

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

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

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

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

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

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

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

Name: James Hancock	Position/Title: Director, Health Policy
Name:	Position/Title:
Name:	Position/Title:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, Baltimore, Maryland 21244.

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

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

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

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

1.1.3 ~ A combination of both of the above.

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

Oklahoma provides an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS.

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

Oklahoma provides an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35.

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

Effective Date: 9/01/01

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Effective date:0/01/01

Implementation date:12/21/01

Effective Date:9/01/01

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

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

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

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

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

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

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

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

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

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

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

- 1) Any child who applies for *Sooner Care* is first screened for Medicaid eligibility. If the child is found eligible for Medicaid under the standards in effect on March 31, 1997, he/she will be promptly enrolled in the Medicaid program. Under no circumstances will the enhanced FMAP available under SCHIP be claimed for a child who is found eligible for Medicaid under the standards in effect on March 31, 1997.
- 2) Any child who applies for *Sooner Care* is also screened for current insurance coverage. If the child has current insurance coverage, he/she will be enrolled in *Sooner Care*, and the State will claim FFP at the regular Medicaid rate. Under no circumstances will the enhanced FMAP available under SCHIP be claimed for a child who has current insurance coverage.
- 3) In order to access the enhanced FMAP available under CHIP, systems modifications have been implemented which will ensure that eligible targeted children under Title XXI will be separately identified and reported.

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

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

On September 1, 2001, for children described in 1902(a)(10)(A)(i)(VII), 85% of the Federal Poverty Level as revised annually in the Federal Register, by family size, will be disregarded from income in Oklahoma (for the purposes of determining Medicaid eligibility). Oklahoma will claim Title 21 enhanced funds for all these above mentioned low income uninsured children who did not have Medicaid eligibility on March 31, 1997.

Oklahoma plans no separate enrollment in its Title XXI State Children's Health Insurance

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 phasing 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 phasing schedule.

Program (SCHIP) which would be separate and distinct from its Medicaid expansion under S.B. 639. Rather, Oklahoma's Medicaid eligibility and enrollment processes are designed to identify existing "creditable" health coverage and/or other factors which limit the applicability of Title XXI funding, thereby ensuring that Title XXI funds will be used to provide coverage only to eligible, targeted, low-income children.

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

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

Simplified Medicaid Enrollment Application:

In an effort to increase participation in the Program, a simplified Medicaid enrollment application (see Attachment C) was developed for the Aid to Families with Dependent Children' (AFDC) and AFDC-related applicants. As a result of the coordinated efforts between representatives of the OHCA, the DHS, and the OSDH the original sixteen (16) page application was greatly simplified to a new one page, two-sided form. Included in this new application are an array of health related questions designed to assist the primary **care** physician's assessment of the patients' health care needs it also provided for the actual enrollment into the **SoonerCare** program. Simplified Medicaid enrollment applications are readily available at a wide variety of locations such as the DHS county offices, the OSDH county offices, WIC offices, and public libraries. A toll-free telephone number is available to

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

provide additional information. In order to reach the Hispanic community, outreach efforts have been suitably modified to more effectively reach this population.

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 (but not necessarily participating in) State employee insurance coverage with incomes at or below 185% of FPL and above the Medicaid AFDC and AFDC-related income levels previously in effect;
2. children eligible for participation in Medicaid under the "old" income levels (those in effect as of 04/15/97 and still in effect as of 11/30/97);

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3. children presently covered by "creditable" health insurance coverage;
4. children whose family income is above the old income levels but at or below 185% of FPL (and for whom No. 1 and 3. do not apply); and
5. children whose (family) incomes are between 186% and 200% of FPL, making them ineligible for participation at the present time BUT making them possibly eligible if Oklahoma chose to expand XIX/XXI to include annual incomes up to 200% FPL.

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

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

"Crowd-Out"

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

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

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

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Section 3. Methods of Delivery and Utilization

Controls (Section 2102)(a)(4))

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

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

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

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

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

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

- 4.1.1. ~ Geographic area served by the Plan:
- 4.1.2. ~ Age:
- 4.1.3. ~ Income:
- 4.1.4. ~ Resources (including any standards relating to spend downs and disposition of resources):
- 4.1.5. ~ Residency (so long as residency requirement is not based on length of time in state) :
- 4.1.6. ~ Disability Status (so long as any standard relating to disability status does not restrict eligibility):
- 4.1.7. ~ Access to or coverage under other health coverage:
- 4.1.8. ~ Duration of eligibility:
- 4.1.9. ~ Other standards (identify and describe):

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

- 4.2.1. ~ These standards do not discriminate on the basis of diagnosis.
- 4.2.2. ~ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
- 4.2.3. ~ These standards do not deny eligibility based on a child having a pre-existing medical condition.

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

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

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

4.4. Describe the procedures that assure that:

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

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

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

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

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

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

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

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4.4.4.4. **If the state provides coverage under a premium assistance program, describe:**

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

The minimum employer contribution.

The cost-effectiveness determination.

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

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

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

Availability:

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

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

- **Press Releases** - The OHCA has developed a generic press release (see Attachment E) targeted to local DHS offices statewide. The press releases will allow for individual adaptation by providing blank sections to be completed by each County Administrator. DHS will distribute the releases to all Administrators statewide. Accompanying the press releases will be a letter outlining the Program and the importance of facilitating outreach through local media outlets. Attached to the letter will be a listing of all Oklahoma counties and the estimated number of individuals potentially impacted by the implementation of this Program in each county. A similar letter will accompany all outreach and marketing materials. This letter will be designed to provide background information on the Program as well as give insight into the collaborative effort of the agencies involved.
- **Broadcast Announcements** - The OHCA has secured a contract with the Oklahoma Association of Broadcasters (OAB), see Attachment F, to coordinate the statewide broadcasts of 30-second announcements through television and radio outlets. Announcements (see Attachment G) creating awareness of the Program and directing prospective clients to application sites have been developed and distributed statewide.

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

- **Postcards and Posters** - The OHCA has designed, developed and produced postcards and posters (see Attachment H). The postcards are intended to be used as "hand-outs" and/or mailed to individual households (where databases are available). The posters are similar to the postcards in design but will allow for more detailed information due to the additional space.
- **Spanish Translation of Materials** - In an effort to reach the Hispanic community, the OHCA has contracted with Variety Health Center for the translation of all outreach materials. Also, the OHCA will attempt to contact a member of the Latino Community Development Agency in order to determine the availability of time on the Latino radio show.
- **Toll-free Hotline Number** - A toll-free number is available, through Benova, Inc., (Benova) the State's Enrollment Agent (see Attachment I), for prospective enrollees to ask questions about and/or request additional information or application materials on the individual programs and enroll in the **SoonerCare** program.
- **Fact Sheets** - A Program "fact sheet" (see Attachment J) has been developed for distribution at community-level meetings anywhere in the State. The content of the fact sheets will be developed in conjunction with a training task force so as to ensure a high level of consistency when addressing the expansion population.

Avenues that will be used to distribute Program information are:

- local DHS County Office networks; databases for direct mail outreach; and through speaking engagements designed to educate local organizations and community leaders;
- develop mechanisms for distributing information through:
 - WIC
 - Food Stamp Program
 - Head Start
 - Health Care Providers Statewide
 - Child Support Programs

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- Immunization (OSIS)
- OSU Extension Offices
- Local United Ways

- X** "target" printed Program materials toward employers who employ the working poor populace;
- X** involve local Chambers of Commerce and Units of Local Government;
- X** empower local coalitions to become actively involved in outreach processes;
- X** develop partnerships with local churches and the broader religious community (i.e. the Oklahoma Conference of Churches).

Enrollment:

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

Oklahoma's . 1115(a) R&D Waiver was built upon the managed care program implemented in August, 1995 within the State's three major metropolitan areas (Oklahoma, Tulsa, and Lawton) under auspices of the State's . 1915(b) Program Waiver. Under the subsuming . 1115(a) R&D Waiver, managed care was extended into all areas of the State, beginning with **State** Fiscal Year (SFYs) 1996. In areas of the **State** not served by Health Maintenance Organizations (HMOs)³ a system of Primary Care Case Management (PCCM) was implemented with services being provided by Primary Care Physicians/Case Managers (PCP/CM). Additionally, HMOs service were expanded into rural counties bordering the metropolitan areas not previously served by **health** plans. The Program created as a result of these two Waivers is currently known as **SoonerCare**. This Program includes two major components: an "urban model" (**SoonerCare Plus**) and a "rural model" (**SoonerCare Choice**). Since July 1, 1995, the State has contracted with fully integrated networks comprised of Federally-qualified and State-certified HMOs in order to enroll and serve Title XIX beneficiaries in the urban areas.

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

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

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

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

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

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

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

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

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

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

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

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

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

As with the *SoonerCare Plus* Program, *SoonerCare Choice* beneficiaries can indicate their enrollment selection on the simplified application which DHS Staff (*refer to section 2.3*) will process, or they can telephone the *SoonerCare* "helpline" to enroll via the telephone. However, when a beneficiary chooses

to enroll by mail through the enrollment agent, they can indicate both their first choice and second choice of a PCP/CM on the pre-paid return address enrollment card.

The OHCA will enroll beneficiaries with their first choice whenever possible. However, in the event that a beneficiary's first choice of a PCP/CM has already reached their patient capacity, the beneficiary's second choice of a PCP/CM will be used. The enrollment agent will also answer questions which beneficiaries have prior to choosing a PCP/CM and encourage them to select a PCP/CM within forty-five (45) miles of their residence. If no selection is made, or if the selections made are not available, the beneficiary will be autoassigned⁴ to the nearest appropriate provider who has capacity and is within forty-five (45) miles of their residence. Each month PCP/CMs receive a roster which lists their patients for the following month. If no provider is available within forty-five (45) miles, the beneficiary will remain in the Medicaid fee-for-service program until an appropriate provider is available. Beneficiaries will be advised of enrollment via a confirmation letter. Each month, PCP/CMs receive a roster which lists their patients for the following month.

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

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

Spanish-speaking operators are available for applicants who speak Spanish as a first language. The program will have translation services available to assist applicants who speak languages other than English or Spanish. A TDD is also available for persons who are hearing impaired.

Applicants will also be able to select a PCP/CM by marking their choice on a pre-addressed and -stamped postcard. The State believes that by offering several methods for provider/network selection, it will minimize the number of cases in which individuals do

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

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not make a choice.

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

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

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

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

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

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

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

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

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

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

6.1.3. ~ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) [Only applicable to New York; Florida; Pennsylvania]
Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

6.1.4. ~ Secretary-Approved coverage. (Section 2103(a)(4)) (42 CFR 457.450)

6.1.4.1. Coverage the same as Medicaid State plan

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

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- 6.1.4.3. Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population
- 6.1.4.4. Coverage that includes benchmark coverage plus additional coverage
- 6.1.4.5. Coverage that is the same as defined by existing comprehensive state-based coverage
- 6.1.4.6. Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)
- 6.1.4.7. Other (Describe)

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

- 6.2.1. ~ Inpatient services (Section 2110(a)(1))
- 6.2.2. ~ Outpatient services (Section 2110(a)(2))
- 6.2.3. ~ Physician services (Section 2110(a)(3))
- 6.2.4. ~ Surgical services (Section 2110(a)(4))
- 6.2.5. ~ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
- 6.2.6. ~ Prescription drugs (Section 2110(a)(6))
- 6.2.7. ~ Over-the-counter medications (Section 2110(a)(7))
- 6.2.8. ~ Laboratory and radiological services (Section 2110(a)(8))
- 6.2.9. ~ Prenatal care and prepregnancy family services and supplies (Section 2110(a)(9))
- 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))
- 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))

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- 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))
- 6.2.13. ~ Disposable medical supplies (Section 2110(a)(13))
- 6.2.14. ~ Home and community-based health care services (See instructions) (Section 2110(a)(14))
- 6.2.15. ~ Nursing care services (See instructions) (Section 2110(a)(15))
- 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))
- 6.2.18. ~ Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
- 6.2.19. ~ Outpatient substance abuse treatment services (Section 2110(a)(19))
- 6.2.20. ~ Case management services (Section 2110(a)(20))
- 6.2.21. ~ Care coordination services (Section 2110(a)(21))
- 6.2.22. ~ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
- 6.2.23. ~ Hospice care (Section 2110(a)(23))
- 6.2.24. ~ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))
- 6.2.25. ~ Premiums for private health care insurance coverage (Section 2110(a)(25))
- 6.2.26. ~ Medical transportation (Section 2110(a)(26))
- 6.2.27. ~ Enabling services (such as transportation, translation, and outreach services) (See instructions) (Section 2110(a)(27))
- 6.2.28. ~ Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))

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

- 6.3.1. ~ 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 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Please describe: *Previously 8.6*

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

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

6.4.1.1 Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; **Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28.** (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))

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

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

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

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

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

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

Section 7. Quality and Appropriateness of Care

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

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

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

- 7.1.1. ~ Quality standards
- 7.1.2. ~ Performance measurement
- 7.1.3. ~ Information strategies
- 7.1.4. ~ Quality improvement strategies

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

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

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

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

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law **or**, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d))

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

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

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

8.1.1. ~ YES

8.1.2. ~ NO, skip to question 8.8.

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

8.2.1. Premiums:

8.2.2. Deductibles:

8.2.3. Coinsurance or copayments:

8.2.4. Other:

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

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

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

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

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

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

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- 8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)
- 8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(e))
- 8.7.1 Please provide an assurance that the following disenrollment protections are being applied:
- State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))
 - The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non payment of cost-sharing charges. (42CFR 457.570(b))
 - In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))
 - The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))
- 8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))
- 8.8.1. ~ No Federal funds will be used toward state matching requirements. (Section 2105(c)(4)) (42CFR 457.220)
- 8.8.2. ~ No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. (Section 2105(c)(5) (42CFR 457.224) (Previously 8.4.5)
- 8.8.3. ~ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))
- 8.8.4. ~ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))

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

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

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

- 9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42CFR 457.710(b))
 - 1. 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. Monitor Program participation so that "crowd-out" does not become problematic.
 - 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)) (42CFR 457.710(c))
 - 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 by the end of FFY 1999 (see Attachment A). Oklahoma recognizes the potential for "crowd-out" - the substitution of SCHIP coverage for private health insurance coverage. The State will implement several initiatives aimed at identifying instances which could be construed as being "crowd-out". In the short run, the State will develop and implement a statistically-valid survey instrument which it will utilize to survey certain Medicaid beneficiaries in order to determine whether or not they voluntarily dropped existing private health insurance coverage due to the availability of publicly-funded SCHIP coverage. Those beneficiaries the State will survey include children who: (1) have enrolled on-or-after December 1, 1997; (2) were determined to be eligible at the State's new (higher) income eligibility standard; and (3) had no Third Party Liability (TPL) indicator on their (Medicaid) Application. This process will enable the State to assess the existence and/or scope of "crowd-out".

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

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

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)) (42CFR 457.710(d))

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.

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

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

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

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

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

- 9.6. **X** The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3)) (42CFR 457.720)
- 9.7. **X** The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42CFR 457.710(e))
- 9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.135)
- 9.8.1. **X** Section 1902(a)(4)(C) (relating to conflict of interest standards)
 - 9.8.2. **X** Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
 - 9.8.3. **X** Section 1903(w) (relating to limitations on provider donations and taxes)
 - 9.8.4. **X** Section 1132 (relating to periods within which claims must be filed)
- 9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107(c)) (42CFR 457.120(a) and (b))

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.

- 9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR , 457.125. (Section 2107(c)) (42CFR 457.120(e))

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

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

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

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

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

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

Effective Date:9/01/01

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Approval Date:12/21/01

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

- . Planned use of funds, including --
 - Projected amount to be spent on health services;
 - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
 - Assumptions on which the budget is based, including cost per child and expected enrollment.
- . Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

Section 10. Annual Reports and Evaluations (Section 2108)

- 10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2)) (42CFR 457.750)
- 10.1.1. **X** The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and
- 10.2. **X** The state assures it will comply with future reporting requirements as they are developed. (42CFR 457.710(e))
- 10.3. **X** The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

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

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

- 11.1 The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101(a)) (42CFR 457.940(b))
- 11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.935(b)) *The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)*
- 11.2.1. ~ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
 - 11.2.2. ~ Section 1124 (relating to disclosure of ownership and related information)
 - 11.2.3. ~ Section 1126 (relating to disclosure of information about certain convicted individuals)
 - 11.2.4. ~ Section 1128A (relating to civil monetary penalties)
 - 11.2.5. ~ Section 1128B (relating to criminal penalties for certain additional charges)
 - 11.2.6. ~ Section 1128E (relating to the National health care fraud and abuse data collection program)

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

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

Eligibility and Enrollment Matters

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

Health Services Matters

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

Premium Assistance Programs

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