

State of Oklahoma
State Children's Health Insurance Program
Under Title XXI Plan of the Social Security Act

Response to Questions and Comments

Section 2. General Background and Description of State Approach to Child Health Coverage

Section 2.2.2

Question #1: What is the status of the Oklahoma Caring Foundation and what is its relationship to this expansion?

Response#1: Blue Cross and Blue Shield of Oklahoma established the Oklahoma Caring Foundation to provide free primary and preventive outpatient health care benefits to uninsured children (those who do not have Medicaid or private insurance) of the working poor. Children 1-19 years of age are eligible for this program based on household income. A Statewide network of providers who accept reduced fees provides a limited array of primary and preventive ~~care~~ services, and outpatient services, prescription drug coverage up to \$100 per year and emergency room treatment in life-threatening situations. The administrative ~~services~~ are donated by Blue Cross and Blue Shield of Oklahoma and the program is financed through private contributions. At the present time the State does not contribute to this program nor does it operate the program. The State fully comprehends that for the purposes of eligibility for Title XXI funds, children receiving health care services from the Blue Cross and Blue Shield of Oklahoma Caring Program cannot be covered as targeted low-income children.

Section 2.3

Question#2: On page 1 and the footnote on page 4 the State indicates that individuals receiving health services from the Indian Health Service (IHS) should be considered insured and therefore, not eligible for services under Title XXI. Please note that, for purposes of eligibility for Title XXI funds, individuals eligible to receive health care services from IHS or IHS grantees, e.g., tribally owned and, or operated health clinics under P.L. 638 contract or compact with IHS, are not considered to have creditable coverage. Therefore, under the Title XXI statute, these children can be covered as

targeted low-income children.

Response #2: The footnote on page 4 of Attachment in our original Title XXI State Plan submission. A merely attempts to outline certain limitations in the use of the CPS data in estimating the number of uninsured children in Oklahoma. Caution is advised in interpreting the number of uninsured children in Oklahoma as this number may include American Indians who qualify for health coverage through the Indian Health Service. Similarly, on page 1 of Attachment A in our original Title XXI State Plan submission, we repeat our concern that the CPS may not directly capture coverage under the Indian Health Service. In no way do we mean to imply that that individuals receiving health services from the Indian Health Service (IHS) should be considered insured and therefore, not eligible for services under Title XXI.

The **State** fully comprehends that for the purposes of eligibility for Title XXI funds, children eligible to receive health care services from IHS or IHS grantees can be covered as targeted low-income children. The State is fully committed to using CHIP funds to meet the compelling health care needs of this vulnerable population. The State will make every effort to engage in meaningful consultation with Federally recognized American Indian Tribes in order to ensure that the rights of these sovereign Tribal governments are fully respected (See answer # 5 for details of the State's efforts to facilitate the enrollment of American Indians in the CHIP Medicaid program).

Question #3: *On page 5, under, "Simplified Medicaid Enrollment Application" there is reference to the enrollment applications being available at a wide variety of locations such as the D.H.S. County Offices, the OSHA county offices, AC offices, and public libraries. However, the application form in attachment C indicates that the applicant must visit the county D.S. Office to get the enrollment packet. Please clarify. Which Statement is correct?*

Response #3: The "Simplified Medicaid Enrollment Application" 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 SoonerCare program they may be eligible for (SoonerCare 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. For cost-containment reasons these are kept at the county DHS offices. However, applicants do not have to visit the county DHS offices to obtain an "enrollment packet" -- they can call a toll-free telephone number for additional assistance in enrolling, or request "enrollment packets" through the mail. All of these measures are aimed at significantly reducing barriers to enrollment in **SoonerCare**. Transportation costs are reduced, the

Compiled April 17, 1998

stigma of going to a social services office is removed, parents do not have to miss work, and local community groups can assist in distributing applications and information regarding Medicaid and CHIP. In conclusion, we expect the "Simplified Medicaid Enrollment Application" and the streamlined application and enrollment process to significantly enhance access to essential health care coverage.

Question #4: What coordination will occur with entities that serve the targeted populations, such as schools, health departments and Federally Qualified Health Centers?

Response #4: The State is making every effort to ensure that all entities that serve the targeted populations coordinate their efforts to enroll eligible targeted low income children in the CHIP Medicaid program. The D.H.S. County offices and the Oklahoma State Department of Health County offices will be working in close cooperation with school districts and sending out applications for enrollment in the CHIP Medicaid program. ~~The OHCA is currently reviewing a contractual agreement with the State Health Department which will cover payment for assistance in outreach efforts. The State Health Department will engage in active outreach including assisting applicants in completion of the enrollment application with special emphasis on making an active choice of health plan and a primary care provider.~~ The OHCA is also conducting conferences and workshops with entities that serve the targeted populations including representatives from the Department of Human Services, Head Start, Community Action Programs, and local youth service organizations. ~~On April 20-21, 1998, in collaboration with the Health Care Financing Administration's Dallas Regional Office and the Shawnee Nation, the OHCA is meeting with the representatives of the various American Indian tribes to discuss ways to facilitate the enrollment of American Indians.~~ In conclusion, while the State will make every attempt to coordinate efforts to ensure that children identified as Medicaid eligible will be promptly enrolled in Medicaid, the eligibility process is designed to incorporate investigation of creditable health coverage in order to ensure that only eligible targeted low income children are covered under CHIP.

Question #5: What measures has the State taken to facilitate the enrollment of American Indians?

Response #5: Prior to the implementation of SB 639 on December 1, 1997, the Oklahoma Health Care Authority's public information office communicated with the Oklahoma Department of Human Services/TANF Section in order to secure a mechanism to provide relevant information on the Medicaid expansion to tribal social services and/or members of the Oklahoma Native Nations Social Services Association (ONSSA). The OHCA developed a press release outlining the newly available services and provided it to the Department of Human Services. DHS, in turn, disseminated the release to representatives of the tribal social services as well as the ONSSA. In terms of the

smaller tribes that do not have social services, DHS provided the press release directly to the Chiefs, directors and presidents of their respective tribes.

In addition to providing the press release to tribal social services located throughout the State, the OHCA secured a tribal mailing list from DHS for use in ongoing communication and dialogue related to Medicaid services. On January 28, 1998, OHCA staff met in Concho, Oklahoma with the Cheyenne and Arapaho tribes to detail the newly expanded health care services available under S.B. 639. The OHCA representatives provided a program overview - emphasizing the tribes' ability to seek healthcare services from any IHS, tribal or urban Indian clinic without a referral or prior authorization from their *SoonerCare* provider. In addition, the streamlined application was summarized and made available to interested parties. OHCA staff made it a priority to assist in the completion of applications and to provide additional information on eligibility. On April 20-21, 1998, in collaboration with the Health Care Financing Administration's Dallas Regional Office and the Shawnee Nation, the OHCA is meeting with the representatives of the various American Indian tribes to discuss ways to facilitate the enrollment of American Indians. The OHCA considers it a priority to appropriately communicate the tribe's flexibility in accessing care through the Medicaid program as well as through their tribal, IHS and urban Indian clinics.

Question #6: What measures has the State taken to ensure that personnel at these sites are trained in assisting potential eligibles in filling out the forms?

Response #6: On November 14, 1997, The DHS Social Workers were presented a SATTRN (Satellite Training Network) Broadcast on the Senate Bill 639 Medicaid Expansion. The Broadcast was developed in collaboration with several other agencies such as DHS and the State Health Department. The broadcast was presented in two sessions. The Broadcast consisted of three parts:

- 1) An introduction that included an explanation of the agencies involved, and the roles and responsibilities of each agency.
- 2) An in-depth explanation of what SB 639 consisted of, and how it affected the overall application processes currently in place and in use at DHS offices.
- 3) Step by step directions on completion of the new shortened medical application and an overview of outreach efforts at each DHS office and collaborating agencies.

Each county worker was provided a training packet that they used to follow along with the SATTRN Broadcast -- the broadcast was taped and videos were provided to each DHS office, Health Department and all agencies that were involved in the application process, upon request. A question and answer session was held throughout the

broadcast and a toll-free number was provided to viewers, as well as live personnel from OHCA, DHS and the State Health Dept, to answer any questions not directly asked on the air.

The broadcast (taped) was shown in January to the OHCA staff and to those that did not have the opportunity to view the broadcast originally. A question and answer session followed the broadcast, facilitated by the *SoonerCare* Training Coordinator. Training packets were given out to participants. Approximately 40 people attended this training session.

An “ongoing” task force meeting is held each month on the first Friday, at OHCA. Currently approximately 35 counties are participating, and the meeting has grown from just four counties to the current number in just a few months. This meeting is facilitated by the *SoonerCare* Training Coordinator and includes several OHCA staff and Family Support Services Division staff, who present current and changing information about *SoonerCare*, as well as address concerns and issues in the field. An agenda is sent out approximately one week ahead to all participants and all participants receive the previous months meeting minutes at the meeting. **An** active discussion of problems, other issues as well as explanations of upcoming events, and program suggestions are solicited from DHS field staff. Current literature and printed marketing materials are shared with DHS staff at this time.

Question #7: *7Xc last paragraph on page 6 and continuing through page 7 (Elimination of the Asset Test- AFDC and AFDC-related) lists the categories of children that the State will identify in order to claim the enhanced or regular federal matching rates for expenditures. The State has chosen to implement Title XXI by expanding Medicaid, and, serving “optional targeted low-income children” as defined in section 1905(u)(2)(C). This definition does not exclude children eligible for, but not participating in, State employee insurance coverage. Thus, the State may receive the enhanced federal matching rate for the provision of Medicaid benefits to these children as well. Therefore, bullet #1, on page 6, should be removed since there is no need to identify those children for purposes of claiming FA CY? Accordingly the State should also modify bullet # 4 to remove the reference to bullet #1.*

Response #7: When the State submitted its Title XXI State plan, it was our understanding as per HCFA’s interpretation of the Title XXI law, that “optional targeted low-income children” excluded children eligible for, but not participating in, State employee insurance coverage. The State is pleased to note that the latest interpretation of “optional targeted low-income children” does not exclude children eligible for, but not participating in, State employee insurance coverage and plans to claim the enhanced federal funds for these children. Accordingly, the State has removed bullet # 1 on page 6, and also modified bullet # 4 to remove the reference to bullet # 1 (see Section 2,

update page #6).

Question #8: *How will the State identify applicants with current health insurance coverage and what will it do to prevent "crowd-out"?*

Response #8: The State is fully cognizant of the potential for substitution of CHIP coverage for Medicaid coverage or private coverage. The State has undertaken several strategies aimed at identifying applicants with current health insurance and preventing CHIP from substituting for Medicaid coverage or private coverage.

- 1) Any child who applies for **SoonerCare** is first screened for Medicaid eligibility (see Section 3, Attachment A, page 2, question # 13 on the application form). If the child is found eligible for Medicaid under the standards in effect on March 31, 1997, he/she will be promptly enrolled in the Medicaid program. Under no circumstances will the enhanced FMAP available under CHIP be claimed for a child who is found eligible for Medicaid under the standards in effect on March 31, 1997.
- 2) Any child who applies for **SoonerCare** is also screened for current insurance coverage (see Section 3, Attachment A, page 2, question # 14 on the application form). If the child has current insurance coverage, he/she will be enrolled in **SoonerCare**, and the State will claim FFP at the regular Medicaid rate. Under no circumstances will the enhanced FMAP available under CHIP be claimed for a child who has current insurance coverage.
- 3) In order to access the enhanced FMAP available under CHIP, systems modifications have been implemented (effective 12/01/97) which will ensure that eligible targeted children under "Title XXI will be separately identified and reported.

Section 4. Eligibility Standards and Methodology

Section 4.3

Question #1: *Please provide an assurance that the Title . XI State plan will be conducted in compliance with all civil rights requirements. This assurance is necessary for all programs involving continuing Federal financial assistance.*

Response #1: Since CHIP funds are being used for a Medicaid expansion, the State has already provided an assurance that the Title XIX State plan will be conducted in compliance with all civil rights requirements (see Attachment B). Therefore, the State also provides an assurance that the Title XXI State plan will be conducted in compliance with all civil rights requirements.

Section 9. Strategic Objectives and Performance Goals for the Plan

Administration

Section 9.1

Question #9: The methodology used by the State to estimate the current number of uninsured children employs population estimates from the CPS and historical insurance factors provided in 1995 by the Urban Institute. The performance goals specified in section 9.1 and 9.2 then propose to reduce the numbers of uninsured children, using this complex CPS/Urban estimate as the baseline. Assuming that CPS population figures and Urban's insurance factors remain unchanged, will the assessment of this reduction be based solely on administrative records? If so, how will the State ensure that the number of uninsured children is reduced, rather than a reduction in the number of children previously covered by group health plans? And if CPS population numbers have changed since 1996, and if the 'historical insurance factor' has changed since 1995, will baseline measures be adjusted accordingly and when can this adjustment be reported to the Secretary?

Response #9: If CPS population estimates and other relevant input factors remain unchanged, the State will, in fact, assess the reduction of Oklahoma's uninsured children based upon data contained within its own administrative records. The State believes it has developed the methodologies necessary to track changes in its uninsured children's population and is presently in the process of developing the tools necessary to operationalize the reporting function. Such belief is based upon the following:

At the time a client recipient completes their Title XIX enrollment Application, the Oklahoma Department of Human Services (DHS) has historically "tracked" and recorded the "uninsured" and "insured" status reported by the client recipient as of that date. Any indicated existing health insurance coverage is reported to and subsequently verified by Third Party Liability (TPL) staff of the OHCA. This practice continues today, with additional refinements implemented as of December 1, 1997, as follows:

Oklahoma chose to develop and implement its Title XXI State Childrens Health Insurance Program (SCHIP) via a Title XIX expansion which took effect on December 1, 1997. As a part of this expansion, the State chose to modify its eligibility standards, implement a "simplified" application form/process, and implement a major outreach campaign. In doing so, the State realized it would be reaching - and enrolling - children who were eligible for Title XIX under the State's previous eligibility standards but were not enrolled in the Program as well as those children newly-eligible under the revised eligibility standards. Additionally, the OHCA and DHS modified data extract reports so that children who are certified Medicaid eligible on-and-after December 1, 1997, could be subdivided into the

following categories:

1. Newly-enrolled children who qualified at the old eligibility standards and
 - a. had other health insurance coverage in effect at the time of their enrollment, or
 - b. did not have other health insurance coverage in effect at that time; and
2. newly-enrolled children who qualified at the new eligibility standards and
 - a. had other health insurance coverage in effect at that time, or
 - b. did not have other health insurance coverage in effect at that time.

This subdivision allows the State the ability to "track" previously-uninsured children who are certified Medicaid eligible on-or-after 12/1/97, at both the "old" and "new" eligibility standards, and allows the State to be able to segregate and report those new enrollees for which the State is eligible to apply for and receive the enhanced Title XXI funding.

Section 9.3

Question #10: If CPS estimates of the percentage of uninsured will be used to measure performance under this plan (section 9.3 and 9.3.2), why weren't CPS estimates of uninsurance used to establish the baseline proportion of uninsured children (section 2.1)? Furthermore, if estimates of the uninsured by age, income, race/ethnicity, and geographic location were not reliable for providing a baseline, how will reliable estimates be provided in the future?

Response #10: CPS data elements were, in fact, utilized in the establishment of, "...the baseline proportion of uninsured children.." (in Section 2.1). 1990 Census and (updated) CPS data elements were an integral part of the Urban Institute's State-level Databook on Health Care Access and Financing. Additionally, the State utilized 1995 and 1996 CPS data in order to "update" estimates of the Uninsured population initially found within the Urban Institute's publication. The uninsured data related to children submitted by Oklahoma as a part of its Title XXI Plan Application differed slightly from the data which HCFA utilized in establishing Oklahoma's initial allotment under the Title XXI Legislation. HCFA utilized a three-year "trended" number to generate 161,000 uninsured children in Oklahoma. When OHCA Staff attempted to "tie" Urban Institute and CPS data to this number (by utilizing current CPS estimates), they were unable to do so (the State's estimates came in much lower). In a later analysis of the year-specific data from which the Title XXI "trended" allotment was generated for Oklahoma, it was discovered that the 1993 uninsured data shown for Oklahoma was unusually "high", skewing future estimates upward. Therefore, when Oklahoma generated its estimates of the State's uninsured population, it utilized actual year-specific CPS estimates in lieu of the "trend". This resulted in State estimates of

uninsured children which were approximately **20,000** fewer than what were originally presented as a portion of the Title XXI Legislation. Oklahoma chose to use these lower estimates because staff felt they better represented the "true" number of uninsured children in the State.

As a result of Question 10's reference to the (questionable) "reliability" of the data which the State utilized in providing a baseline and in its subsequent reference to the (questionable) "reliability" of future estimates, OHCA staff realized that a typographical error was contained in the Title XXI Application (Section 2-2.1) that was filed with HCFA. What should have been stated in this particular Section was **that the State was unable to locate any recognized data sources that estimated the State's uninsured populace by race/ethnicity, therefore it (the State) would not be able to report a decrease in the uninsured children's population with one of the variables being race/ethnicity (see Section 2, update page 3).** The State should, however, be able to modify certain of its **PS-2 and or Recipient Master File data sets in order to be able to report decreases in the uninsured ~ ~ ~ ~ largely omitted of increases in Medicaid enrollments of individuals who did NOT have health insurance at the time of enrollment) according to the variables of age, gender, income level, and County of residence.** While race/ethnicity may be data elements the State gathers at the time of enrollment into Medicaid, there may not be a corresponding (historical or projected) data base which would list estimated number of "uninsured" data by race/ethnicity and against which the State could compare the results of its outreach efforts (again, increases in enrollments/decreases in uninsured according to race/ethnicity).

Section 9.5

Question #11: What are the State's plans for annual assessments and reports?

Response #11: The OHCA will be responsible for the annual assessment and reports of the effectiveness of the State Plan in increasing the number of children with creditable health coverage. The State will mainly rely on the Current Population Survey (CPS) data, Medicaid program information, as well as other relevant/reliable information that may become available. The State is currently working on formalizing internal policies and procedures for annual assessment and reports under the CHIP program. The State is also waiting to receive guidance on financial reporting under CHIP at the CHIP Financial Training Conference in the Dallas Regional Office on April **22-23**,

Section 9.9

Question #12: How has the State sought input from stakeholder groups in the development of the outreach program?

Response #12: The State realizes that a successful outreach effort requires cooperation **among**

diverse entities, hence every opportunity for potential partnership with school districts, community-based organizations, local health and human service providers, Head **Start** programs, private businesses, foundations, advocacy groups, and child care centers is being explored. The State is making every effort to involve as many stakeholder groups as possible in the development of the outreach program for Senate Bill 639. In order to promote public awareness about the value of this program to the children of this State news coverage about CHIP has been regularly provided since the issue was presented to the Oklahoma legislature through press releases, broadcast announcements, postcards and posters, and fact sheets.

A marketing and outreach task force met several times to discuss establishment of outreach objectives, methods, critical timelines and determination of individual stakeholder responsibilities. The Oklahoma Health Care Authority has worked and continues to work in close collaboration with the Department of Human Services, the Oklahoma State Department of Health (MCH), the American Indian Tribes, the Oklahoma Commission on Children and Youth, WIC, Food Stamp program, Head **Start**, licensed day care facilities, healthcare providers, public schools, child support programs, local United Ways, local churches, Chambers of Commerce, local businesses, Maternal Child Health and other local coalitions to develop and implement a comprehensive marketing and outreach plan.

The State is fully committed to involving all stakeholder groups in the development of the outreach program and will continue to invite new partnerships and seek creative ways to strengthen old ones.

Question #13: Did the State seek and receive public comment or input in the development of your proposed Title XXI application form?

Response #13: The Title XXI application form was developed as a result of considerable cooperation among stakeholders. The OHCA was directed by the Oklahoma Legislature to prepare several options for a Title XXI application. The **Oklahoma** Legislature subsequently held several public hearings and solicited input from various stakeholders. The OHCA worked in close collaboration with several stakeholders including the Governor's Office, several legislators, legislative staffers, Department of Human Services, and the Oklahoma State Department of Health, in the development of the Title XXI application form. The application form was discussed in the OHCA Board meetings and Medical Advisory Committee meetings. Public suggestions and comments received during the development process were incorporated in the application form.

Question #14: What specific steps will the State take to involve the groups in implementing the plan?

Response #14: See answers # 4, 5, 6, 12, 13.

Question #15: Will there **be any** consultation with Indian tribes?

Response #15: See answer # 5.

Section 9.10

Question #16: What are the sources **of** the non-federal share?

Response #16: The non-federal share of CHIP expenditures is accounted for entirely by State appropriated funds.

Question #17: The State should provide more detailed budget information. For example, the performance goals listed in **section 9.2** indicate that the State expects to enroll 45% of the eligibles, or 42,750 children, in **SFY 98**, but this does not **appear to be** reflected anywhere on the budget table. How many eligible, uninsured children **does the State** expect to enroll? At what cost? What participation rates does the budget assume?

Response #17: Please see the revised budget (*see* Attachment C). Additionally, section 9.2 has been updated **to** reflect the correct number of "uninsured new eligible children that the State expects to enroll during FFY 98, see attached update section.

SCHIP BUDGET- FFY 2003

	FFY 2003
Benefit Costs	
Insurance payments	
Managed Care	\$33,103,405
Per member/Per month rate @ # of eligibles	\$111.4901@ 43,639
Fee for Service	
Total Benefit Costs	\$33,103,405
<i>(Offsetting beneficiary cost sharing payments)</i>	0
Net Benefit Costs	\$33,103,405

Administration Costs	
Personnel	
General Administration	\$1,077,000
Contractors/Brokers (e.g., enrollment contractors)	
Claims Processing	
Outreach/Marketing costs	
Other	
Total Administration Costs	\$1,077,000
10% Administrative Cap (net benefit costs ÷ 9)	\$3,678,156

Federal Title XXI Share (.7939)	\$27,135,824
State Share (.2061)	\$7,044,581

TOTAL COSTS OF APPROVED SCHIP PLAN	34,180,405
---	-------------------

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 (such as United Way, sponsorship)
- Other (specify)

Section 2. General Background and Description of State Approach to Child Health Coverage
(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 section 2110(c)(2)). 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).

The State undertook a systematic survey of the available data and developed a methodology to estimate the number of potential new participants in the expansion, the number of current Medicaid eligibles who are not enrolled, the number of "uninsured" eligibles, and the total number of participants in the Medicaid expansion (see Attachment A). The primary data sources for the State's estimates were: the US Census Bureau's *Current Population Survey* (CPS), Calendar Years 1994-96; the FFY (Federal Fiscal Year) 1997 HCFA 2082 data for Oklahoma (through August 31,1997); the Urban Institute's *State-level Databook on Health Care Access and Financing*, published in 1995 (1990-93 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 broken down by race and ethnicity. According, to the Oklahoma State Insurance Commissioner's Office, health insurance program that involve a public-private partnership do not currently exist in the State.

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

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

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

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

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

2.3. Describe how the new State Title XXI program(s) is(are) designed to be coordinated with such efforts to increase the number of children with creditable health coverage so that only eligible targeted low-income children are covered: (Section 2102)(a)(3)

Prior to the enactment of the new Children's Health Insurance Program (CHIP) under the Balanced Budget Act of 1997, the Oklahoma Legislature recognized the need to establish a coordinated approach to delivering quality health care services to under-served/uninsured populations (specifically children and pregnant females). Accordingly S.B. 639 was enacted during the State's 1997 Legislative Session. This Bill expanded Medicaid eligibility through the State's successful Medicaid managed care program, *SoonerCare*¹, originally implemented through the State's § 1915(b) Program Waiver, subsequently expanded under the State's § 1115(a) Research and Demonstration (R & D) Waiver (refer to section **5.I Outreach and Coordination**, for an overview of the § 1115(a) R&D Waiver).

S.B. 639 required the Oklahoma Health Care Authority (OHCA) to expand Medicaid coverage to children under the age of one year by increasing Oklahoma's maximum income level for these children from 150% of the Federal Poverty Level (FPL) up to a maximum family income level of 185% of the FPL. The bill also required OHCA to expand Medicaid coverage to children from one year through five years of age from a maximum family income level of 133% of the FPL to a maximum family income level of 185% of the FPL. Additionally, children six years of age and those born on or after 10-1-83 were increased to 185% of the FPL. These children were required to be covered at 100% of the FPL, pursuant to federal regulation. Under these federal regulations, such children born before 10-1-83 would be phased into Medicaid, one age group each year, starting with the youngest age group, through 17 years. The groups that are phased-in according to federal regulations will be eligible at 185%

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

February 10,2003 - Revisions

of the FPL instead of the 100% FPL requirement. This expansion became effective December 1, 1997.

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

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

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

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

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

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

1. children eligible for participation in Medicaid under the "old" income levels (those in effect as of 04/15/97 and still in effect as of 11/30/97); **n**
2. children presently covered by "creditable" health insurance coverage;
3. children whose family income is above the old income levels but at or below 185% FPL (and for whom No. 2. does not apply); and **6**

Proposed Effective Date: 12/01/97
opt.1

February 10,2003 - Revisions

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

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

FFP for Medicaid expenditures related to children identified above under No. 3. qualify for and will be claimed at the higher Title XXI rate. These expenditures will be clearly delineated **on** the HCFA-64.

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

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))

1. Decrease the number of children in the State who lack creditable health insurance coverage.
2. Increase the enrollment of currently-eligible (but not participating) AFDC and AFDC-related Children in the Medicaid Program.
3. By the end of FFY (Federal Fiscal Year) 1999, enroll newly-eligible (expansion group) children at a rate commensurate with the one established for the existing eligibles.
4. Ensure that the Medicaid enrollment (participation) percentages are the same for both the rural *SoonerCare Choice* and urban *SoonerCare Plus* Programs.
5. Reduce the number of short-term ("medical") enrollments into the Medicaid program which result in periods of retroactive eligibility.
6. Minimize the autoassignment rate for newly-enrolled individuals (for both the existing unenrolled eligibles and the new eligibles) in the selection of a PCCM or MCO.

9.2. Specify one or more performance goals for each strategic objective identified (section 2107(a)(3))

1. Depending on the Federal Poverty Level (either 185% or 200%) to which Oklahoma increases AFDC (and Related) Medicaid eligibility, and whether or not the **State** chooses to include 18 year olds as children will impact the number of children the State hopes to enroll in its Medicaid expansion. By the end of FFY 1998, the State hopes to have forty-five (45%) percent of the newly-eligible uninsured children enrolled, and, by the end of FFY 1999, 75%.
2. Presently, of the 317,000 children believed to be eligible for Medicaid under the existing eligibility criteria (based on 1996 C.P.S. data estimates), only 212,000 (66.88%) are enrolled (see Attachment A). The National average Medicaid enrollment percentage is 75%. Through a statewide outreach effort, the State hopes to increase participation by the end of FFY 1998 to 70%, and, by the end of FFY 1999, to 75%.
3. Of the estimated 40,000 newly-eligible uninsured children (through 185% of Federal Poverty Income Guidelines), the State hopes to have 45% enrolled in Medicaid by the end of FFY 1998. Additionally, the State hopes to have a total of 75% enrolled

February 10,2003 - Revisions

by the end of FFY 1999 (see Attachment A).

4. Outreach programs/efforts will be structured and implemented to ensure effective, statewide participation in the expansion, such that the cumulative enrollment percentages for the affected urban and rural eligibles will be (essentially) the same by the end of FFY 1999.
5. DHS historical data indicates that more than 90% of Oklahoma Medicaid's (medical only) short-term certifications involve a period of retroactive eligibility (eligibility effective date precedes application date). Through effective outreach efforts, the State's goal is to reduce such (after-the-fact) enrollments by fifty (50%) by the end of FFY 1999.
6. Through effective outreach and recipient (client) education programs, enrollment autoassignment rates will be less than fifty (50%) percent by the end of FFY 1998 and less than 40% by the end of FFY 1999. Based upon recent data related to the *SoonerCare Plus* Program, autoassignment rates vary between 39.24% and 88.61%.

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))

The State will utilize a number of tools and/or measurement devices to monitor progress toward accomplishing the goals and objectives set forth herein. In addition to the ones indicated in subsequent §9.3.1. to 9.3.8., the State will monitor:

- Current Population Survey (C.P.S.) data, produced and published by the U.S. Census Bureau (for items related to estimates of Medicaid eligibility, numbers and/or percentages of uninsured, age/gender demographics, etc.)
- rural and urban autoassignment rates, tabulated internally by the OHCA
- Medicaid enrollment data related to funding under both Title XIX and Title XXI, tracked by the Health Care Authority and reported to HCFA on the quarterly HCFA Form 64 and/or other appropriate reporting mechanism
- individual and aggregate periods of retroactive eligibility associated with newly-eligible populations as identified by the Oklahoma Department of Human Services, Family Support Division

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

February 10,2003 - Revisions

- 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.
 - Consumer Assessment of Health Plan Survey (CAHPS) ~~satisfaction~~ survey
 - Oklahoma ~~State~~ Immunization Information System (OSIIS) ~~data~~ set
- 9.3.7. If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
 - 9.3.7.1. **Immunizations**
 - 9.3.7.2. Well child care
 - 9.3.7.3. Adolescent well visits
 - 9.3.7.4. **Satisfaction** with care
 - 9.3.7.5. Mental health
 - 9.3.7.6. Dental care
 - 9.3.7.7. other, please list: _____
- 9.3.8. Performance measures for special targeted populations.
- 9.4. ■ 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)~~)
- 9.5. ■ The ~~state assures~~ it ~~will~~ comply with the ~~annual~~ assessment and evaluation required under Section ~~10.1.~~ and ~~10.2.~~ (See Section ~~10~~) Briefly describe the ~~state's~~ plan for these ~~annual~~ assessments and reports. (~~Section 2107(b)(2)~~)

The OHCA will be responsible for the annual assessment and reports of the effectiveness of the State Plan in increasing the number of children with creditable health coverage. The ~~Spate~~ will mainly rely on the Current Population Survey (CPS) data, Medicaid program information, as well as other relevant/reliable information that may become available. The

February 10,2003 - Revisions

State is currently working on formalizing internal policies and procedures for annual assessment and reports under the CHIP program. The State is also waiting to receive guidance on financial reporting under CHIP at the CHIP Financial Training Conference in the Dallas Regional Office on April 22-23.

- 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 of audit. (Section 2107(b)(8))
- 9.7. ■ The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed.
- 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(c))
 - 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 § 1115 (relating to waiver authority)
 - 9.8.5. ■ Section 1116 (relating to administrative and judicial review), but only insofar as consistent with Title XXI
 - 9.8.6. ■ Section 1124 (relating to disclosure of ownership and related information)
 - 9.8.7. ■ Section 1126 (relating to disclosure of information about certain convicted individuals)
 - 9.8.8. ■ Section 1128A (relating to civil monetary penalties)
 - 9.8.9. ■ Section 1128B(d) (relating to criminal penalties for certain additional charges)
 - 9.8.10. ■ 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))

February 10,2003 - Revisions

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

9.10, Provide a budget for this program. Include details on the planned use of funds and sources of the non-Federal share of plan expenditures. (section 2107(d))

A financial form for the budget is being developed, with input from all interested parties, for states to utilize.

Budget appropriations, included herein as Attachment A, Table IV, assumes 75% participation.