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State/Territory Name: Oklahoma

State Plan Amendment (SPA) #: OK-20-0030

This file contains the following documents in the order listed:

1) Approval Letter
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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, Maryland 21244-1850

Children and Adults Health Programs Group

September 1, 2022

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

Dear Ms. Anthony:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA) number OK-20-0030 has been approved. Through this SPA, Oklahoma has demonstrated compliance with section 5022 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act. This SPA has an effective date of July 1, 2020, except for the changes noted below.

Section 5022 of the SUPPORT Act added Section 2103(c)(5) to the Social Security Act (the Act) and requires child health and pregnancy related assistance to include coverage of services necessary to prevent, diagnose, and treat a broad range of behavioral health symptoms and disorders. Additionally, Section 2103(c)(5)(B) of the Act requires that these behavioral health services be delivered in a culturally and linguistically appropriate manner. Oklahoma demonstrated compliance by providing the necessary assurances and benefit descriptions that the state covers a range of behavioral health services in a culturally and linguistically appropriate manner.

Oklahoma added Medication Assisted Treatment coverage effective October 1, 2020. In addition, the Centers for Medicare & Medicaid Services requested that Oklahoma update its member and provider handbooks, and other materials on its website to more fully describe available behavioral services under the state's CHIP (*Soon-to-be-Sooner*). The state updated their website with the requested materials on June 1, 2022.

Your Project Officer is Ms. Sandra Phelps. She is available to answer your questions concerning this amendment and other CHIP-related matters. Ms. Phelps' contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-1968
E-mail: Sandra.Phelps@cms.hhs.gov

If you have additional questions, please contact Meg Barry, Division Director, Division of State Coverage Programs, at (410) 786-1536. We look forward to continuing to work with you and your staff.

Sincerely,

/Signed by Amy Lutzky/

Amy Lutzky
Deputy Director

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

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

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40(b))____ (Signature of Governor, or designee, of State/Territory, Date Signed)

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

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

Name: Kevin Corbett Position/Title: Chief Executive Officer
Name: Brandon Keppner Position/Title: Chief Operating Officer
Name: Traylor Rains Position/Title: State Medicaid Director

Disclosure Statement This information is being collected to pursuant to 42 U.S.C. 1397aa, which requires states to submit a State Child Health Plan in order to receive federal funding. This mandatory information collection will be used to demonstrate compliance with all requirements of title XXI of the Act and implementing regulations at 42 CFR part 457. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #34). Public burden for all of the collection of information requirements under this control number is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Introduction: Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 1005-33 amended the Social Security Act (the Act) by adding a new title XXI, the Children's Health Insurance Program (CHIP). In February 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) renewed the program. The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, further modified the program. The HEALTHY KIDS Act

and The Bipartisan Budget Act of 2018 together resulted in an extension of funding for CHIP through federal fiscal year 2027.

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

- Combined the instruction document with the CHIP SPA template to have a single document. Any modifications to previous instructions are for clarification only and do not reflect new policy guidance.
- Incorporated the previously issued guidance and templates (see the Key following the template for information on the newly added templates), including:
  - Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
  - Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
  - Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
  - Dental and supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
  - Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
  - Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
  - Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)
- Moved sections 2.2 and 2.3 into section 5 to eliminate redundancies between sections 2 and 5.
- Removed crowd-out language that had been added by the August 17 letter that later was repealed.
- Added new provisions related to delivery methods, including managed care, to section 3 (81 FR 27498, issued May 6, 2016)

States are not required to resubmit existing State plans using this current updated template. However, States must use this updated template when submitting a new State Plan Amendment.

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

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

state plan.

The template includes the following sections:

1. **General Description and Purpose of the Children's Health Insurance Plans and the Requirements**- This section should describe how the State has designed their program. It also is the place in the template that a State updates to insert a short description and the proposed effective date of the SPA, and the proposed implementation date(s) if different from the effective date. (Section 2101); (42 CFR, 457.70)
2. **General Background and Description of State Approach to Child Health Coverage and Coordination**- This section should provide general information related to the special characteristics of each state's program. The information should include the extent and manner to which children in the State currently have creditable health coverage, current State efforts to provide or obtain creditable health coverage for uninsured children and how the plan is designed to be coordinated with current health insurance, public health efforts, or other enrollment initiatives. This information provides a health insurance baseline in terms of the status of the children in a given State and the State programs currently in place. (Section 2103); (42 CFR 457.410(A))
3. **Methods of Delivery and Utilization Controls**- This section requires the State to specify its proposed method of delivery. If the State proposes to use managed care, the State must describe and attest to certain requirements of a managed care delivery system, including contracting standards; enrollee enrollment processes; enrollee notification and grievance processes; and plans for enrolling providers, among others. (Section 2103); (42 CFR Part 457. Subpart L)
4. **Eligibility Standards and Methodology-** The plan must include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. This section includes a list of potential eligibility standards the State can check off and provide a short description of how those standards will be applied. All eligibility standards must be consistent with the provisions of Title XXI and may not discriminate on the basis of diagnosis. In addition, if the standards vary within the state, the State should describe how they will be applied and under what circumstances they will be applied. In addition, this section provides information on income eligibility for Medicaid expansion programs (which are exempt from Section 4 of the State plan template) if applicable. (Section 2102(b)); (42 CFR 457.305 and 457.320)
5. **Outreach-** This section is designed for the State to fully explain its outreach activities. Outreach is defined in law as outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs. The purpose is to inform these families of the availability of, and to assist them in enrolling their children in, such a program. (Section 2102(c)(1)); (42 CFR 457.90)
6. **Coverage Requirements for Children's Health Insurance**- Regarding the required scope of health insurance coverage in a State plan, the child health assistance provided must consist of any of the four types of coverage outlined in Section 2103(a) (specifically, benchmark coverage; benchmark-equivalent coverage; existing comprehensive state-based coverage; and/or Secretary-approved coverage). In this section States identify the scope of coverage and benefits offered

under the plan including the categories under which that coverage is offered. The amount, scope, and duration of each offered service should be fully explained, as well as any corresponding limitations or exclusions. (Section 2103); (42 CFR 457.410(A))

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

Program Options. As mentioned above, the law allows States to expand coverage for children through

a separate child health insurance program, through a Medicaid expansion program, or through a combination of these programs. These options are described further below:

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

  Medicaid Expansion- CHIP SPA Requirements
  In order to expedite the SPA process, states choosing to expand coverage only through an expansion of Medicaid eligibility would be required to complete sections:
    - 1 (General Description)
    - 2 (General Background)

  They will also be required to complete the appropriate program sections, including:
    - 4 (Eligibility Standards and Methodology)
    - 5 (Outreach)
    - 9 (Strategic Objectives and Performance Goals and Plan Administration including the budget)
    - 10 (Annual Reports and Evaluations).

  Medicaid Expansion- Medicaid SPA Requirements
  States expanding through Medicaid-only will also be required to submit a Medicaid State plan amendment to modify their Title XIX State plans. These states may complete the first check-off and indicate that the description of the requirements for these sections are incorporated by reference through their State Medicaid plans for sections:
    - 3 (Methods of Delivery and Utilization Controls)
    - 4 (Eligibility Standards and Methodology)
    - 6 (Coverage Requirements for Children's Health Insurance)
    - 7 (Quality and Appropriateness of Care)
    - 8 (Cost Sharing and Payment)
    - 11 (Program Integrity)
    - 12 (Applicant and Enrollee Protections)

- **Combination of Options-** CHIP allows states to elect to use a combination of the Medicaid program and a separate child health program to increase health coverage for children. For example, a State may cover optional targeted-low income children in families with incomes of up to 133 percent of poverty through Medicaid and a targeted group of children above that level through a separate child

health program. For the children the State chooses to cover under an expansion of Medicaid, the description provided under “Option to Expand Medicaid” would apply. Similarly, for children the State chooses to cover under a separate program, the provisions outlined above in “Option to Create a Separate Program” would apply. States wishing to use a combination of approaches will be required to complete the Title XXI State plan and the necessary State plan amendment under Title XIX.

Where the state’s assurance is requested in this document for compliance with a particular requirement of 42 CFR 457 et seq., the state shall place a check mark to affirm that it will be in compliance no later than the applicable compliance date.

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

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

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

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

Guidance: Check below if child health assistance shall be provided primarily through the development of a separate program that meets the requirements of Section 2101, which details coverage requirements and the other applicable requirements of Title XXI.

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

Guidance: Check below if child health assistance shall be provided primarily through providing expanded eligibility under the State's Medicaid program (Title XIX). Note that if this is selected the State must also submit a corresponding Medicaid SPA to CMS for review and approval.

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

Guidance: Check below if child health assistance shall be provided through a combination of both 1.1.1. and 1.1.2. (Coverage that meets the requirements of Title XXI, in conjunction with an expansion in the State's Medicaid program). Note that if this is selected the state must also submit a corresponding Medicaid state plan amendment to CMS for review and approval.

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

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

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

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

Oklahoma operates a combination program.

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

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

Soon-To-Be-Sooners (STBS/Separate CHIP)
Under this program unborn children of families earning up to and including 185 percent of the federal poverty level, converted to the MAGI-equivalent percent of FPL and applicable disregards, are covered. This program allows coverage of pregnancy related services under Title **XX**I for the benefit of unborn children enrolled through the STBS program through birth. Oklahoma does not intend to include the Insure Oklahoma premium assistance program as an option for members participating in the STBS program.

Insure Oklahoma (IO/Separate CHIP):
Oklahoma manages a standalone CHIP program, IO for children in families earning up to and including 225 percent of the federal poverty level, allowing select groups the ability to receive benefits through the Premium Assistance Employer Sponsored Insurance (ESI) coverage. ESI is a benefit plan providing premium assistance to qualified children in families employed by an Oklahoma business with access to a private-market, employer sponsored insurance plan. With ESI the cost of health insurance premiums is shared by the employer, the children's family and the Oklahoma Health Care Authority. The state assures that Title **XX**I funds are used only for the coverage of children. By nature of the enrollment methods established by private, group employer sponsored insurance plans, children participate in subsidized ESI plans as a dependent child on their parents/guardians employment-based private coverage. In areas of this SPA the reader finds mention of employee or family processes and procedures which correspond to their dependent children's private group coverage, the state assures this mention is included only for clarification/explanation of processes and procedures used to gain subsidized coverage for dependent children.

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

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

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

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

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

Original Plan:
Effective Date: 12/01/97

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

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

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

Technical SPA:
Date: 02/24/03

Separate SCHIP program for unborn children:
Effective date: 01/01/08
Implementation Date: 04/01/08

STBS:

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

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

OK-CHIPSPA#6: To cover children above 185 to 300% of FPL with two options:
1) direct coverage or 2) premium assistance.
Date Submitted; June 22, 2009
Date Approved: December 18, 2009
Effective Date: December 1, 2009

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

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

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

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
		CS15	Assurance that state will apply MAGI based income methodologies for all separate CHIP covered groups	current section 4.1.3
OK-14-0003 **Effective/Implementation Date: January 1, 2014**	MAGI Eligibility for children covered under title XXI funded Medicaid program	CS3	Converts state's existing income eligibility standards to MAGI-equivalent standards, by age group	Section 4.0 of the current CHIP state plan
OK-14-0004 **Effective/Implementation Date: January 1, 2014**	Establish 2101 (f) Groups	CS14	Eligibility – Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	Incorporate within a separate subsection under section 4.1
OK-14-0005 **Effective/Implementation Date: Oct 1, 2013**	MAGI-based Eligibility Processing	CS24	An alternative single, streamlined application, screening and enrollment process, renewals	Supersedes the current sections 4.3 and 4.4
OK-14-0006	MAGI Eligibility	CS17 CS18 CS19 CS20	Non-financial eligibility policies on: Residency Citizenship Social Security Number Substitution of Coverage	Section 4.1.5 Section 4.1.0; 4.1-LR; 4.1.1-LR Section 4.1.9.1 Section 4.4.4

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
Effective/Implementation Date: January 1, 2014		CS21 CS23	Non-Payment of Premiums Other Eligibility Standards	Section 8.7 Section 4.1.9

OK-16-0007: Establishing multiple new Health Services Initiatives (HSIs). 1) Provide LARC devices to a target population, 2) to provide education to provider's about those devices, 3) Naloxone kits, 4) services for foster care children, and 5) Academic Detailing.

Date Submitted; March 11, 2016
Date Approved: May 26, 2016
Effective Date: July 1, 2016

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

SPA # 18-0013 Revise and Update CHIP Goals & Objectives
Proposed effective date: 09/01/2018
Proposed implementation date: 09/01/2018
SPA # 18-0016: Implementation of new Health Service Initiative (HSI)
Proposed effective date: 11/01/18
Proposed implementation date: 11/01/18

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

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

SPA #20-0030 Purpose of SPA: Demonstrate compliance with SUPPORT Act requirements

Proposed effective date: July 1, 2020
Proposed implementation date: July 1, 2020
Implementation date for services other than MAT: July 1, 2020
Implementation date for MAT services: October 1, 2020

SPA #20-0031: Request to provide continuous eligibility to the unborn population and delay changes in circumstances when needed for this population during the COVID-19 public health emergency.
Proposed effective date: March 1, 2020
Proposed implementation date: March 1, 2020

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

A Tribal consultation public notice was sent to tribal partners on March 18, 2020. A virtual face-to-face tribal consultation took place on April 1, 2020.

There were thirty (30) attendees at the April 1, 2020 meeting; there were no comments regarding the OK SPA 20-0030 proposal.

A copy of the SPA proposal was posted on the Agency's public webpage for public comment from May 29, 2020 until June 28, 2020; there were no comments received.

TN No: OK SPA 20-0030 Approval Date___________ Effective Date: 07/01/2020

Section 6. **Coverage Requirements for Children's Health Insurance**

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan and proceed to Section 7 since children covered under a Medicaid expansion program will receive all Medicaid covered services including EPSDT.

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

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

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

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

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

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

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

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

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

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

- the coverage includes benefits for items and services within each of the categories of basic services described in 42 CFR 457.430:
  - dental services
  - inpatient and outpatient hospital services,
  - physicians' services,
  - surgical and medical services,
  - laboratory and x-ray services,
  - well-baby and well-child care, including age-appropriate immunizations, and
  - emergency services;
- the coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages (FEHBP-equivalent coverage, State

employee coverage, or coverage offered through an HMO coverage plan that has the largest insured commercial enrollment in the state); and

- the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the additional categories in such package, if offered, as described in 42 CFR 457.430:
  - coverage of prescription drugs,
  - mental health services,
  - vision services and
  - hearing services.

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

The actuarial report must be prepared by an individual who is a member of the American Academy of Actuaries. This report must be prepared in accordance with the principles and standards of the American Academy of Actuaries. In preparing the report, the actuary must use generally accepted actuarial principles and methodologies, use a standardized set of utilization and price factors, use a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan, apply the same principles and factors in comparing the value of different coverage (or categories of services), without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used, and take into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage. **(**Section 2103(a)(2))

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

Guidance: A State approved under the provision below, may modify its program from time to time so long as it continues to provide coverage at least equal to the lower of the actuarial value of the coverage under the program as of August 5, 1997, or one of the benchmark programs. If "existing comprehensive state-based coverage" is modified, an actuarial opinion documenting that the actuarial value of the

modification is greater than the value as of August 5, 1997, or one of the benchmark plans must be attached. Also, the fiscal year 1996 State expenditures for "existing comprehensive state-based coverage" must be described in the space provided for all states. (Section 2103(a)(3))

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

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

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

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

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

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

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

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

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

6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage

6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage applicable only New York, Pennsylvania, or Florida (under 457.440)

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

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

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

6.1.4.7. ☒ Other (Describe)

No alterations are being made to Oklahoma's current ability to provide expanded eligibility under the state's Medicaid plan to CHIP SoonerCare children. Pertaining to the Soon-To-Be-Sooners (separate SCHIP) program, also known as the Unborn Child program: The state elects to provide pregnancy related benefits covered under Title XXI through the STBS (separate SCHIP) program. Professional services, ante

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Clinic services coverage for CHIP SoonerCare children will be the same as under

Title XIX.

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

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

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

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

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

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

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

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

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

Prenatal care and pre-pregnancy family services and supplies coverage for CHIP SoonerCare children will be the same as under Title XIX.

Pre-pregnancy family services are not covered for eligible Unborn Children.

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

(including associated tests and procedures such as ultrasounds, non-stress tests, amniocentesis and other pregnancy specific tests, procedures and services as covered under Title XIX) are provided as medically necessary to support optimal pregnancy outcomes, and are billed using the appropriate CPT/HCPC codes. In addition, visits with specialists and subspecialists and the related tests and procedures will be covered to provide evaluation and management of maternal or fetal conditions, diseases and disorders that may impact the pregnancy, and/or maternal/fetal outcomes. Examples of these visits would be an outpatient office or clinic visit with an endocrinologist regarding a maternal (pre) diabetic condition, or a visit with a cardiologist regarding a preexisting maternal heart defect and potential care and treatment during pregnancy needed in order to maximize fetal well-being. Services to treat maternal conditions that bear no relationship to fetal well-being and outcomes will not be covered. Examples of non-covered care are evaluation and treatment of maternal cataracts, evaluation and treatment of maternal hearing loss. Eligible Unborn Children will receive the services described in 6.1.4.7 and 6.2 with fee-for-service reimbursement, and will not be enrolled with a PCP.

6.2.10. ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))

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

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

6.2.11. ☒ Disposable medical supplies (Section 2110(a)(13))

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

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

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

6.2.12. ☒ Home and community-based health care services (Section 2110(a)(14))

CHIP SoonerCare children eligible for services HCBS receive TXIX services and any additional HCBS services covered under the waiver.

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

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

6.2.13. ☒ Nursing care services (Section 2110(a)(15))

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

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

6.2.14. ☒ 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)

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

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

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

ESI-Dental program covered as medically necessary and includes coverage for Class A, B, C, and orthodontia services. All coverage provided as necessary to prevent disease, promote and restore oral health, and treat emergency conditions. Dental services follow the AAPD periodicity schedule which can be found online at http://www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf
Prior authorization required. Class A covered as medically necessary and includes preventive, diagnostic care such as cleanings, check-ups, X-rays, and fluoride

treatments, no co-pay; Class B covered as medically necessary and includes basic, restorative, endodontic, periodontic, oral and maxillofacial surgery care such as fillings, extractions, periodontal care, and some root canal, $10 co-pay; Class C covered as medically necessary and includes major, prosthodontic care such as crowns, bridges and dentures, $25 co-pay; Class D covered as medically necessary and includes orthodontic care, orthodontics is not covered for cosmetic and purposes not medical in nature, $25 co-pay; Emergency Dental Services covered as medically necessary, no co-pay.

6.2.16. ☒ Vision screenings and services (Section 2110(a)(24))
Vision screening and services coverage for CHIP SoonerCare children is the same as under Title XIX.

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

6.2.17. ☒ Hearing screenings and services (Section 2110(a)(24))

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

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

6.2.18. ☒ Case management services (Section 2110(a)(20))

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

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

6.2.19. ☒ Care coordination services (Section 2110(a)(21))

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

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

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

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

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

6.2.21. ☒ Hospice care (Section 2110(a)(23))

Hospice care coverage for CHIP SoonerCare children is the same as under Title XIX.

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

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

6.2.22. ☒ EPSDT consistent with requirements of sections 1905(r) and 1902(a)(43) of the Act

6.2.22.1 ☒ The state assures that any limitations applied to the amount, duration, and scope of benefits described in Sections 6.2 and 6.3- BH of the CHIP state plan can be exceeded as medically necessary.

Guidance: Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative service may be provided, whether in a facility, home, school, or other setting, if recognized by State law and only if the service is: 1) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as prescribed by State law; 2) performed

under the general supervision or at the direction of a physician; or 3) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

6.2.23. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (Section 2110(a)(24))

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

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

6.2.24. ☒ Premiums for private health care insurance coverage (Section 2110(a)(25)) Premiums for private group health care insurance coverage is covered as outlined in 6.4.2 "Additional State Option for Providing Premium Assistance as authorized under CHIPRA".

6.2.25. ☒ Medical transportation (Section 2110(a)(26))

Medical transportation coverage for CHIP SoonerCare children is the same as under Title XIX.

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

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

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

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

6.2-BH Behavioral Health Coverage Section 2103(c)(5) requires that states provide coverage to prevent, diagnose, and treat a broad range of mental health and substance use disorders in a culturally

and linguistically appropriate manner for all CHIP enrollees, including pregnant women and unborn children.

Guidance: Please attach a copy of the state's periodicity schedule. For pregnancy-related coverage, please describe the recommendations being followed for those services.

6.2.1- BH Periodicity Schedule The state has adopted the following periodicity schedule for behavioral health screenings and assessments. Please specify any differences between any covered CHIP populations:

☐ State-developed schedule
☒ American Academy of Pediatrics/ Bright Futures
☐ Other Nationally recognized periodicity schedule (please specify:)
☐ Other (please describe:)

6.3- BH Covered Benefits Please check off the behavioral health services that are provided to the state's CHIP populations, and provide a description of the amount, duration, and scope of each benefit. For each benefit, please also indicate whether the benefit is available for mental health and/or substance use disorders. If there are differences in benefits based on the population or type of condition being treated, please specify those differences.

If EPSDT is provided, as described at Section 6.2.22 and 6.2.22.1, the state should only check off the applicable benefits. It does not have to provide additional information regarding the amount, duration, and scope of each covered behavioral health benefit.

Guidance: Please include a description of the services provided in addition to the behavioral health screenings and assessments described in the assurance below at 6.3.1.1-BH.

6.3.1- BH ☒ Behavioral health screenings and assessments. (Section 2103(c)(6)(A))

6.3.1.1- BH ☒ The state assures that all developmental and behavioral health recommendations outlined in the AAP Bright Futures periodicity schedule and United States Public Preventive Services Task Force (USPSTF) recommendations graded as A and B are covered as a part of the CHIP benefit package, as appropriate for the covered populations.

Guidance: Examples of facilitation efforts include requiring managed care organizations and their networks to use such tools in primary care practice, providing education, training, and technical resources, and covering the costs of administering or purchasing the tools.

6.3.1.2- BH ☒ The state assures that it will implement a strategy to facilitate the use of age-appropriate validated behavioral health screening tools in primary care settings. Please describe how the state will facilitate the use of validated screening tools.

On its website, the State provides a list of validated screening tools and a toolkit for providers to know how to bill for these tools. Additionally, the State requires behavioral health screenings in Patient Centered Medical Homes. The technical assistance page with information and resources can be found at http://www.okhca.org/providers.aspx?id=12532.
Information on approved behavioral health screening tools for outpatient behavioral health providers can be found at www.okhca.org/behavioral-health.

The State partners with the Oklahoma Department of Mental Health & Substance Abuse (ODMHSAS) to train providers. ODMHSAS is the authority in training behavioral health providers and they perform this activity periodically throughout the year, as needed.

The webpage and any other state developed items are revised as necessary with a minimum of an annual review. The website is updated and providers will receive a web alert that describes the update and provides a link to page. If a change is more substantive, a global message is sent to contracted providers. Behavioral health staff are also available to assist providers with any individualized technical assistance.

6.3.2- BH ☒ Outpatient services (Sections 2110(a)(11) and 2110(a)(19))

Guidance: Psychosocial treatment includes services such as psychotherapy, group therapy, family therapy and other types of counseling services.

6.3.2.1- BH ☒ Psychosocial treatment
Provided for: ☒ Mental Health ☒ Substance Use Disorder

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

6.3.2.2- BH ☒ Tobacco cessation
Provided for: ☒ Substance Use Disorder

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

Guidance: In order to provide a benefit package consistent with section 2103(c)(5) of the Act, MAT benefits are required for the treatment of opioid use disorders. However, if the state provides MAT for other SUD conditions, please include a description of those benefits below at section 6.3.2.3- BH.

6.3.2.3- BH ☒ Medication Assisted Treatment
Provided for: ☒ Substance Use Disorder

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

6.3.2.3.1- BH ☒ Opioid Use Disorder

6.3.2.3.2- BH ☐ Alcohol Use Disorder

6.3.2.3.3- BH ☐ Other

6.3.2.4- BH ☒ Peer Support
Provided for: ☒ Mental Health ☒ Substance Use Disorder

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

6.3.2.5- BH ☒ Caregiver Support
Provided for: ☒ Mental Health ☒ Substance Use Disorder

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

6.3.2.6- BH ☒ Respite Care
Provided for: ☒ Mental Health ☒ Substance Use Disorder

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

6.3.2.7- BH ☒ Intensive in-home services
Provided for: ☒ Mental Health ☐ Substance Use Disorder

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

6.3.2.8- BH ☒ Intensive outpatient
Provided for: ☒ Mental Health ☒ Substance Use Disorder

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

6.3.2.9- BH ☒ Psychosocial rehabilitation
Provided for: ☒ Mental Health ☒ Substance Use Disorder

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

Guidance: If the state considers day treatment and partial hospitalization to be the same benefit, please indicate that in the benefit description. If there are differences between these benefits, such as the staffing or intensity of the setting, please specify those in the description of the benefit's amount, duration, and scope.

6.3.3- BH ☒ Day Treatment
Provided for: ☒ Mental Health ☐ Substance Use Disorder

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

6.3.3.1- BH ☒ Partial Hospitalization
Provided for: ☒ Mental Health ☒ Substance Use Disorder

PHP coverage for eligible Unborn Children enrolled in the Soon-To-Be-Sooners (separate SCHIP) program will be covered as medically necessary and only when services benefit

the unborn child throughout the pregnancy and birth.

6.3.4- BH ☒ Inpatient services, including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Sections 2110(a)(10) and 2110(a)(18))
Provided for: ☒ Mental Health ☒ Substance Use Disorder

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

Guidance: If applicable, please clarify any differences within the residential treatment benefit (e.g. intensity of services, provider types, or settings in which the residential treatment services are provided).

6.3.4.1- BH ☒ Residential Treatment
Provided for: ☒ Mental Health ☒ Substance Use Disorder

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

6.3.4.2- BH ☒ Detoxification
Provided for: ☒ Substance Use Disorder

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

Guidance: Crisis intervention and stabilization could include services such as mobile crisis, or short term residential or other facility based services in order to avoid inpatient hospitalization.

6.3.5- BH ☒ Emergency services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

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

6.3.5.1- BH ☒ Crisis Intervention and Stabilization
Provided for: ☒ Mental Health ☒ Substance Use Disorder

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

6.3.6- BH ☒ Continuing care services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

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

6.3.7- BH ☒ Care Coordination.
Provided for: ☒ Mental Health ☒ Substance Use Disorder

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

6.3.7.1- BH ☒ Intensive wraparound
Provided for: ☒ Mental Health ☒ Substance Use Disorder

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

6.3.7.2- BH ☒ Care transition services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

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

6.3.8- BH ☒ Case Management
Provided for: ☒ Mental Health ☒ Substance Use Disorder

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

6.3.9- BH ☐ Other
Provided for: ☐ Mental Health ☐ Substance Use Disorder

N/A

6.4- BH Assessment Tools

6.4.1- BH Please specify or describe all of the tool(s) required by the state and/or each managed care entity:

☒ ASAM Criteria (American Society Addiction Medicine)
☐ Mental Health ☒ Substance Use Disorders

☐ InterQual
☐ Mental Health ☐ Substance Use Disorders

☐ MCG Care Guidelines
☐ Mental Health ☐ Substance Use Disorders

☐ CALOCUS/LOCUS (Child and Adolescent Level of Care Utilization System)
☐ Mental Health ☐ Substance Use Disorders

☐ CASII (Child and Adolescent Service Intensity Instrument)
☐ Mental Health ☐ Substance Use Disorders

☐ CANS (Child and Adolescent Needs and Strengths)
☐ Mental Health ☐ Substance Use Disorders

☒ State-specific criteria (e.g. state law or policies) (please describe)
☒ Mental Health ☒ Substance Use Disorders

- If the service focus is mental health (MH): the Client Assessment Record (CAR) is required. The Addiction Severity Index (ASI), or the Teen Addiction Severity Index (TASI), both nationally-recognized tools, is optional.
- If the service focus is substance abuse (SA): the ASI or TASI is required; the CAR is optional.
- If the service focus is co-occurring: the CAR is required; the ASI or TASI is also required.

☐ Plan-specific criteria (please describe)
☐ Mental Health ☐ Substance Use Disorders

☐ Other (please describe)

☐ Mental Health ☐ Substance Use Disorders

☐ No specific criteria or tools are required
☐ Mental Health ☐ Substance Use Disorders

Guidance: Examples of facilitation efforts include requiring managed care organizations and their networks to use such tools to determine possible treatments or plans of care, providing education, training, and technical resources, and covering the costs of administering or purchasing the assessment tools.

6.4.2- BH ☒ Please describe the state's strategy to facilitate the use of validated assessment tools for the treatment of behavioral health conditions.

OHCA will provide information to behavioral health providers by letter, global messages, trainings, etc., of available reimbursement opportunities for the utilization of behavioral health assessment tools.

The OHCA has a dedicated Behavioral Health department that is available for education and support on an ongoing and as needed basis. Additionally, the OHCA's provider manual (rules) states that behavioral health providers must utilize validated/evidence-based assessment tools to determine possible treatments or plans of care of behavioral health conditions. SoonerCare Choice primary care providers are also kept informed and have access to applicable information via letters, globals, provider services staff, and behavioral health unit staff.

The webpage and any other state developed items are revised as necessary with a minimum of an annual review. Behavioral health staff are available to assist providers with any individualized technical assistance.

6.2.5- BH Covered Benefits The State assures the following related to the provision of behavioral health benefits in CHIP:

☒ All behavioral health benefits are provided in a culturally and linguistically appropriate manner consistent with the requirements of section 2103(c)(6), regardless of delivery system.

☒ The state will provide all behavioral health benefits consistent with 42 CFR 457.495 to ensure there are procedures in place to access covered services as well as appropriate and timely treatment and monitoring of children with chronic, complex or serious conditions.

applied to different tiers of prescription drugs are determined based on reasonable factors,

regardless of whether a drug is generally prescribed for medical/surgical benefits or mental health/substance use disorder benefits (§457.496(d)(3)(ii)(A))

9.10. Provide a 1-year projected budget. A suggested financial form for the budget is below. 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 expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc.
    - All cost sharing, benefit, payment, eligibility need to be reflected in the budget.
- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
- Include a separate budget line to indicate the cost of providing coverage to pregnant women.
- States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.
- Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.
- Include a separate budget line to indicate the cost of implementing Express Lane Eligibility.
- Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:
    - Total 1-year cost of adding prenatal coverage
    - Estimate of unborn children covered in year 1

CHIP Budget

STATE: OKLAHOMA	**FFY 2021 Budget**
Federal Fiscal Year	**FFY 2021**
State's enhanced FMAP rate	77.59%
Benefit Costs	
Insurance payments	
Managed care	259,110,195

STATE: OKLAHOMA	FFY 2021 Budget
per member/per month rate	
Fee for Service	18,313,048
Total Benefit Costs	277,423,243
(Offsetting beneficiary cost sharing payments)	
Net Benefit Costs	**$277,423,243**
Cost of Proposed SPA Changes – Benefit	
Administration Costs	
Personnel	
General administration	9,881,917
Contractors/Brokers	
Claims Processing	
Outreach/marketing costs	
Health Services Initiatives	2,656,425
Other	
Total Administration Costs	**$12,538,342**
10% Administrative Cap	30,824,805
Cost of Proposed SPA Changes	**$26,710**
Federal Share	224,981,194
State Share	64,980,391
Total Costs of Approved CHIP Plan	**$289,961,585**

NOTE: Include the costs associated with the current SPA.

The Source of State Share Funds: State Appropriation and Tobacco Tax Funds

Per member/per month rate	FFY'2021	
	# of eligibles	$ PMPM
Managed Care	145,139	$178
Fee for Service	9,069	$195

Section 10. Annual Reports and Evaluations

Guidance: The National Academy for State Health Policy (NASHP), CMS and the states developed framework for the annual report that states have the option to use to complete the required evaluation report. The framework recognizes the diversity in State approaches to

implementing CHIP and provides consistency across states in the structure, content, and format of the evaluation report. Use of the framework and submission of this information will allow comparisons to be made between states and on a nationwide basis. The framework for the annual report can be obtained from NASHP's website at http://www.nashp.org. Per the title XXI statute at Section 2108(a), states must submit reports by January 1st to be compliant with requirements.

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

10.1.1. ☒ The progress made in reducing the number of uninsured low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

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

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

10.3-DC ☒ The State agrees to submit yearly the approved dental benefit package and to submit quarterly current and accurate information on enrolled dental providers in the State to the Health Resources and Services Administration for posting on the Insure Kids Now! Website. Please update Sections 6.2-DC and 9.10 when electing this option.

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

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

11.1. ☒ The State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101(a)) (42CFR 457.940(b))

11.2. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX: (Section 2107(e)) (42CFR 457.935(b)) (The items below were moved from section 9.8. Previously 9.8.6. - 9.8.9.)

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

11.2.2. ☒ Section 1124 (relating to disclosure of ownership and related information)
11.2.3. ☒ Section 1126 (relating to disclosure of information about certain convicted individuals)
11.2.4. ☒ Section 1128A (relating to civil monetary penalties)
11.2.5. ☒ Section 1128B (relating to criminal penalties for certain additional charges)
11.2.6. ☒ Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and Enrollee Protections (Sections 2101(a))

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

12.1. **Eligibility and Enrollment Matters-** Describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120. Describe any special processes and procedures that are unique to the applicant's rights when the State is using the Express Lane option when determining eligibility.
The review process for eligibility and enrollment is the same as the Medicaid Fair Hearing Process.

Guidance: "Health services matters" refers to grievances relating to the provision of health care.

12.2. **Health Services Matters-** Describe the review process for health services matters that complies with 42 CFR 457.1120.
The review process for health services matters is the same as the Medicaid Fair Hearing Process.

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

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

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

Key for Newly Incorporated Templates
The newly incorporated templates are indicated with the following letters after the numerical section throughout the template.

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

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

Region 10- Seattle	Idaho Washington	Alaska Oregon	Carol Peverly carol.peverly@cms.hhs.gov	2001 Sixth Avenue MS RX-43 Seattle, WA 98121

GLOSSARY

Adapted directly from Sec. 2110. DEFINITIONS.

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

1. Inpatient hospital services.
2. Outpatient hospital services.
3. Physician services.
4. Surgical services.
5. Clinic services (including health center services) and other ambulatory health care services.
6. Prescription drugs and biologicals and the administration of such drugs and biologicals, only if such drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.
7. Over-the-counter medications.
8. Laboratory and radiological services.
9. Prenatal care and prepregnancy family planning services and supplies.
10. Inpatient mental health services, other than services described in paragraph (18) but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.
11. Outpatient mental health services, other than services described in paragraph (19) but including services furnished in a State-operated mental hospital and including community-based services.
12. Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices).
13. Disposable medical supplies.
14. Home and community-based health care services and related supportive services (such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home).
15. Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services) in a home, school, or other setting.
16. Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.
17. Dental services.
18. Inpatient substance abuse treatment services and residential substance abuse treatment services.
19. Outpatient substance abuse treatment services.
20. Case management services.
21. Care coordination services.
22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

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

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

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

assistance under Section 1902(l)(2) for the age of such child.

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

ADDITIONAL DEFINITIONS- For purposes of this title:

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