR 457.310(d). Coverage for this population will cease when the last child protected from loss of Medicaid coverage as a result of the elimination of income disregards has been afforded 12 months of coverage in a separate CHIP (expected to be no later than April 1, 2016).

Describe the methodology used by the state to identify and enroll children in a separate CHIP who are subject to the protection afforded by Section 2101(f) of the Affordable Care Act:

- The state has demonstrated and CMS has agreed that all children qualifying for section 2101(f) protection will qualify for the state's existing separate CHIP.
- The state will enroll all children in a separate CHIP who lose Medicaid eligibility because of an increase in family income at their first renewal applying MAGI methods.

- The state will enroll children in a separate CHIP whose family income falls above the converted MAGI Medicaid FPL but at or below the following percentage of FPL. The state has demonstrated and CMS has agreed that all or almost all the children who would have maintained Medicaid eligibility if former disregards were applied will be within this income range and therefore covered in the separate CHIP.

% FPL

- The state will enroll children in a separate CHIP who are found to be ineligible for Medicaid based on MAGI but whose family income has not increased since the child's last determination of Medicaid eligibility or who would have remained eligible for Medicaid (based on the 2013 Medicaid income standard) if the value of their 2013 disregards had been applied to the family income as determined by MAGI methodology.
- Other.

Describe the benefits provided to this population:

- This population will be provided the same benefits as are provided to children in the state's Medicaid program.
- This population will be provided the same benefits as are provided to children in the state's separate CHIP.
- Other (consistent with Section 2103 of the SSA and 42 CFR 457 Subpart D).

Describe premiums and cost sharing required of this population:

- Cost sharing is the same as for children in the Medicaid program.



CHIP Eligibility

- Premiums and cost sharing are the same as for targeted low-income children in the state's separate CHIP.
- No premiums, copayments, deductibles, coinsurance or other cost sharing is required.
- Other premiums and/or cost-sharing requirements (consistent with Section 2103(e) of the SSA and 42 CFR 457 Subpart E).

PRA Disclosure Statement

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CHIP Eligibility

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Separate Child Health Insurance Program
Non-Financial Eligibility - Citizenship **CS18**

Sections 2105(c)(9) and 2107(e)(1)(J) of the SSA and 42 CFR 457.320(b)(6), (c) and (d)

Citizenship

The CHIP Agency provides CHIP eligibility to otherwise eligible citizens and nationals of the United States and certain non-citizens, including the time period during which they are provided with reasonable opportunity to submit verification of their citizenship, national status or satisfactory immigration status.

The CHIP Agency provides eligibility under the Plan to otherwise eligible individuals:

Who are citizens or nationals of the United States; or

Who are qualified non-citizens as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (8 U.S.C. §1641), or whose eligibility is required by section 402(b) of PRWORA (8 U.S.C. §1612(b)) and is not prohibited by section 403 of PRWORA (8 U.S.C. §1613); or

Who have declared themselves to be citizens or nationals of the United States, or an individual having satisfactory immigration status, during a reasonable opportunity period pending verification of their citizenship, nationality, or satisfactory immigration status consistent with requirements of 1903(x), 1137(d), and 1902(ee) of the Act, and 42 CFR 435.406, 407, 956 and 457.380.

The reasonable opportunity period begins on and extends 90 days from the date the notice of reasonable opportunity is received by the individual.

The agency provides for an extension of the reasonable opportunity period if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency needs more time to complete the verification process.

 Yes

The agency begins to furnish benefits to otherwise eligible individuals during the reasonable opportunity period on a date earlier than the date the notice is received by the individual.

 Yes

The date benefits are furnished is:

- The date of application containing the declaration of citizenship or immigration status.
- The date the reasonable opportunity notice is sent.
- Other date, as described:

The CHIP Agency elects the option to provide CHIP coverage to otherwise eligible children up to age 19, lawfully residing in the United States, as provided in Section 2107(e)(1)(J) of the SSA (Section 214 of CHIPRA 2009, P.L. 111-3).

 No

The CHIP Agency elects the option to provide CHIP coverage to otherwise eligible pregnant women, lawfully residing in the United States, as provided in Section 214 of CHIPRA 2009, P.L. 111-3. The state may not select this option unless the state also elects to cover lawfully residing children. A state may not select this option unless the state also covers Targeted Low-Income Pregnant Women.

 No

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Page 1 of 2



CHIP Eligibility

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

**Separate Child Health Insurance Program
Non-Financial Eligibility - Citizenship** **CS18**

Sections 2105(e)(9) and 2107(e)(1)(J) of the SSA and 42 CFR 457.320(b)(6), (c) and (d)

Citizenship

The CHIP Agency provides CHIP eligibility to otherwise eligible citizens and nationals of the United States and certain non-citizens, including the time period during which they are provided with reasonable opportunity to submit verification of their citizenship, national status or satisfactory immigration status.

The CHIP Agency provides eligibility under the Plan to otherwise eligible individuals:

Who are citizens or nationals of the United States; or

Who are qualified non-citizens as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (8 U.S.C. §1641), or whose eligibility is required by section 402(b) of PRWORA (8 U.S.C. §1612(b)) and is not prohibited by section 403 of PRWORA (8 U.S.C. §1613); or

Who have declared themselves to be citizens or nationals of the United States, or an individual having satisfactory immigration status, during a reasonable opportunity period pending verification of their citizenship, nationality, or satisfactory immigration status consistent with requirements of 1903(x), 1137(d), and 1902(ee) of the Act, and 42 CFR 435.406, 407, 956 and 457.380.

The reasonable opportunity period begins on and extends 90 days from the date the notice of reasonable opportunity is received by the individual.

The agency provides for an extension of the reasonable opportunity period if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency needs more time to complete the verification process.

Yes

The agency begins to furnish benefits to otherwise eligible individuals during the reasonable opportunity period on a date earlier than the date the notice is received by the individual.

Yes

The date benefits are furnished is:

- The date of application containing the declaration of citizenship or immigration status.
- The date the reasonable opportunity notice is sent.
- Other date, as described:

The CHIP Agency elects the option to provide CHIP coverage to otherwise eligible children up to age 19, lawfully residing in the United States, as provided in Section 2107(e)(1)(J) of the SSA (Section 214 of CHIPRA 2009, P.L. 111-3).

No

The CHIP Agency elects the option to provide CHIP coverage to otherwise eligible pregnant women, lawfully residing in the United States, as provided in Section 214 of CHIPRA 2009, P.L. 111-3. The state may not select this option unless the state also elects to cover lawfully residing children. A state may not select this option unless the state also covers Targeted Low-Income Pregnant Women.

No

SPA# OK-14-0006

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Page 1 of 2



CHIP Eligibility

PRA Disclosure Statement

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Page 2 of 2

Oklahoma Title XXI Effective: November 1, 2019

Superseded section 4.1.1 , 4.1.2. & 4.1.3. (CS7, CS9, CS15, CS13)



CHIP Eligibility

OMB Control Number: 0938-1148
 Expiration date: 10/31/2014

Separate Child Health Insurance Program Eligibility - Targeted Low-Income Children **CS7**

2102(b)(1)(B)(v) of the SSA and 42 CFR 457.310, 315 and 320

Targeted Low-Income Children - Uninsured children under age 19 whose household income is within standards established by the state.

The CHIP Agency operates this covered group in accordance with the following provisions:

Age

Must be under age 19.

Income Standards

Income standards are applied statewide. **Yes**

Are there any exceptions, e.g. populations in a county which may qualify under either a statewide income standard or a county income standard? **No**

Statewide Income Standards

Begin with lowest age range first.

Please note that the lower bound for CHIP eligibility should be the highest standard used for Medicaid poverty-level children for the same age group or groups entered here.

	From Age	To Age	Above (% FPL)	Up to & including (% FPL)	
+	0	19	205	225	X

Age ranges may overlap. If there is an overlap, provide an explanation. Include the age ranges for each income standard that has overlapping ages and the reason for having different income standards.

Please see Oklahoma's CS23 PDF page, which reflects "other eligibility standards" for the population described on this PDF page.

Special Program for Children with Disabilities

Does the state have a special program for children with disabilities? **No**

PRA Disclosure Statement



CHIP Eligibility

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Page 2 of 2



CHIP Eligibility

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Separate Child Health Insurance Program Eligibility - Coverage From Conception to Birth	CS9
42 CFR 457.10	
<input checked="" type="checkbox"/> Coverage From Conception to Birth - Coverage from conception to birth when the mother is not eligible for Medicaid. <input checked="" type="checkbox"/> The CHIP Agency operates this covered group in accordance with the following provisions:	
Age Standard From conception through birth. Does the state have an additional age definition or other age-related conditions? <input type="checkbox"/> No	
Income Standards Income standards are applied statewide. <input type="checkbox"/> Yes Are there any exceptions, e.g. populations in a county which may qualify under either a statewide income standard or a county income standard? <input type="checkbox"/> No Statewide Income Standard The statewide income standard is: From zero up to <input type="text" value="205"/> % FPL.	
<input checked="" type="checkbox"/> Exempted from requirement of providing or applying for a Social Security Number. <input checked="" type="checkbox"/> Exempted from requirement of verifying citizenship status.	

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Page 1 of 1



CHIP Eligibility

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

**Separate Child Health Insurance Program
MAGI-Based Income Methodologies** **CS15**

2102(b)(1)(B)(v) of the SSA and 42 CFR 457.315

The CHIP Agency will apply Modified Adjusted Gross Income methodologies for all separate CHIP covered groups, as described below, and consistent with 42 CFR 457.315 and 435.603(b) through (i).

In the case of determining ongoing eligibility for enrollees determined eligible for CHIP on or before December 31, 2013, MAGI-based income methodologies will not be applied until March 31, 2014 or the next regularly-scheduled renewal of eligibility, whichever is later.

If the state covers pregnant women, in determining family size for the eligibility determination of a pregnant woman, she is counted as herself plus each of the children she is expected to deliver.

In determining family size for the eligibility determination of the other individuals in a household that includes a pregnant woman:

- The pregnant woman is counted just as herself.
- The pregnant woman is counted just as herself, plus one.
- The pregnant woman is counted as herself, plus the number of children she is expected to deliver.

Financial eligibility is determined consistent with the following provisions:

When determining eligibility for new applicants, financial eligibility is based on current monthly income and family size.

When determining eligibility for current beneficiaries, financial eligibility is based on:

- Current monthly household income and family size.
- Projected annual household income for the remaining months of the current calendar year and family size.

In determining current monthly or projected annual household income, the state will use reasonable methods to:

- Include a prorated portion of the reasonably predictable increase in future income and/or family size.
- Account for a reasonably predictable decrease in future income and/or family size.

Except as provided at 42 CFR 457.315 and 435.603(d)(2) through (d)(4), household income is the sum of the MAGI-based income of every individual included in the individual's household.

Household income includes actually available cash support, exceeding nominal amounts, provided by the person claiming an individual described at §435.603(f)(2)(i) as a tax dependent.

The CHIP Agency certifies that it has submitted and received approval for the conversion for all separate CHIP covered group income standards to MAGI-equivalent standards.

An attachment is submitted.

PRA Disclosure Statement

SPA# OK-14-0002

Approval Date: Jan 29 2015

Approval Date: Jan 29 2015



CHIP Eligibility

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V.20130917



CHIP Eligibility

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Separate Child Health Insurance Program Eligibility - Deemed Newborns	CS13
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Section 2112(e) of the SSA and 42 CFR 457.360

Deemed Newborns - Children born to targeted low-income pregnant women are deemed to have applied for and be eligible for CHIP or Medicaid until the child turns one.

The state operates this covered group in accordance with the following provisions:

- The child was born to an eligible targeted low-income pregnant woman under section 2112 of the SSA.**
- The child is deemed to have applied for and been found eligible for CHIP or Medicaid, as appropriate, as of the date of the child's birth, and remains eligible without regard to changes in circumstances until the child's first birthday.**

The state elects the following option(s):

- The state elects to cover as a deemed newborn a child born to a mother who is covered as a targeted low-income child under the state's separate CHIP on the date of the newborn's birth.**
- The state elects to recognize a child's deemed newborn status from another state and provides benefits in accordance with the requirements of section 2112(e) of the SSA.**
- The state elects to cover as a deemed newborn a child born to a mother who is covered under Medicaid or CHIP through the authority of the state's section 1115 demonstration on the date of the newborn's birth.**

PRA Disclosure Statement

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Superseded section 4.1.5 (CS 17)



CHIP Eligibility

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

**Separate Child Health Insurance Program
Non-Financial Eligibility - Residency** **CS17**

42 CFR 457.320

Residency

The CHIP Agency provides CHIP to otherwise eligible residents of the state, including residents who are absent from the state under certain conditions.

A child is considered to be a resident of the state under the following conditions:

- A non-institutionalized child, if capable of indicating intent and who is emancipated or married, if the child is living in the state and:
 1. Intends to reside in the state, including without a fixed address, or
 2. Has entered the state with a job commitment or seeking employment, whether or not currently employed.
- A non-institutionalized child not described above and a child who is not a ward of the state:
 1. Residing in the state, with or without a fixed address, or
 2. The state of residency of the parent or caretaker, in accordance with 42 CFR.435.403(h)(1), with whom the individual resides.
- An institutionalized child, who is not a ward of the state, if the state is the state of residence of the child's custodial parent or caretaker at the time of placement, or
- A child who is a ward of the state regardless of where the child lives, or
- A child physically located in the state when there is a dispute with one or more states as to the child's actual state of residence.

If the state covers pregnant women, a pregnant woman is considered to be a resident under the following conditions:

- A non-institutionalized pregnant woman who is living in the state and:
 1. Intends to reside in the state, including without a fixed address, or if incapable of indicating intent, is living in the state, or
 2. Entered with a job commitment or seeking employment, whether or not currently employed.
- An institutionalized pregnant woman placed in an out-of-state-institution, as defined in 42 CFR 435.1010, including foster care homes, by an agency of the state, or
- An institutionalized pregnant woman residing in an in-state-institution, as defined in 42 CFR 435.1010, whether or not the individual established residency in the state prior to entering the institution, or
- A pregnant woman physically located in the state when there is a dispute with one or more states as to the pregnant woman's actual state of residence.

The state has in place related to the residency of children and pregnant women (if covered by the state):



CHIP Eligibility

One or more interstate agreement(s). Yes

The state has interstate agreements with the following other states:

- | | | | |
|--|---|--|--|
| <input checked="" type="checkbox"/> Alabama | <input checked="" type="checkbox"/> Illinois | <input checked="" type="checkbox"/> Montana | <input checked="" type="checkbox"/> Rhode Island |
| <input checked="" type="checkbox"/> Alaska | <input checked="" type="checkbox"/> Indiana | <input checked="" type="checkbox"/> Nebraska | <input checked="" type="checkbox"/> South Carolina |
| <input checked="" type="checkbox"/> Arizona | <input checked="" type="checkbox"/> Iowa | <input checked="" type="checkbox"/> Nevada | <input checked="" type="checkbox"/> South Dakota |
| <input checked="" type="checkbox"/> Arkansas | <input checked="" type="checkbox"/> Kansas | <input checked="" type="checkbox"/> New Hampshire | <input checked="" type="checkbox"/> Tennessee |
| <input checked="" type="checkbox"/> California | <input checked="" type="checkbox"/> Kentucky | <input checked="" type="checkbox"/> New Jersey | <input checked="" type="checkbox"/> Texas |
| <input checked="" type="checkbox"/> Colorado | <input checked="" type="checkbox"/> Louisiana | <input checked="" type="checkbox"/> New Mexico | <input checked="" type="checkbox"/> Utah |
| <input checked="" type="checkbox"/> Connecticut | <input checked="" type="checkbox"/> Maine | <input type="checkbox"/> New York | <input checked="" type="checkbox"/> Vermont |
| <input checked="" type="checkbox"/> Delaware | <input checked="" type="checkbox"/> Maryland | <input checked="" type="checkbox"/> North Carolina | <input checked="" type="checkbox"/> Virginia |
| <input checked="" type="checkbox"/> District of Columbia | <input checked="" type="checkbox"/> Massachusetts | <input checked="" type="checkbox"/> North Dakota | <input checked="" type="checkbox"/> Washington |
| <input checked="" type="checkbox"/> Florida | <input checked="" type="checkbox"/> Michigan | <input checked="" type="checkbox"/> Ohio | <input checked="" type="checkbox"/> West Virginia |
| <input checked="" type="checkbox"/> Georgia | <input checked="" type="checkbox"/> Minnesota | <input type="checkbox"/> Oklahoma | <input checked="" type="checkbox"/> Wisconsin |
| <input checked="" type="checkbox"/> Hawaii | <input checked="" type="checkbox"/> Mississippi | <input checked="" type="checkbox"/> Oregon | <input type="checkbox"/> Wyoming |
| <input checked="" type="checkbox"/> Idaho | <input checked="" type="checkbox"/> Missouri | <input checked="" type="checkbox"/> Pennsylvania | |

The interstate agreement contains a procedure for providing CHIP to individuals pending resolution of their residency status and criteria for resolving disputed residency of individuals who: (Select all that apply)

- Are in the state only for the purpose of attending school.
- Are out of the state only for the purpose of attending school.
- Retain addresses in both states.
- Other type of individual:

A policy related to individuals in the state only for educational purposes. No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Superseded section 4.1.9. (CS 23)



CHIP Eligibility

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Separate Child Health Insurance Program Non-Financial Requirements - Other Eligibility Standards	CS23
<input checked="" type="checkbox"/> Other eligibility standards:	
Name of eligibility standard: <input style="width: 80%;" type="text" value="Insure Oklahoma Coverage of Dependent Children in ESI"/>	<input type="button" value="Remove"/>
To which covered group(s) does this standard apply?	
<input checked="" type="checkbox"/> Targeted Low-Income Children <input type="checkbox"/> Targeted Low-Income Pregnant Women <input type="checkbox"/> Coverage from Conception to Birth <input type="checkbox"/> Children with Access to Public Employee Coverage <input type="checkbox"/> Pregnant Women with Access to Public Employee Coverage <input type="checkbox"/> Children Eligible for Dental Only Supplemental Coverage <input type="checkbox"/> Deemed Newborns	
Describe how this standard affects eligibility:	
<div style="border: 1px solid black; padding: 5px;"> Targeted low-income children are eligible for premium assistance only, with no direct state plan option, based on whether a child that meets the age and income standard specified on the CS7 page also meets additional criteria associated with their parents access to premium assistance for group coverage under section 1115 demonstration authority. </div>	
<input type="button" value="Add"/>	

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Page 1 of 1

Section 4.1.9.1. (CS 19)



CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

**Separate Child Health Insurance Program
Non-Financial Eligibility - Social Security Number** **CS19**

42 CFR 457.340(b)

Social Security Number

As a condition of eligibility, the CHIP Agency must require individuals who have a social security number or are eligible for one as determined by the Social Security Administration, to furnish their social security number, or numbers if they have more than one number.

- The CHIP Agency requires individuals, as a condition of eligibility, to furnish their social security number(s), with the following exceptions:

Individuals refusing to obtain a social security number (SSN) because of well established religious objections, or

Individuals who are not eligible for an SSN, or

Individuals who are issued an SSN only for a valid non-work purpose.

- The CHIP Agency assists individuals, who are required to provide their SSN, to apply for or obtain an SSN from the Social Security Administration if the individual does not have or forgot their SSN.
- The CHIP Agency informs individuals required to provide their SSN:

By what statutory authority the number is solicited; and

How the state will use the SSN.

- The CHIP Agency provides assurance that it will verify each SSN furnished by an applicant or beneficiary with the Social Security Administration, not deny or delay services to an otherwise eligible applicant pending issuance or verification of the individual's SSN by the Social Security Administration and that the state's utilization of the SSNs is consistent with sections 205 and 1137 of the Social Security Act and the Privacy Act of 1974.

The state may request non-applicant household members to voluntarily provide their SSN, if the state meets the requirements below.

The state requests non-applicant household members to voluntarily provide their SSN.

Yes

- When requesting an SSN for non-applicant household members, the state assures that:

- At the time such SSN is requested, the state informs the non-applicant that this information is voluntary and provides information regarding how the SSN will be used; and

- The state only uses the SSN for determination of eligibility for CHIP or other insurance affordability programs, or for a purpose directly connected with the administration of the state plan.

PRA Disclosure Statement



CHIP Eligibility

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Page 2 of 2

Superseded section 4.3. & 4.4. (CS24)



CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program General Eligibility - Eligibility Processing	CS24
2102(b)(3) & 2107(e)(1)(O) of the SSA and 42 CFR 457, subpart C	
<input checked="" type="checkbox"/> The CHIP Agency meets all of the requirements of 42 CFR 457, subpart C for application processing, eligibility screening and enrollment.	
Application Processing	
Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard:	
<input checked="" type="checkbox"/> The single, streamlined application developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act.	
<input checked="" type="checkbox"/> An alternative single, streamlined application developed by the state and approved by the Secretary in accordance with section 1413(b)(1)(B) of the Affordable Care Act.	
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;">An attachment is submitted.</div>	
<input type="checkbox"/> An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.	
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;">An attachment is submitted.</div>	
<input checked="" type="checkbox"/> The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in CFR 457.340(a), by telephone, via mail, in person and other commonly available electronic means.	
The agency accepts applications in the following other electronic means:	
<input type="checkbox"/> Other electronic means:	
Screen and Enroll Process	
<input checked="" type="checkbox"/> The CHIP Agency has coordinated eligibility and enrollment screening procedures in place that are applied at time of initial application, periodic redeterminations, and follow-up eligibility determinations. The procedures ensure that only targeted low-income children are provided CHIP coverage and that enrollment is facilitated for applicants found to be potentially eligible for other insurance affordability programs.	
Procedures include:	
<input checked="" type="checkbox"/> Screening of application to identify all individuals eligible or potentially eligible for CHIP or other insurance affordability programs; and	
<input checked="" type="checkbox"/> Income eligibility test, with calculation of household income consistent with 42 CFR 457.315 for individuals identified as potentially eligible for Medicaid or other insurance affordability programs based on household income; and	

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Page 1 of 2



CHIP Eligibility

- Screening process for individuals who may qualify for Medicaid on a basis other than having household income at or below the applicable MAGI standard, based on information in the single streamlined application.

The CHIP agency has entered into an arrangement with the Exchange to make eligibility determinations for advanced premium tax credits in accordance with section 1943(b)(2) of the SSA.

No

Redetermination Processing

- Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 457.343:

- Once every 12 months.

- Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency.

- If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

Screening by Other Insurance Affordability Programs

- The CHIP Agency provides assurance that it has adopted procedures to accept and process electronic accounts of individuals screened as potentially eligible for CHIP by other insurance affordability programs in accordance with the requirements of 42 CFR 457.348(b) and to determine eligibility in accordance with 42 CFR 457.340 in the same manner as if the application had been submitted directly to, and processed by the state.

- The CHIP Agency elects the option to accept CHIP eligibility decisions made by the Exchange or other agencies administering insurance affordability programs as provided in 42 CFR 457.348 and to furnish CHIP in accordance with requirements of 42 CFR 457.340 to the same extent and in the same manner as if the applicant had been determined by the state to be eligible for CHIP.

- The CHIP Agency has entered into an agreement with agencies administering other insurance affordability programs to fulfill the requirements of 457.348(b) and will provide this agreement to the Secretary upon request.

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Superseded section 4.4.4 (CS20)



CHIP Eligibility

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

**Separate Child Health Insurance Program
Non-Financial Eligibility - Substitution of Coverage** **CS20**

Section 2102(b)(3)(C) of the SSA and 42 CFR 457.340(d)(3), 457.350(i), and 457.805

Substitution of Coverage

The CHIP Agency provides assurance that it has methods and policies in place to prevent the substitution of group health coverage or other commercial health insurance with public funded coverage. These policies include:

Substitution of coverage prevention strategy:

	Name of policy	Description	
+	Oklahoma Administrative Code on Creditable Coverage and Pregnant Women	To receive pregnancy related benefits under Title XXI, a pregnant woman must not be covered by creditable insurance, either through a group health plan or other commercial health insurance plan.	X
+	Use of the Third Party Liability Unit	All members are screened for other third party 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.	X

A waiting period during which an individual is ineligible due to having dropped group health coverage.

If the state elects to offer dental only supplemental coverage, the following assurances apply:

The other coverage exclusion does not apply to children who are otherwise eligible for dental only supplemental coverage as provided in section 2110(b)(5) of the SSA.

The waiting period does not apply to children eligible for dental only supplemental coverage.

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Superseded section 8.7 (CS21)



CHIP Eligibility

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Separate Child Health Insurance Program		CS21
Non-Financial Eligibility - Non-Payment of Premiums		
42 CFR 457.570		
Non-Payment of Premiums		
Does the state impose premiums or enrollment fees?		<input type="checkbox"/> No

PRA Disclosure Statement

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Page 1 of 1