

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

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

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

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

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

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

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

Name: Becky Pasternik-Ikard

Position/Title: Chief Executive Officer

Name: Carrie Evans

Position/Title: ~~Chief Financial Officer~~ Deputy Chief

Executive Officer

Name: Tywanda Cox

Position/Title: Chief, Federal & State Authorities

*Disclosure. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #34). The time required to complete this information collection is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Introduction: Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 105-33 amended the Social Security Act (the Act) by adding a new title XXI, the Children's Health Insurance Program

(CHIP). In February 2009, the Children’s Health Insurance Program Reauthorization Act (CHIPRA) renewed the program. The Patient Protection and Affordable Care Act of 2010 further modified the program.

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

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

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

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

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

state plan.

The template includes the following sections:

1. **General Description and Purpose of the Children's Health Insurance Plans and the Requirements-** This section should describe how the State has designed their program. It also is the place in the template that a State updates to insert a short description and the proposed effective date of the SPA, and the proposed implementation date(s) if different from the effective date. (Section 2101); (42 CFR 457.70)
2. **General Background and Description of State Approach to Child Health Coverage and Coordination-** This section should provide general information related to the special characteristics of each state's program. The information should include the extent and manner to which children in the State currently have creditable health coverage, current State efforts to provide or obtain creditable health coverage for uninsured children and how the plan is designed to be coordinated with current health insurance, public health efforts, or other enrollment initiatives. This information provides a health insurance baseline in terms of the status of the children in a given State and the State programs currently in place. (Section 2103); (42 CFR 457.410(A))
3. **Methods of Delivery and Utilization Controls-** This section requires a description that must include both proposed methods of delivery and proposed utilization control systems. This section should fully describe the delivery system of the Title XXI program including the proposed contracting standards, the proposed delivery systems and the plans for enrolling providers. (Section 2103); (42 CFR 457.410(A))
4. **Eligibility Standards and Methodology-** The plan must include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. This section includes a list of potential eligibility standards the State can check off and provide a short description of how those standards will be applied. All eligibility standards must be consistent with the provisions of Title XXI and may not discriminate on the basis of diagnosis. In addition, if the standards vary within the state, the State should describe how they will be applied and under what circumstances they will be applied. In addition, this section provides information on income eligibility for Medicaid expansion programs (which are exempt from Section 4 of the State plan template) if applicable. (Section 2102(b)); (42 CFR 457.305 and 457.320)
5. **Outreach-** This section is designed for the State to fully explain its outreach activities. Outreach is defined in law as outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs. The purpose is to inform these families of the availability of, and to assist them in enrolling their children in, such a program. (Section 2102(c)(1)); (42 CFR 457.90)
6. **Coverage Requirements for Children's Health Insurance-** Regarding the required scope of health insurance coverage in a State plan, the child health assistance provided must consist of any of the four types of coverage outlined in Section 2103(a) (specifically, benchmark coverage; benchmark-equivalent coverage; existing comprehensive state-based coverage; and/or Secretary-approved coverage). In this section States identify the scope of coverage and benefits offered under the plan including the categories under which that coverage is offered. The amount, scope,

and duration of each offered service should be fully explained, as well as any corresponding limitations or exclusions. (Section 2103); (42 CFR 457.410(A))

7. **Quality and Appropriateness of Care-** This section includes a description of the methods (including monitoring) to be used to assure the quality and appropriateness of care and to assure access to covered services. A variety of methods are available for State's use in monitoring and evaluating the quality and appropriateness of care in its child health assistance program. The section lists some of the methods which states may consider using. In addition to methods, there are a variety of tools available for State adaptation and use with this program. The section lists some of these tools. States also have the option to choose who will conduct these activities. As an alternative to using staff of the State agency administering the program, states have the option to contract out with other organizations for this quality of care function. (Section 2107); (42 CFR 457.495)
8. **Cost Sharing and Payment-** This section addresses the requirement of a State child health plan to include a description of its proposed cost sharing for enrollees. Cost sharing is the amount (if any) of premiums, deductibles, coinsurance and other cost sharing imposed. The cost-sharing requirements provide protection for lower income children, ban cost sharing for preventive services, address the limitations on premiums and cost-sharing and address the treatment of pre-existing medical conditions. (Section 2103(e)); (42 CFR 457, Subpart E)
9. **Strategic Objectives and Performance Goals and Plan Administration-** The section addresses the strategic objectives, the performance goals, and the performance measures the State has established for providing child health assistance to targeted low income children under the plan for maximizing health benefits coverage for other low income children and children generally in the state. (Section 2107); (42 CFR 457.710)
10. **Annual Reports and Evaluations-** Section 2108(a) requires the State to assess the operation of the Children's Health Insurance Program plan and submit to the Secretary an annual report which includes the progress made in reducing the number of uninsured low income children. The report is due by January 1, following the end of the Federal fiscal year and should cover that Federal Fiscal Year. In this section, states are asked to assure that they will comply with these requirements, indicated by checking the box. (Section 2108); (42 CFR 457.750)
11. **Program Integrity-** In this section, the State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Sections 2101(a) and 2107(e); (42 CFR 457, subpart I)
12. **Applicant and Enrollee Protections-** This section addresses the review process for eligibility and enrollment matters, health services matters (i.e., grievances), and for states that use premium assistance a description of how it will assure that applicants and enrollees are given the opportunity at initial enrollment and at each redetermination of eligibility to obtain health benefits coverage other than through that group health plan. (Section 2101(a)); (42 CFR 457.1120)

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

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

Medicaid Expansion- CHIP SPA Requirements

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

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

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

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

Medicaid Expansion- Medicaid SPA Requirements

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

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

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

a Separate Program” would apply. States wishing to use a combination of approaches will be required to complete the Title XXI State plan and the necessary State plan amendment under Title XIX.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
OK-14-0002	MAGI Eligibility	CS7	Coverage of targeted low-income children	Supersedes the current sections 4.1.1, 4.1.2, and 4.1.3
		CS9	Coverage of children from conception to birth when	Supersedes the

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
Effective/Implementation Date: January 1, 2014		CS13 CS15	mother is not eligible for Medicaid Cover as deemed newborns children covered by section 1115 demonstration Oklahoma SoonerCare Assurance that state will apply MAGI based income methodologies for all separate CHIP covered groups	current sections 4.1.1, 4.1.2, and 4.1.3 Supersedes the current section 4.1.3 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

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
OK-14-0006	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
		Effective/Implementation Date: January 1, 2014		

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

Proposed implementation date: 10/01/18

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

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

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

Proposed implementation date: 10/02/2017

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

Tribal consultation for this SPA proposal took place on 05/16/2018

TN No: Approval Date Effective Date 10/02/2017

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, two visits per month with specialists and subspecialists and the related tests and procedures will be covered to provide evaluation and management of maternal or fetal conditions, diseases and disorders that may impact the pregnancy, and/or maternal/fetal outcomes. Examples of these visits would be an outpatient office or clinic visit with an endocrinologist regarding a maternal (pre) diabetic condition, or a visit with a cardiologist regarding a preexisting maternal heart defect and potential care and treatment during pregnancy needed in order to maximize fetal well-being. Services to treat maternal conditions that bear no relationship to fetal well-being and outcomes will not be covered. Examples of non-covered care are evaluation and treatment of maternal cataracts, evaluation and treatment of maternal hearing loss or outpatient psychosocial rehabilitation services for mental illness.

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.

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

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.

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

6.2.3. ☒ 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, two visits per month with specialists and subspecialists and the related tests and procedures will be covered to provide evaluation and management of maternal or fetal conditions, diseases and disorders that may impact the pregnancy, and/or maternal/fetal outcomes. Examples of these visits would be an outpatient office or clinic visit with an endocrinologist regarding a maternal (pre) diabetic condition, or a visit with a cardiologist regarding a preexisting maternal heart defect and potential care and treatment during pregnancy needed in order to maximize fetal well-being. Services to treat maternal conditions that bear no relationship to fetal well-being and outcomes will not be covered. Examples of non-covered care are evaluation and treatment of maternal cataracts, evaluation and treatment of maternal hearing loss or outpatient psychosocial rehabilitation services for mental illness.

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

6.2.4. ☒

Surgical services (Section 2110(a)(4))

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

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

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

6.2.5. ☒

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

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

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

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

6.2.6. ☒

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.

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

6.2.7. ☐

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

6.2.8. ☒

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.

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

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, two visits per month with specialists and subspecialists and the related tests and procedures will be covered to provide evaluation and management of maternal or fetal conditions, diseases and disorders that may impact the pregnancy, and/or maternal/fetal outcomes. Examples of these visits would be an outpatient office or clinic visit with an endocrinologist regarding a maternal (pre) diabetic condition, or a visit with a cardiologist regarding a preexisting maternal heart defect and potential care and treatment during pregnancy needed in order to maximize fetal well-being. Services to treat maternal conditions that bear no relationship to fetal well-being and outcomes will not be covered. Examples of non-covered care are evaluation and treatment of maternal cataracts, evaluation and treatment of maternal hearing loss or outpatient psychosocial rehabilitation services for mental illness. Eligible Unborn Children will receive the services described in 6.1.4.7 and 6.2 with fee-for-service reimbursement, and will not be enrolled with a PCP.

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

6.2.10. ☒

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

~~IP program includes inpatient acute detox, partial and residential treatment centers with 30 days for children per State Fiscal Year, 2 days of partial or residential treatment centers service equals 1 day accruing to maximum.~~

~~Inpatient mental health services day limits are separate from outpatient mental health services day limits, and are separate from Inpatient substance abuse treatment services and residential substance abuse treatment services. Prior authorization required, \$50 per admission co-pay.~~

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))

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

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.

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

6.2.13. ☒

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.

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

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.

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

6.2.16. ☒ 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 IP program covered as medically necessary and includes coverage for~~

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

~~\$25 co-pay; Emergency Dental Services covered as medically necessary, no co-pay. (See attachment C.1)~~

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))

~~IP program includes inpatient acute detox, partial and residential treatment centers with 30 days for children per State Fiscal Year, 2 days of partial or residential treatment centers service equals 1 day accruing to maximum, prior authorization required, \$50 per admission co-pay.~~

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))

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

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))

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

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))

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

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))

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

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.

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

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))
~~IP program includes coverage as medically necessary for emergency medical transportation, \$50 copay per occurrence, waived if admitted. Non-emergency transportation not a covered service.~~
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))
~~IP program includes coverage as medically necessary for emergency services defined at 42CFR457.10.~~

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)

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3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)
4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999)
5. Periodontic (treatment of gum disease) (CDT codes: D4000-D4999)
6. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999)
7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999)
8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)
9. Emergency Dental Services

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

6.2.1.1-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(l).

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:

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

- Planned use of funds, including:
 - Projected amount to be spent on health services;
 - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
 - Assumptions on which the budget is based, including cost per child and expected enrollment.
 - Projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc.
 - All cost sharing, benefit, payment, eligibility need to be reflected in the budget.
- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
- Include a separate budget line to indicate the cost of providing coverage to pregnant women.
- States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.
- Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.
- Include a separate budget line to indicate the cost of implementing Express Lane Eligibility.
- Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:
 - Total 1-year cost of adding prenatal coverage
 - Estimate of unborn children covered in year 1

CHIP Budget

STATE: OKLAHOMA	FFY 2019 Budget
Federal Fiscal Year	2019
State's enhanced FMAP rate	96.67%
Benefit Costs	
Insurance payments	
Managed care	\$202,810,952
per member/per month rate (See below)	
Fee for Service	\$25,472,563
Total Benefit Costs	\$228,283,515
(Offsetting beneficiary cost sharing payments)	-

STATE: OKLAHOMA	FFY 2019 Budget
Net Benefit Costs	\$228,283,515
Cost of Proposed SPA Changes – Benefit	
Administration Costs	
Personnel	
General administration	\$10,322,773
Contractors/Brokers	
Claims Processing	
Outreach/marketing costs	
Health Services Initiatives	\$3,450,765
Other	
Total Administration Costs	\$13,773,538
10% Administrative Cap	\$25,364,835
Cost of Proposed SPA Changes	\$524,722
Federal Share	\$233,996,553
State Share	\$8,060,500
Total Costs of Approved CHIP Plan	\$242,057,053

NOTE: Include the costs associated with the current SPA.

There are no costs associated with this SPA proposal; the purpose of this SPA request is to comply with parity federal regulation requirements.

The Source of State Share Funds: N/A for this SPA request.

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.

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

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

Key for Newly Incorporated Templates

The newly incorporated templates are indicated with the following letters after the numerical section throughout the template.

- PC- Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
- PW- Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
- TC- Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
- DC- Dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- DS- Supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- PA- Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
- EL- Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
- LR- Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)

CMS Regional Offices				
CMS Regional Offices	States		Associate Regional Administrator	Regional Office Address
Region 1- Boston	Connecticut Massachusetts Maine	New Hampshire Rhode Island Vermont	Richard R. McGreal richard.mcgreall@cms.hhs.gov	John F. Kennedy Federal Bldg. Room 2275 Boston, MA 02203-0003
Region 2- New York	New York Virgin Islands	New Jersey Puerto Rico	Michael Melendez michael.melendez@cms.hhs.gov	26 Federal Plaza Room 3811 New York, NY 10278-0063
Region 3- Philadelphia	Delaware District of Columbia Maryland	Pennsylvania Virginia West Virginia	Ted Gallagher ted.gallagher@cms.hhs.gov	The Public Ledger Building 150 South Independence Mall West Suite 216 Philadelphia, PA 19106
Region 4- Atlanta	Alabama Florida Georgia Kentucky	Mississippi North Carolina South Carolina Tennessee	Jackie Glaze jackie.glaze@cms.hhs.gov	Atlanta Federal Center 4 th Floor 61 Forsyth Street, S.W. Suite 4T20 Atlanta, GA 30303-8909
Region 5- Chicago	Illinois Indiana Michigan	Minnesota Ohio Wisconsin	Verlon Johnson verlon.johnson@cms.hhs.gov	233 North Michigan Avenue, Suite 600 Chicago, IL 60601
Region 6- Dallas	Arkansas Louisiana New Mexico	Oklahoma Texas	Bill Brooks bill.brooks@cms.hhs.gov	1301 Young Street, 8th Floor Dallas, TX 75202
Region 7- Kansas City	Iowa Kansas	Missouri Nebraska	James G. Scott james.scott1@cms.hhs.gov	Richard Bulling Federal Bldg. 601 East 12 Street, Room 235 Kansas City, MO 64106-2808
Region 8- Denver	Colorado Montana North Dakota	South Dakota Utah Wyoming	Richard Allen richard.allen@cms.hhs.gov	Federal Office Building, Room 522 1961 Stout Street Denver, CO 80294-3538
Region 9- San Francisco	Arizona California Hawaii Nevada	American Samoa Guam Northern Mariana Islands	Gloria Nagle gloria.nagle@cms.hhs.gov	90 Seventh Street Suite 5-300 San Francisco Federal Building San Francisco, CA 94103
Region 10- Seattle	Idaho Washington	Alaska Oregon	Carol Peverly carol.peverly@cms.hhs.gov	2001 Sixth Avenue MS RX-43 Seattle, WA 98121

GLOSSARY

Adapted directly from Sec. 2110. DEFINITIONS.

CHILD HEALTH ASSISTANCE- For purposes of this title, the term ‘child health assistance’ means payment for part or all of the cost of health benefits coverage for targeted low-income children that includes any of the following (and includes, in the case described in Section 2105(a)(2)(A), payment for part or all of the cost of providing any of the following), as specified under the State plan:

1. Inpatient hospital services.
2. Outpatient hospital services.
3. Physician services.
4. Surgical services.
5. Clinic services (including health center services) and other ambulatory health care services.
6. Prescription drugs and biologicals and the administration of such drugs and biologicals, only if such drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.
7. Over-the-counter medications.
8. Laboratory and radiological services.
9. Prenatal care and prepregnancy family planning services and supplies.
10. Inpatient mental health services, other than services described in paragraph (18) but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.
11. Outpatient mental health services, other than services described in paragraph (19) but including services furnished in a State-operated mental hospital and including community-based services.
12. Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices).
13. Disposable medical supplies.
14. Home and community-based health care services and related 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).
15. Nursing care services (such as 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.
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.
17. Dental services.
18. Inpatient substance abuse treatment services and residential substance abuse treatment services.
19. Outpatient substance abuse treatment services.
20. Case management services.
21. Care coordination services.
22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
23. Hospice care.

24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is--
 - a. prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law,
 - b. performed under the general supervision or at the direction of a physician, or
 - c. 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.
25. Premiums for private health care insurance coverage.
26. Medical transportation.
27. Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.
28. Any other health care services or items specified by the Secretary and not excluded under this section.

TARGETED LOW-INCOME CHILD DEFINED- For purposes of this title--

1. **IN GENERAL-** Subject to paragraph (2), the term ‘targeted low-income child’ means a child--
 - a. who has been determined eligible by the State for child health assistance under the State plan;
 - b. (i) who is a low-income child, or
(ii) is a child whose family income (as determined under the State child health plan) exceeds the Medicaid applicable income level (as defined in paragraph (4)), but does not exceed 50 percentage points above the Medicaid applicable income level; and
 - c. who is not found to be eligible for medical assistance under title XIX or covered under a group health plan or under health insurance coverage (as such terms are defined in Section 2791 of the Public Health Service Act).
2. **CHILDREN EXCLUDED-** Such term does not include--
 - a. a child who is a resident of a public institution or a patient in an institution for mental diseases; or
 - b. a child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State.
3. **SPECIAL RULE-** A child shall not be considered to be described in paragraph (1)(C) notwithstanding that the child is covered under a health insurance coverage program that has been in operation since before July 1, 1997, and that is offered by a State which receives no Federal funds for the program's operation.
4. **MEDICAID APPLICABLE INCOME LEVEL-** The term ‘Medicaid applicable income level’ means, with respect to a child, the effective income level (expressed as a percent of the poverty line) that has been specified under the State plan under title XIX (including under a waiver authorized by the Secretary or under Section 1902(r)(2)), as of June 1, 1997, for the child to be eligible for medical assistance under Section 1902(l)(2) for the age of such child.
5. **TARGETED LOW-INCOME PREGNANT WOMAN.**—The term ‘targeted low-income pregnant

woman' means an individual— (A) during pregnancy and through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends; (B) whose family income exceeds 185 percent (or, if higher, the percent applied under subsection (b)(1)(A)) of the poverty line applicable to a family of the size involved, but does not exceed the income eligibility level established under the State child health plan under this title for a targeted low-income child; and (C) who satisfies the requirements of paragraphs (1)(A), (1)(C), (2), and (3) of Section 2110(b) in the same manner as a child applying for child health assistance would have to satisfy such requirements.

ADDITIONAL DEFINITIONS- For purposes of this title:

1. **CHILD-** The term 'child' means an individual under 19 years of age.
2. **CREDITABLE HEALTH COVERAGE-** The term 'creditable health coverage' has the meaning given the term 'creditable coverage' under Section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)) and includes coverage that meets the requirements of section 2103 provided to a targeted low-income child under this title or under a waiver approved under section 2105(c)(2)(B) (relating to a direct service waiver).
3. **GROUP HEALTH PLAN; HEALTH INSURANCE COVERAGE; ETC-** The terms 'group health plan', 'group health insurance coverage', and 'health insurance coverage' have the meanings given such terms in Section 2191 of the Public Health Service Act.
4. **LOW-INCOME CHILD -** The term 'low-income child' means a child whose family income is at or below 200 percent of the poverty line for a family of the size involved.
5. **POVERTY LINE DEFINED-** The term 'poverty line' has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.
6. **PREEXISTING CONDITION EXCLUSION-** The term 'preexisting condition exclusion' has the meaning given such term in section 2701(b)(1)(A) of the Public Health Service Act (42 U.S.C. 300gg(b)(1)(A)).
7. **STATE CHILD HEALTH PLAN; PLAN-** Unless the context otherwise requires, the terms 'State child health plan' and 'plan' mean a State child health plan approved under Section 2106.
8. **UNINSURED CHILD-** The term 'uninsured child' means a child that does not have creditable health coverage.