Oklahoma CARTS FY2022 Report

Welcome!

We already have some information about your state from our records.
If any information is incorrect, please contact the CARTS Help Desk.

1. State or territory name:

Oklahoma

2. Program type:

- (●) Both Medicaid Expansion CHIP and Separate CHIP
- ( ) Medicaid Expansion CHIP only
- ( ) Separate CHIP only

3. CHIP program name(s):

The Oklahoma Health Care Authority, the Medicaid Program is SoonerCare

Who should we contact if we have any questions about your report?

4. Contact name:

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5. Job title:

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PRA Disclosure Statement.
This information is being collected to assist the Centers for Medicare & Medicaid Services (CMS) in partnership with States with the ongoing management of Medicaid and CHIP programs and policies. This mandatory information collection (42 U.S.C. 1397hh) will be used to help each state meet the statutory requirements at section 2108(a) of the Social Security Act to assess the operation of the State child health plan in each Federal fiscal year and to report the results of the assessment including the progress made in reducing the number of uncovered, low-income children. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #1). The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather all 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.

Part 1: Medicaid Expansion CHIP Enrollment Fees, Premiums, and Delivery Systems

1. Does your program charge an enrollment fee?

- ○ Yes
- ◉ No

2. Does your program charge premiums?

- ○ Yes
- ◉ No

3. Is the maximum premium a family would be charged each year tiered by FPL?

- ○ Yes
- ◉ No

3b. What's the maximum premium a family would be charged each year?

$

4. Do premiums differ for different Medicaid Expansion CHIP populations beyond FPL (for example, by eligibility group)? If so, briefly explain the fee structure breakdown.

5. Which delivery system(s) do you use?
Select all that apply.

- ☐ Managed Care
- ☑ Primary Care Case Management
- ☑ Fee for Service

6. Which delivery system(s) are available to which Medicaid Expansion CHIP populations? Indicate whether eligibility status, income level, age range, or other criteria determine which delivery system a population receives.

PCCM In Oklahoma, the only populations NOT enrolled into the PCCM delivery system includes: • Residents of long-term care facilities; • Dually eligible individuals; • Individuals in benefit programs that are limited in scope (e.g. family planning); • Non-qualified or ineligible aliens; • Individuals with private HMO coverage; • Individuals eligible for HCBS waiver services; • Children in subsidized adoptions; • Children in state or tribal custody; • Individuals in the former foster care children's group.

Part 2: Separate CHIP Enrollment Fees, Premiums, and Delivery Systems

1. Does your program charge an enrollment fee?

- ○ Yes
- ◉ No

2. Does your program charge premiums?

- ○ Yes
- ◉ No

3. Is the maximum premium a family would be charged each year tiered by FPL?

- ○ Yes
- ◉ No

3b. What's the maximum premium fee a family would be charged each year?

$ 0

4. Do your premiums differ for different CHIP populations beyond FPL (for example, by eligibility group)? If so, briefly explain the fee structure breakdown.

na In additiion, The State does not charge premiums to those eligible under its Separate CHIP program.

5. Which delivery system(s) do you use?
Select all that apply.

- ☐ Managed Care
- ☐ Primary Care Case Management
- ☑ Fee for Service

6. Which delivery system(s) are available to which CHIP populations? Indicate whether eligibility status, income level, age range, or other criteria determine which delivery system a population receives.

All Separate CHIP populations are in the fee for service delivery system.

Part 3: Medicaid Expansion CHIP Program and Policy Changes

Indicate any changes you've made to your Medicaid Expansion CHIP program policies in the past federal fiscal year.

1. Have you made any changes to the eligibility determination process?

- ○ Yes
- ◉ No
- ○ N/A

2. Have you made any changes to the eligibility redetermination process?

- ○ Yes
- ◉ No
- ○ N/A

3. Have you made any changes to the eligibility levels or target populations?
For example: increasing income eligibility levels.

- ○ Yes
- ◉ No
- ○ N/A

4. Have you made any changes to the benefits available to enrollees?
For example: adding benefits or removing benefit limits.

- ○ Yes
- ◉ No
- ○ N/A

5. Have you made any changes to the single streamlined application?

- ◉ Yes
- ○ No
- ○ N/A

6. Have you made any changes to your outreach efforts?
For example: allotting more or less funding for outreach, or changing your target population.

- ○ Yes
- ◉ No
- ○ N/A

7. Have you made any changes to the delivery system(s)?
For example: transitioning from Fee for Service to Managed Care for different Medicaid Expansion CHIP populations.

- ○ Yes
- ◉ No
- ○ N/A

8. Have you made any changes to your cost sharing requirements?
For example: changing amounts, populations, or the collection process.

- ○ Yes
- ◉ No
- ○ N/A

9. Have you made any changes to the substitution of coverage policies?
For example: removing a waiting period.

- ○ Yes
- ◉ No
- ○ N/A

10. Have you made any changes to the enrollment process for health plan selection?

- ○ Yes
- ○ No
- ◉ N/A

11. Have you made any changes to the protections for applicants and enrollees?
For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

- ○ Yes
- ◉ No
- ○ N/A

12. Have you made any changes to premium assistance?
For example: adding premium assistance or changing the population that receives premium assistance.

- ○ Yes
- ◉ No
- ○ N/A

13. Have you made any changes to the methods and procedures for preventing, investigating, or referring fraud or abuse cases?

- ○ Yes
- ◉ No
- ○ N/A

14. Have you made any changes to eligibility for "lawfully residing" pregnant individuals?

- ○ Yes
- ◉ No
- ○ N/A

15. Have you made any changes to eligibility for "lawfully residing" children?

- ○ Yes
- ◉ No
- ○ N/A

16. Have you made changes to any other policy or program areas?

- ○ Yes
- ◉ No
- ○ N/A

17. Briefly describe why you made these changes to your Medicaid Expansion CHIP program.

Changes that were previously made due to the COVID-19 global pandemic continue to be in effect in FFY 2022 to accommodate the CMS guidance received during the COVID-19 Public Health Emergency (PHE). OHCA received CMS approval for the State Plan Amendment submitted in FFY 2020 that aligns the CHIP program with the Section 5022 of the SUPPORT Act of 2018. Changes were made year before last and are still ongoing this year to accommodate for CMS guidance received during the COVID-19 Public Health Emergency (PHE).

18. Have you already submitted a State Plan Amendment (SPA) to reflect any changes that require a SPA?

- ○ Yes
- ○ No
- ◉ N/A

Part 4: Separate CHIP Program and Policy Changes

Indicate any changes you've made to your Separate CHIP program and policies in the past federal fiscal year.

1. Have you made any changes to the eligibility determination process?

- ○ Yes
- ◉ No
- ○ N/A

2. Have you made any changes to the eligibility redetermination process?

- ○ Yes
- ◉ No
- ○ N/A

3. Have you made any changes to the eligibility levels or target populations?
For example: increasing income eligibility levels.

- ○ Yes
- ◉ No
- ○ N/A

4. Have you made any changes to the benefits available to enrolees?
For example: adding benefits or removing benefit limits.

- ○ Yes
- ◉ No
- ○ N/A

5. Have you made any changes to the single streamlined application?

- ○ Yes
- ◉ No
- ○ N/A

6. Have you made any changes to your outreach efforts?
For example: allotting more or less funding for outreach, or changing your target population.

- ○ Yes
- ◉ No
- ○ N/A

7. Have you made any changes to the delivery system(s)?
For example: transitioning from Fee for Service to Managed Care for different Separate CHIP populations.

- ○ Yes
- ◉ No
- ○ N/A

8. Have you made any changes to your cost sharing requirements?
For example: changing amounts, populations, or the collection process.

- ○ Yes
- ◉ No
- ○ N/A

9. Have you made any changes to substitution of coverage policies?
For example: removing a waiting period.

- ○ Yes
- ◉ No
- ○ N/A

10. Have you made any changes to an enrollment freeze and/or enrollment cap?

- ○ Yes
- ◉ No
- ○ N/A

11. Have you made any changes to the enrollment process for health plan selection?

- ○ Yes
- ◉ No
- ○ N/A

12. Have you made any changes to the protections for applicants and enrollees?
For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

- ○ Yes
- ◉ No
- ○ N/A

13. Have you made any changes to premium assistance?
For example: adding premium assistance or changing the population that receives premium assistance.

- ○ Yes
- ◉ No
- ○ N/A

14. Have you made any changes to the methods and procedures for preventing, investigating, or referring fraud or abuse cases?

- ○ Yes
- ◉ No
- ○ N/A

15. Have you made any changes to your conception to birth expansion (as described in the October 2, 2002 final rule)?
For example: expanding eligibility or changing this population's benefit package.

- ○ Yes
- ◉ No
- ○ N/A

16. Have you made any changes to coverage for your CHIP pregnant individuals eligibility group?
For example: expanding eligibility or changing this population's benefit package.

- ○ Yes
- ◉ No
- ○ N/A

17. Have you made any changes to eligibility for "lawfully residing" pregnant individuals?

- ○ Yes
- ◉ No
- ○ N/A

18. Have you made any changes to eligibility for "lawfully residing" children?

- ○ Yes
- ◉ No
- ○ N/A

19. Have you made changes to any other policy or program areas?

- ○ Yes
- ◉ No
- ○ N/A

Part 1: Number of Children Enrolled in CHIP

This table is pre-filled with your SEDS data for the two most recent federal fiscal years (FFY). If the information is inaccurate, adjust your data in SEDS (go to line 7: "Unduplicated Number Ever Enrolled" in your fourth quarter SEDS report) and then refresh this page. If you're adjusting data in SEDS, allow one business day for the CARTS data below to update.

Program	Number of children enrolled in FFY 2021	Number of children enrolled in FFY 2022	Percent change
Medicaid Expansion CHIP	224,149	230,875	3.001%
Separate CHIP	13,288	10,357	-22.057%

1. If you had more than a 3% percent change from last year, what are some possible reasons why your enrollment numbers changed?

We attribute the percent change/drop from last year in the Separate Chip program to the fact that we stopped extending enrollment for the Soon to be Sooners population as PHE protections did not apply to this group but the increase in the Medicaid expansion CHIP can be attributed to COVID-19 economic impact and relief measures (continuity of care and postponing recertifications) as well as the welcome mat effect of our Medicaid expansion.

Part 2: Number of Uninsured Children in Your State

This table is pre-filled with data on uninsured children (age 18 and under) who are below 200% of the Federal Poverty Level (FPL) based on annual estimates from the American Community Survey. Due to the impacts of the COVID-19 PHE on collection of ACS data, the Census Bureau did not release standard one-year ACS estimates in 2020 and that row is intentionally left blank.

Year	Number of uninsured children	Margin of error	Percent of uninsured children (of total children in your state)	Margin of error
2013	Not Available	Not Available	Not Available	Not Available
2014	Not Available	Not Available	Not Available	Not Available
2015	45,000	4,000	4.5%	0.4%
2016	41,000	4,000	4.2%	0.4%
2017	42,000	4,000	4.3%	0.4%
2018	41,000	4,000	4.1%	0.4%
2019	44,000	5,000	4.5%	0.5%
2020	Not Available	Not Available	Not Available	Not Available
2021	38,000	3,000	3.9%	0.3%

Percent change between 2019 and 2021
-13.33%

1. What are some reasons why the number and/or percent of uninsured children has changed?

The reduction in Oklahoma's uninsured kids can be attributed to COVID-19 economic impact and relief measures (continuity of care and postponing recertifications) as well as the welcome mat effect of our Medicaid expansion.

2. Are there any reasons why the American Community Survey estimates wouldn't be a precise representation of the actual number of uninsured children in your state?

- ○ Yes
- ◉ No

3. Do you have any alternate data source(s) or methodology for measuring the number and/or percent of uninsured children in your state?

- ○ Yes
- ◉ No

4. Is there anything else you'd like to add about your enrollment and uninsured data?

NA

5. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Program Outreach

1. Have you changed your outreach methods in the last federal fiscal year?

- ○ Yes
- ◉ No

2. Are you targeting specific populations in your outreach efforts?
For example: minorities, immigrants, or children living in rural areas.

- ○ Yes
- ◉ No

3. What methods have been most effective in reaching low-income, uninsured children?

For example: TV, school outreach, or word of mouth.

With the Public Health Emergency (PHE) declaration, targeted efforts were made to ensure that our Patient-Centered Medical Home provider (PCMH) network was providing adequate primary care access to members assigned to them. Provider education specialists provided education concerning the allowance for the expanded use of telehealth services and continued to provide the network with educational and training support during this time. OHCA also hosted a series of webinars that focused on the PHE and the expanded use of telehealth service for providers and interested parties.

4. Is there anything else you'd like to add about your outreach efforts?

The Oklahoma Health Care Authority (OHCA) continues targeted efforts with our provider network as we bring them more information and resources concerning LARCs (Long Acting Reversible Contraceptives). During this reporting period 89 providers were trained through the Focus Forward outreach.

5. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
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Substitution of Coverage

Substitution of coverage (also known as crowd-out) occurs when someone with private insurance drops their private coverage and substitutes it with publicly funded insurance such as CHIP.

1. Do you track the number of CHIP enrollees who have access to private insurance?

- ○ Yes
- ◉ No
- ○ N/A

2. Do you match prospective CHIP enrollees to a database that details private insurance status?

- ○ Yes
- ◉ No
- ○ N/A

3. What percent of applicants screened for CHIP eligibility cannot be enrolled because they have group health plan coverage?

%

4. If you have a Separate CHIP program, do you require individuals to be uninsured for a minimum amount of time before enrollment ("the waiting period")?

- ○ Yes
- ◉ No
- ○ N/A

5. Is there anything else you'd like to add about substitution of coverage that wasn't already covered? Did you run into any limitations when collecting these data?

no

6. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Renewal, Denials, and Retention

Part 1: Eligibility Renewal and Retention

1. Does your state provide presumptive eligibility, allowing children to access CHIP services pending a final determination of eligibility?

- ○ Yes
- ◉ No
- ○ N/A

2. In an effort to retain children in CHIP, do you conduct follow-up communication with families through caseworkers and outreach workers?

- ○ Yes
- ◉ No

3. Do you send renewal reminder notices to families?

(•) Yes

3a. How many notices do you send to families before disenrolling a child from the program?

one

3b. How many days before the end of the eligibility period did you send reminder notices to families?

45

( ) No

4. What else have you done to simplify the eligibility renewal process for families?

Passive renewal - redetermination of eligibility without requiring information from the member if able to do so based on reliable information contained in the individual's account or other more current information available to the agency, including information accessed through data exchanges.

5. Which retention strategies have you found to be most effective?

The strategies have not been officially evaluated for effectiveness by a third party.

6. How do you measure the effectiveness of your retention strategies? What data sources and methodology do you use to track retention?

The strategies have not been evaluated for effectiveness by a third party; however, the OHCA has not received complaints regarding its determination or redetermination strategies.

7. Is there anything else you'd like to add that wasn't already covered?

no

Part 2: CHIP Eligibility Denials (Not Redetermination)

1. How many applicants were denied CHIP coverage in FFY 2022?
Don't include applicants being considered for redetermination - these data will be collected in Part 3.

9175

2. How many applicants were denied CHIP coverage for procedural reasons?
For example: They were denied because of an incomplete application, missing documentation, or a missing enrollment fee.

570

3. How many applicants were denied CHIP coverage for eligibility reasons?
For example: They were denied because their income was too high or too low, they were determined eligible for Medicaid instead, or they had other coverage available.

8479

3a. How many applicants were denied CHIP (Title XXI) coverage and determined eligible for Medicaid (Title XIX) instead?

5894

4. How many applicants were denied CHIP coverage for other reasons?

126

5. Did you have any limitations in collecting these data?

NA

Table: CHIP Eligibility Denials (Not Redetermination)
This table is auto-populated with the data you entered above.

	Percent
Total denials	100%
Denied for procedural reasons	6.21%
Denied for eligibility reasons	92.41%
Denials for other reasons	1.37%

Part 3: Redetermination in CHIP

Redetermination is the process of redetermining whether a child is eligible to renew in CHIP (Title XXI) every 12 months. This section doesn't apply to any mid-year changes in circumstances that may affect eligibility (for example: income, relocation, or aging out of the program).

1. How many children were eligible for redetermination in CHIP in FFY 2022?

232364

2. Of the eligible children, how many were then screened for redetermination?

231387

3. How many children were retained in CHIP after redetermination?

111009

4. How many children were disenrolled in CHIP after the redetermination process? This number should be equal to the total of 4a, 4b, and 4c below.

5437

4a. How many children were disenrolled for procedural reasons? This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

318

4b. How many children were disenrolled for eligibility reasons? This could be due to income that was too high or too low, eligibility in Medicaid (Title XIX) instead, or access to private coverage.

3951

4c. How many children were disenrolled for other reasons?

1168

5. Did you have any limitations in collecting these data?

NA

Table: Redetermination in CHIP
These tables are auto-populated with the data you entered above.

	Percent
Children screened for redetermination	100%
Children retained after redetermination	47.98%
Children disenrolled after redetermination	2.35%

Table: Disenrollment in CHIP after Redetermination

	Percent
Children disenrolled after redetermination	100%
Children disenrolled for procedural reasons	5.85%
Children disenrolled for eligibility reasons	72.67%
Children disenrolled for other reasons	21.48%

Part 4: Redetermination in Medicaid

Redetermination is the process of redetermining whether a child is eligible to renew in Medicaid (Title XIX) every 12 months. This section doesn't apply to any mid-year

changes in circumstances that may affect eligibility (for example: income, relocation, or aging out of the program).

1. How many children were eligible for redetermination in Medicaid in FFY 2022?

615051

2. Of the eligible children, how many were then screened for redetermination?

607122

3. How many children were retained in Medicaid after redetermination?

588768

4. How many children were disenrolled in Medicaid after the redetermination process?
This number should be equal to the total of 4a, 4b, and 4c below.

11061

4a. How many children were disenrolled for procedural reasons?
This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

419

4b. How many children were disenrolled for eligibility reasons?
This could be due to an income that was too high and/or eligibility in CHIP instead.

7513

4c. How many children were disenrolled for other reasons?

3129

5. Did you have any limitations in collecting these data?

NA

Table: Redetermination in Medicaid
These tables are auto-populated with the data you entered above.

	Percent
Children screened for redetermination	100%
Children retained after redetermination	96.98%
Children disenrolled after redetermination	1.82%

Table: Disenrollment in Medicaid after Redetermination

	Percent
Children disenrolled after redetermination	100%
Children disenrolled for procedural reasons	3.79%
Children disenrolled for eligibility reasons	67.92%
Children disenrolled for other reasons	28.29%

Part 5: Tracking a CHIP cohort over 18 months

Tracking a cohort of children enrolled in CHIP (Title XXI) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.
To track your cohort, identify a group of children ages 0 to 16 years who are newly enrolled in CHIP and/or Medicaid as of January through March 2022 (the second quarter of FFY 2022). Children in this cohort must be 16 years and 0 months or younger when they enroll to ensure they don't age out of the program by the end of

the 18-month tracking period.
You'll identify a new cohort every two years. This year you'll report on the number of children at the start of the cohort (Jan - Mar 2022) and six months later (July - Sept 2022). Next year you'll report numbers for the same cohort at 12 months (Jan - Mar 2023) and 18 months later (July - Sept 2023). If data are unknown or unavailable, leave it blank - don't enter a zero unless these data are known to be zero.

Helpful hints on age groups
Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2022. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2022 must be born after January 2006. Similarly, children who are newly enrolled in February 2022 must be born after February 2006, and children newly enrolled in March 2022 must be born after March 2006.

1. How does your state define "newly enrolled" for this cohort?

◉ Newly enrolled in CHIP: Children in this cohort weren't enrolled in CHIP (Title XXI) during the previous month. For example: Newly enrolled children in January 2022 weren't enrolled in CHIP in December 2021.

○ Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2022 weren't enrolled in CHIP or Medicaid in December 2021.

2. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-16 years) instead.

- (●) Yes
- ( ) No

January - March 2022 (start of the cohort)

3. How many children were newly enrolled in CHIP between January and March 2022?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
7887	3257	3678	1544

July - September 2022 (6 months later)

4. How many children were continuously enrolled in CHIP six months later?
Only include children that didn't have a break in coverage during the six-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
7633	3090	3496	1476

5. How many children had a break in CHIP coverage but were re-enrolled in CHIP six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
0			

6. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

7. How many children were no longer enrolled in CHIP six months later?
Possible reasons for no longer being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
254	167	182	68

8. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
<11	<11	<11	<11

9. Is there anything else you'd like to add about your data?

NA

January - March 2023 (12 months later): to be completed next year
Next year you'll report data about your cohort for this section.

10. How many children were continuously enrolled in CHIP 12 months later?
Only include children that didn't have a break in coverage during the 12-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

11. How many children had a break in CHIP coverage but were re-enrolled in CHIP 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

12. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

13. How many children were no longer enrolled in CHIP 12 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

14. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

July - September of 2023 (18 months later): to be completed next year
Next year you'll report data about your cohort for this section.

15. How many children were continuously enrolled in CHIP 18 months later? Only include children that didn't have a break in coverage during the 18-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

16. How many children had a break in CHIP coverage but were re-enrolled in CHIP 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

17. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

18. How many children were no longer enrolled in CHIP 18 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

19. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

20. Is there anything else you'd like to add about your data?

Part 6: Tracking a Medicaid Cohort over 18 months

Tracking a cohort of children enrolled in Medicaid (Title XIX) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.
To track your cohort, identify a group of children ages 0 to 16 years, who are newly enrolled in Medicaid and/or CHIP as of January through March 2022 (the second quarter of FFY 2022). Children in this cohort must be 16 years and 0 months or younger when they enroll to ensure they don't age out of the program by the end of the 18-month tracking period.
You'll identify a new cohort every two years. This year you'll report the number of

children identified at the start of the cohort (Jan-Mar 2022) and six months later (July-Sept 2022). Next year you'll report numbers for the same cohort at 12 months (Jan-Mar 2023) and 18 months later (July-Sept 2023). If data is unknown or unavailable, leave it blank - don't enter a zero unless the data is known to be zero.

Helpful hints on age groups
Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2022. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2022 must be born after January 2006. Similarly, children who are newly enrolled in February 2022 must be born after February 2006, and children newly enrolled in March 2022 must be born after March 2006.

1. How does your state define "newly enrolled" for this cohort?

◉ Newly enrolled in Medicaid: Children in this cohort weren't enrolled in Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2022 weren't enrolled in Medicaid in December 2021.

○ Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2022 weren't enrolled in CHIP or Medicaid in December 2021.

2. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-16 years) instead.

◉ Yes

○ No

January - March 2022 (start of the cohort)

3. How many children were newly enrolled in Medicaid between January and March 2022?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
564	452	977	747

July - September 2022 (6 months later)

4. How many children were continuously enrolled in Medicaid six months later? Only include children that didn't have a break in coverage during the six-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
545	431	951	730

5. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

6. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

7. How many children were no longer enrolled in Medicaid six months later?
Possible reasons for no longer being enrolled:
• Transferred to another health insurance program other than Medicaid
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
19	21	26	17

8. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
<11	<11	<11	<11

9. Is there anything else you'd like to add about your data?

NA

January - March 2023 (12 months later): to be completed next year
Next year, you'll report data about your cohort for this section.

10. How many children were continuously enrolled in Medicaid 12 months later?
Only include children that didn't have a break in coverage during the 12-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

11. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

12. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

13. How many children were no longer enrolled in Medicaid 12 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than Medicaid
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

14. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

July - September of 2023 (18 months later): to be completed next year
Next year you'll report data about your cohort for this section.

15. How many children were continuously enrolled in Medicaid 18 months later?
Only include children that didn't have a break in coverage during the 18-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

16. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

17. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

18. How many children were no longer enrolled in Medicaid 18 months later?
Possible reasons for not being enrolled:
- Transferred to another health insurance program other than Medicaid
- Didn't meet eligibility criteria anymore
- Didn't complete documentation
- Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

19. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

20. Is there anything else you'd like to add about your data?

Cost Sharing (Out-of-Pocket Costs)

States can choose whether or not to require cost sharing in their CHIP program. Cost sharing includes payments such as enrollment fees, premiums, deductibles, coinsurance, and copayments.

1. Does your state require cost sharing?

- ○ Yes
- ◉ No

Employer Sponsored Insurance and Premium Assistance

States with a premium assistance program can use CHIP funds to purchase coverage through employer sponsored insurance (ESI) on behalf of eligible children and parents.

1. Does your state offer ESI including a premium assistance program under the CHIP State Plan or a Section 1115 Title XXI demonstration?

- (●) Yes
- ( ) No

1. Under which authority and statutes does your state offer premium assistance? Check all that apply.

- [ ] Purchase of Family Coverage under CHIP State Plan [2105(c)(3)]
- [ ] Additional Premium Assistance Option under CHIP State Plan [2105(c)(10)]
- [x] Section 1115 Demonstration (Title XXI)

2. Does your premium assistance program include coverage for adults?

- (●) Yes
- ( ) No

3. What benefit package is offered as part of your premium assistance program, including any applicable minimum coverage requirements?

This only applies to states operating an 1115 demo.

The Employer Sponsored Insurance program offers multiple commercial plans that include major medical packages and pregnancy benefits.

4. Does your premium assistance program provide wrap-around coverage for gaps in coverage?
This only applies to states operating an 1115 demo.

- (●) Yes
- ( ) No

5. Does your premium assistance program meet the same cost sharing requirements as that of the CHIP program?
This only applies to states operating an 1115 demo.

- (●) Yes
- ( ) No
- ( ) N/A

6. Are there protections on cost sharing for children (such as the 5% out-of-pocket maximum) in your premium assistance program?
This only applies to states operating an 1115 demo.

- (●) Yes

  6a. How do you track cost sharing to ensure families don't pay more than 5% of the aggregate household income in a year?

  Subscriber premium payments are automatically tracked in MMIS (added to the household out of pocket panel). Members also submit claims with documentation for co-payments, co-insurance and deductible. These claims are added to the out of pocket panels. Once the amount exceeds 5% of household income, members are issued a warrant for those claims.

- ( ) No

7. How many children were enrolled in the premium assistance program on average each month in FFY 2022?

325

8. What's the average monthly contribution the state pays towards coverage of a child?

$ 29,991

9. What's the average monthly contribution the employer pays towards coverage of a child?

$ 0

10. What's the average monthly contribution the employee pays towards coverage of a child?

$ 0

Table: Coverage breakdown

Child

State	Employer	Employee
29991	0	0

11. What's the range in the average monthly contribution paid by the state on behalf of a child?

Average Monthly Contribution

Starts at		Ends at
$ 3,376	→	$ 91,973

12. What's the range in the average monthly contribution paid by the state on behalf of a parent?

Average Monthly Contribution

Starts at		Ends at
$ 0	→	$ 0

13. What's the range in income levels for children who receive premium assistance (if it's different from the range covering the general CHIP population)?

Federal Poverty Levels

Starts at		Ends at
139	→	200

14. What strategies have been most effective in reducing the administrative barriers in order to provide premium assistance?

We are currently working to change rules and waivers to increase enrollment in the program.

15. What challenges did you experience with your premium assistance program in FFY 2022?

Covid continues to be one of the biggest challenges the state of Oklahoma has faced. The public health emergency (PHE) is another challenge caused by COVID that we are still dealing with.

16. What accomplishments did you experience with your premium assistance program in FFY 2022?

Our biggest accomplishment has been maintaining coverage for all Insure Oklahoma members during this public health emergency (PHE).

17. Is there anything else you'd like to add that wasn't already covered?

Since Expansion has gone into effect, the population count for the Insure Oklahoma program has decreased. We're working to change rules and waivers for the program to allow more applicants to gain eligibility.

18. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
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Browse...

Program Integrity

States with a premium assistance program can use CHIP funds to purchase coverage through employer sponsored insurance (ESI) on behalf of eligible children and parents.

1. Do you have a written plan with safeguards and procedures in place for the prevention of fraud and abuse cases?

- (●) Yes
- ( ) No

2. Do you have a written plan with safeguards and procedures in place for the investigation of fraud and abuse cases?

- (●) Yes
- ( ) No

3. Do you have a written plan with safeguards and procedures in place for the referral of fraud and abuse cases?

- (●) Yes
- ( ) No

4. What safeguards and procedures are in place for the prevention, investigation, and referral of fraud and abuse cases?

OHCA's MMIS has an extensive pre-payment edit system that checks all claims against specified criteria prior to payment which will result in either continued processing or denial of claims. The system compares the provider information against eligibility criteria to ensure that the provider was active at the time service was given and has been approved for payment. Should the provider have a lapsed or terminated contract, the claim will be denied. Preliminary and Full Investigations. Preliminary investigations are considered a necessary audit step prior to undertaking a full investigation. A preliminary investigation is initiated whenever a complaint or questionable practice is identified. For cases in which fraud and / or abuse is suspected that information is provided to OHCA's Office of Legal Counsel and, where appropriate, a referral is made by the Office of Legal Counsel to the appropriate law enforcement agency. Program Integrity Referral Forms are utilized to notify the Oklahoma Department of Human Services Office of Inspector General (OKDHS OIG). Notification in writing is submitted to MFCU when a provider is in question. Investigation Procedures. Providers. The purpose of the preliminary provider investigation is to determine whether further investigation is warranted and whether fraud and / or abuse is suspected. The actual methods used in preliminary investigations vary depending on the situation. Techniques that may be used include queries, reports and data mining to identify unusual dollar amounts, units of service and / or billing patterns that may indicate that further investigation is necessary. Procedures applied depend on the issue, but often large-scale data extracts are performed and analyzed, on-site reviews are performed, medical records are requested and reviewed, billing patterns analyzed, etc. For the preliminary investigation of a single provider / member, a query is developed to review the billing or service utilization behaviors of the provider / member. If data indicates unusual or unexpected behavior, other actions are taken such as analysis of previous reviews and findings as well as claimed dollars and service utilization. This information is evaluated to determine whether a full investigation is warranted. For preliminary investigations on populations such as provider types or provider billing practices, once the issue is isolated a universe of claims is created based on those that could be affected by the review. From this universe, the number of providers and claim dollars impacted by the errors are identified. For new areas of review, onsite reviews are conducted to validate the query results. An example of a preliminary investigation would be the concern that

a provider is up-coding. In this case, Program Integrity (PI) staff develops a query to report the span of CPT codes utilized by the provider. If the query results in only high-level codes claimed, with no mid or lower-level codes billed, further investigation takes place. Further confirmation would include review of the provider contract, the amounts claimed and paid, and other audits or reviews evaluating the provider's behaviors. This information is taken to the Case Selection Committee for discussion and identification of next steps. If fraud or abuse is suspected, the matter is referred to the OHCA Office of Legal Counsel, which makes the final determination as to whether the matter should be referred to MFCU or other law enforcement agency for full investigation. Where the referral is based on an audit, the MFCU is provided copies of PI audit documentation, findings and appeals results. Eligibility referrals are screened to determine potential fraud, waste, or abuse, and associated claims are reviewed. Member eligibility is reviewed and compared to referrals received using a variety of tools and data sources. The review includes a determination of whether immediate or delayed case action is necessary, as well as a decision to pursue further investigation and/or seek remedy to eligibility inaccuracies. Information requests are issued through Program Integrity and through the online eligibility MMIS system depending on circumstances presented. Once the investigation is complete the eligibility is updated, closed, or left unchanged based on reviewer findings. Case actions occur through the online eligibility system, and appropriate notices are issued. Hearings are completed through normal channels for negative actions related to eligibility. Referrals to OIG may occur when fraud is suspected after review by Member Audit.

5. Do the Managed Care plans contracted by your Separate CHIP program have written plans with safeguards and procedures in place?

- ○ Yes
- ○ No
- ◉ N/A

6. How many eligibility denials have been appealed in a fair hearing in FFY 2022?

80

7. How many cases have been found in favor of the beneficiary in FFY 2022?

<11

8. How many cases related to provider credentialing were investigated in FFY 2022?

177

9. How many cases related to provider credentialing were referred to appropriate law enforcement officials in FFY 2022?

3

10. How many cases related to provider billing were investigated in FFY 2022?

177

11. How many cases were referred to appropriate law enforcement officials in FFY 2022?

3

12. How many cases related to beneficiary eligibility were investigated in FFY 2022?

336

13. How many cases related to beneficiary eligibility were referred to appropriate law enforcement officials in FFY 2022?

12

14. Does your data for Questions 8-13 include cases for CHIP only or for Medicaid and CHIP combined?

- ○ CHIP only
- ◉ Medicaid and CHIP combined

15. Do you rely on contractors for the prevention, investigation, and referral of fraud and abuse cases?

- ○ Yes
- ◉ No

16. Do you contract with Managed Care health plans and/or a third party contractor to provide this oversight?

- ○ Yes
- ◉ No

17. Is there anything else you'd like to add that wasn't already covered?

In regards to provider fraud investigations and any subsequent referrals to law enforcement, OHCA does not differentiate or distinguish between the CHIP and Medicaid programs. *Additionally, OHCA does not categorize provider fraud referrals based on the type of potential fraud, i.e. provider credentialing v. provider billing. A provider fraud referral can contain multiple different reasons and OHCA does not separately track referrals based on the type of provider fraud. Eligibility related investigations and referrals are categorized by program type.

18. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Dental Benefits

Tell us about the children receiving dental benefits in your Separate CHIP program. Include children who are receiving full benefits and those who are only receiving supplemental dental benefits. Include the unduplicated number of children enrolled in all types of delivery systems (Managed Care, PCCM, and Fee for Service).

Note on age groups
Children should be in age groups based on their age on September 30th, the end of the federal fiscal year (FFY). For example, if a child turns three years old on September 15th, the child should be included in the "ages 3-5' group. Even if the child received dental services on September 1st while they were still two years old, all dental services should be counted as their age at the end of the FFY.

1. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-18 years) instead.

- (●) Yes
- ( ) No

2. How many children were enrolled in Separate CHIP for at least 90 continuous days during FFY 2022?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
1042	7439	13448	32332	44075	51911

3. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received at least one dental care service during FFY 2022?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
24	1080	4840	16112	21457	23620

Dental care service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D0100-D9999 (or equivalent CDT codes D0100-D9999, or equivalent CPT codes) based on an unduplicated paid, unpaid, or denied claim.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

4. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received at least one preventative dental care service during FFY 2022?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
<11	820	4283	14892	19522	20487

Dental care service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D0100 - D9999 (or equivalent CDT codes D0100 - D9999, or equivalent CPT codes) based on an unduplicated paid, unpaid, or denied claim.
All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

5. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received dental treatment services during FFY 2022?
This includes orthodontics, periodontics, implants, oral and maxillofacial surgery, and other treatments.

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
19	84	1168	6296	9135	11939

Dental treatment service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D2000-D9999 (or equivalent CDT codes D2000-D9999 or equivalent CPT codes that involve periodontics, maxillofacial prosthetics, implants, oral and maxillofacial surgery, orthodontics, adjunctive general services) based on an unduplicated paid, unpaid, or denied claim.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

6. How many children in the "ages 6-9" group received a sealant on at least one permanent molar tooth during FFY 2022?

2476

Sealant codes and definitions
The sealant on a permanent molar tooth is provided by a dental professional for whom placing a sealant is within their scope of practice. It's defined by HCPCS code D1351 (or equivalent CDT code D1351) based on an unduplicated paid, unpaid, or denied claim. Permanent molars are teeth numbered 2, 3, 14, 15, 18, 19, 30, and 31, and additionally - for states covering sealants on third molars ("wisdom teeth") - teeth numbered 1, 16, 17, and 32.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

7. Do you provide supplemental dental coverage?

- ○ Yes
- ◉ No

8. Is there anything else you'd like to add about your dental benefits? If you weren't able to provide data, let us know why.

NA

9. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

CAHPS Survey Results

Children's Health Insurance Program Reauthorization Act (CHIPRA) requires that all CHIP programs submit survey results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS). The survey assesses your CHIP program quality and customer satisfaction. For the 2022 CARTS report, the only option for reporting CAHPS results will be through the submission of raw data to the Agency for Healthcare Research and Quality (AHRQ) CAHPS Database.

1. Did you collect the CAHPS survey?

- (●) Yes

  1a. Did you submit your CAHPS raw data to the AHRQ CAHPS database? Please note this is a requirement for FFY 2022.

  - (●) Yes
  - ( ) No

- ( ) No

Part 2: You didn't collect the CAHPS survey

Health Services Initiative (HSI) Programs

All states with approved HSI program(s) should complete this section.
States can use up to 10% of the total computable amount of their fiscal year allotment to develop Health Services Initiatives (HSI) that provide direct services and other public health initiatives for low-income children. [See Section 2105(a)(1)(D)(ii) of the Social Security Act, 42 CFR 457.10 and 457.618.] States may only claim HSI expenditures after funding other costs to administer their CHIP State Plan.

1. Does your state operate Health Services Initiatives using CHIP (Title XXI) funds? Even if you're not currently operating the HSI program, if it's in your current approved CHIP State Plan, please answer "yes."

- (●) Yes
- ( ) No

Tell us about your HSI program(s).

1. What is the name of your HSI program?

Focus Forward Oklahoma Policy, Communication, and Outreach

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

a. 18 and younger

4. How many children do you estimate are being served by the HSI program?

120000

5. How many children in the HSI program are below your state's FPL threshold?

100

Computed: 0.8%

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

a. Teen Birth Rates

7. What outcomes have you found when measuring the impact?

a. 11% decrease in teen birth rate since 2016 b. 9% decrease in teen birth rate from 2019-2020

8. Is there anything else you'd like to add about this HSI program?

a. Oklahoma ranked #2 in the nation in teen births when the program started. Oklahoma now ranks #5. HSI #1 has worked to increase access and utilization to the full range of contraceptive options including LARC devices for Oklahoma teens. This effort has revised the Oklahoma State Plan Amendment related to LARC reimbursement to increase access to LARC devices including a new policy change to reimburse FQHCs for LARC devices separate from the PPS rate. In addition, this effort has worked on addressing other policy/reimbursement issues that impact same day access to contraception. The effort has also been working with local, state, and national entities to align resources and strategies. Currently over 25 organizations are engaged in the program's advisory group with leadership from state-funded universities, the state health department, and the two large private payers in Oklahoma represented on the group. In addition regional teen pregnancy prevention organizations from the two largest counties in Oklahoma (Oklahoma County and Tulsa County) have engaged with the advisory group and the program to promote access through their networks. We have seen a significant reduction in teen birth rates for both of these large counties. In additional several national organizations have taken interest in the program and have begun engaging with the program staff. The program now has a website that serves as a hub of information for the entire state including providers, non-profits, parents, and teens. A library of evidence-based and peer-reviewed literature (currently totaling over 500 resources) has also been established and is available through the program. We continue to work on addressing barriers in rural and underserved communities.

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. What is the name of your HSI program?

Focus Forward Oklahoma Workforce Training Program

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

a. 18 and younger

4. How many children do you estimate are being served by the HSI program?

120000

5. How many children in the HSI program are below your state's FPL threshold?

100

Computed: 0.8%

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

a. Teen birth rates b. Targeted Providers: Increase in LARC Claims

7. What outcomes have you found when measuring the impact?

a. 11% decrease in teen birth rate since 2016 b. 9% decrease in teen birth rate from 2019-2020 c. 21% increase in all contraception claims for trained providers d. 24% increase in LARC claims for trained providers

8. Is there anything else you'd like to add about this HSI program?

a. In 2016, less than half of Oklahoma Medicaid contracted providers with contraception claims provide LARC. HSI #2 aims to increase this number by providing a comprehensive LARC training program for Oklahoma family planning providers (who serve the under 19 population) and their clinical and administrative staff. This effort has resulted in the development of a comprehensive training program that provides up-to-date counseling skills, medical management of contraception information, and hands-on LARC procedure skills for Oklahoma providers, conducted by Oklahoma providers. We have also added multiple brief lectures on special populations or topics such as providing contraceptive care to adolescents, cultural humility, and LGBTQI+ populations. This program is a partnership with the University of Oklahoma Health Sciences Center, the University of Oklahoma Tulsa, and the Oklahoma State University Center for Health Sciences. To-date the training program has trained over 450 providers from over 50 counties from across the state of Oklahoma. A little over 30% of these providers were located in a rural county and 70% were family practice providers. A little over half (56%) were physicians and 40% were advanced practice practitioners.

9. Optional: Attach any additional documents.

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Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. What is the name of your HSI program?

Overdose Education and Naloxone Distribution for Youth and Young adults

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

Youth under age 19 at risk of experiencing or witnessing an opioid overdose.

4. How many children do you estimate are being served by the HSI program?

4000

5. How many children in the HSI program are below your state's FPL threshold?

4000

Computed: 100%

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

Number of naloxone kits distributed to youth under age 19 or youth-serving organizations and training to recognize and respond to opioid overdose. The intent is to reduce opioid overdose deaths among youth; the increased availability of fentanyl has greatly impacted overdose risk

7. What outcomes have you found when measuring the impact?

Youth and adults working with youth serving organizations report feeling confident recognizing and responding to opioid overdose and naloxone administration.

8. Is there anything else you'd like to add about this HSI program?

The HSI program meets a significant need due to restrictions on SAMHSA funding that only allows naloxone distribution to adults over age 18.

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. What is the name of your HSI program?

Academic Detailing

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

Members age ≤ 18

4. How many children do you estimate are being served by the HSI program?

1300

5. How many children in the HSI program are below your state's FPL threshold?

100

Computed: 7.69%

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

Changes in presence of appropriate diagnosis

7. What outcomes have you found when measuring the impact?

13% increase in presence of appropriate diagnosis

8. Is there anything else you'd like to add about this HSI program?

NA

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. What is the name of your HSI program?

Oklahoma Pediatric Psychotropic Prescribing Resource Guide

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

Members age ≤ 18

4. How many children do you estimate are being served by the HSI program?

3684

5. How many children in the HSI program are below your state's FPL threshold?

99

Computed: 2.69%

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

Reviewing pediatric claims for antipsychotics for polypharmacy, metabolic monitoring, adherence and appropriate diagnosis. Education is provided to prescribers who are outliers. Claims reviews will be done on a semi-annual basis. a. Increase in percentage of members with glucose monitoring if utilizing antipsychotics. b. Decrease in the very young (<5 years) pediatrics utilizing psychotropics.

7. What outcomes have you found when measuring the impact?

a. 5.03% increase in percentage of members with glucose monitoring if utilizing antipsychotics. b. 40% decrease in the very young (≤ 5 years) pediatrics utilizing psychotropics.

8. Is there anything else you'd like to add about this HSI program?

As a part of the program the Pediatric Behavioral and Emotional Health ECHO program at OSU Center for Health is being supported with funds to aid in community outreach for clinicians caring for all Oklahoma youth. The Resource Guide has been presented in full on our Pediatric Behavioral and Emotional Health ECHO. Additionally, the resource guide has been presented at various statewide continuing medical education programs as well as to prescribers found to be outliers. The resource guide has been distributed to over 120 practicing physicians across Oklahoma. Utilization of online resource guide with a total of 851 views of the resource guide. ECHO participant Data: As a part of the program the Pediatric Behavioral and Emotional Health ECHO program at OSU Center for Health is being supported with funds to aid in community outreach for clinicians caring for all Oklahoma youth. The Resource Guide has been presented in full on our Pediatric Behavioral and Emotional Health ECHO. Additionally, the resource guide has been presented at various statewide continuing medical education programs as well as to prescribers found to be outliers. The resource guide has been distributed to over 120 practicing physicians across Oklahoma. Utilization of online resource guide with a total of 851 views of the resource guide. ECHO participant Data: Session Date Range Total Participants from 10-01-2021 to 12-31-2021 204 from 01-01-2022 to 03-31-2022 285 from 04-01-2022 to 06-30-2022 281 from 07-01-2022 to 9-30-2022 218 Total Participation 988 See attachment

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. What is the name of your HSI program?

Sickle Cell Disease Care Kits

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

18 years of aged and younger

4. How many children do you estimate are being served by the HSI program?

10

5. How many children in the HSI program are below your state's FPL threshold?

100

Computed: 1000%

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

10 care kits total to be created/distributed in FY2022

7. What outcomes have you found when measuring the impact?

100% have been completed

8. Is there anything else you'd like to add about this HSI program?

The Health Services Initiative (HIS) Sickle Cell Disease (SCD) care kit projects provides outreach to parent/caregivers of babies newly diagnosed with SCD and those with an existing diagnosis to promote self-care best practices, self-efficacy, and improve health outcomes. The care kits are created to include the necessary tools, education, and community support services for the parent/caregiver of a child diagnosed with SCD. The contracted group, Supporters of Families with Sickle Cell Disease (SFWSCD) report that families are appreciative of the support and items contained in the basket as they navigate the new diagnosis of their child.

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. What is the name of your HSI program?

Reach Out and Read (ROR)

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

6 month - 5 years old

4. How many children do you estimate are being served by the HSI program?

45648

5. How many children in the HSI program are below your state's FPL threshold?

Computed:

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

Metric 1-The percentage of SoonerCare members 9-36 months of age with a paid developmental screening performed by a ROR provider compared to those performed by a non-ROR provider. Metric 2-The percentage of SoonerCare members 6-59 months of age with paid well-child visit(s) performed by a ROR provider compared to those performed by a non-ROR provider.

7. What outcomes have you found when measuring the impact?

Well Child Visits and Developmental Screening continue to show higher completion rates in the ROR participating practices FY2021, than FY2022. (Due to Covid, our numbers decreased.) See the SFY 2021-2022 attached document template with Developmental Screening & Well-Child Visits Chart/Data.

8. Is there anything else you'd like to add about this HSI program?

As the data shows above, we have found that rates of both developmental screening and well-child visit are higher among practices enrolled as ROR providers in FY2021, than FY2022. (Due to Covid, our numbers decreased.) See the SFY 2021-2022 attached document template with Developmental Screening & Well-Child Visits Chart/Data.

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. What is the name of your HSI program?

Focus Forward Oklahoma Uninsured LARC Access Initiative

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

a. Uninsured under 19

4. How many children do you estimate are being served by the HSI program?

120000

5. How many children in the HSI program are below your state's FPL threshold?

100

Computed: 0.8%

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

a. Teen birth rates b. # of uninsured under 19 choosing LARC

7. What outcomes have you found when measuring the impact?

a. 11% decrease in teen birth rate since 2016 b. 9% decrease in teen birth rate for ages 15-19 c. 421 uninsured under 19 access of LARC devices.

8. Is there anything else you'd like to add about this HSI program?

a. To date 60 of the 77 counties in Oklahoma have received devices based on their client needs. Most of these county health departments are in rural Oklahoma and are designated as health professional shortage areas. Since this health service initiative was started 421 devices have been issued to uninsured clients under the age of 19. County health departments continue to work to provide LARC to uninsured clients under the age of 19 through these funds.

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. What is the name of your HSI program?

Infant Safe Sleep

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

Newborns

4. How many children do you estimate are being served by the HSI program?

205

5. How many children in the HSI program are below your state's FPL threshold?

175

Computed: 85.37%

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

At admission to the program, participants are given education on best practices with respect to infant sleep. Participants in the program are asked to complete a follow-up survey which enquires about use of a sleep sack, a portable crib, and infant safe sleep practices. Questions related to sleep practices include: frequency of sleep sack and portable crib use, infant sleep position, sleep environment, and co-sleeping. The survey is administered between one and three months postpartum. Subjects entering the program through participating hospitals are administered the survey by telephone. Metric 1--Percent of participants reporting use of crib when infant sleeps. Metric 2-- Frequency of how often participant's infant always or almost always sleeps in:1) Crib 2) Portable crib

7. What outcomes have you found when measuring the impact?

Metric 1--Percent of participants reporting use of crib when infant sleeps- 97.1% Metric 2-- Frequency of how often participant's infant always or almost always sleeps in: 1) Crib - 30.6% 2) Portable Crib - 69.1%

8. Is there anything else you'd like to add about this HSI program?

The project continues to show success, albeit mitigated somewhat by the conditions of the pandemic. Compared to mothers participating in the Pregnancy Risk Assessment Monitoring System (PRAMS), mothers participating in the Infant Safe Sleep project (Cribs) had improved rates of safe sleep practices. For example, 77.6% of mothers in PRAMS reported placing their infants on their backs to sleep compared to 97.1% of Cribs mothers doing the same. Additionally, Cribs mothers had better safe sleep practices compared to PRAMS mothers (Table 1). It has to be noted that the survey questions are slightly different between the two projects. See attached Template

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another HSI Program in this list?

Optional

Part 1: Tell us about your goals and objectives

Tell us about the progress you've made on your performance goals in the past year. The objectives and goals you add to this section should match those reflected in your CHIP State Plan, Section 9. Submit a CHIP State Plan Amendment (SPA) if any of them are different.
Objective 1 is required. We've provided examples for other objectives, but you can edit them so they match the objectives in your CHIP State Plan. You can add additional objectives and goals to fit what's in your CHIP State Plan.

1. Briefly describe your goal.

For example: In an effort to reduce the number of uninsured children, our goal is to increase enrollment by 1.5% annually until the state achieves 90% enrollment of all eligible children in the CHIP program.

a. Decrease the number of uninsured Oklahoma children by 2%, during the 10/01/18 through 09/30/23 Insure Oklahoma demonstration renewal period, under 19 years of age, under 186% of FPL.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP in the last federal fiscal year.

a. Increase/Decrease in number of children enrolled in SoonerCare at the baseline date (10/01/18) through (09/30/2022)

4. Numerator (total number)

123401

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total estimated number of children eligible for CHIP within the state in the last federal fiscal year.

a. Total number of children enrolled in SoonerCare at the baseline date (October 2018)

6. Denominator (total number)

520151

Computed: 23.72%

7. What is the date range of your data?

Start

mm/yyyy

10 / 2021

End

mm/yyyy

09 / 2022

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

Numerator is a +32,588

10. What are you doing to continually make progress towards your goal?

At this time we are monitoring the increase/decrease and reporting trend of data for this SPA period to determine the best course of action for the next SPA period.

11. Anything else you'd like to tell us about this goal?

NA

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal.

For example: In an effort to reduce the number of uninsured children, our goal is to increase enrollment by 1.5% annually until the state achieves 90% enrollment of all eligible children in the CHIP program.

b. Increase the number of qualified Oklahoma businesses participating in the Insure Oklahoma program by 2%, during the 10/01/19 through 09/30/2023 Insure Oklahoma demonstration renewal period.

2. What type of goal is it?

- ( ) New goal
- (•) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP in the last federal fiscal year.

b. The increase/decrease in the number of small businesses enrolled in ESI at the baseline date (10/01/18) through (09/30/2021)

4. Numerator (total number)

1227

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total estimated number of children eligible for CHIP within the state in the last federal fiscal year.

b. The number of small businesses enrolled in ESI at the baseline date (October 2018).

6. Denominator (total number)

4365

Computed: 28.11%

7. What is the date range of your data?

Start

mm/yyyy

10 / 2021

End

mm/yyyy

09 / 2022

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

Numerator is a negative 181 less than the previous yaer

10. What are you doing to continually make progress towards your goal?

At this time we are monitoring the increase/decrease and reporting trend of data for this SPA period to determine the best course of action for the next SPA period.

11. Anything else you'd like to tell us about this goal?

NA

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

You can edit the suggested objective so it matches what's in your CHIP State Plan.

Increase CHIP Enrollment

1. Briefly describe your goal as it relates to this objective.

For example: In an effort to increase access to care for underserved populations, our goal is to increase the number of children of Hispanic ethnicity who have visited a primary care physician by 5% annually over the next five years (ending in 2028).

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

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children of Hispanic ethnicity enrolled in CHIP who visited a primary care physician in the last federal fiscal year.

a. Increase/decrease in the unduplicated number of pregnant women enrolled in STBS at the baseline date (10/01/18) through (09/30/2021)

4. Numerator (total number)

164

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children of Hispanic ethnicity enrolled in CHIP in the last federal fiscal year.

a. The unduplicated number of pregnant women enrolled in STBS at baseline (10/2018).

6. Denominator (total number)

3561

Computed: 4.61%

7. What is the date range of your data?

Start

mm/yyyy

10 / 2021

End

mm/yyyy

09 / 2022

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

Numerator is a plus 3,558 Dominator remain the same

10. What are you doing to continually make progress towards your goal?

At this time we are monitoring the increase/decrease and reporting trend of data for this SPA period to determine the best course of action for the next SPA period.

11. Anything else you'd like to tell us about this goal?

NA

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal as it relates to this objective.

For example: In an effort to increase access to care for underserved populations, our goal is to increase the number of children of Hispanic ethnicity who have visited a primary care physician by 5% annually over the next five years (ending in 2028).

b. Increase the number of Insure Oklahoma enrolled children by 2% within 5 years beginning 10/01/18, under 19 years of age, 186-300% FPL, converted to the MAGI-equivalent percent of FPL and applicable disregards.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children of Hispanic ethnicity enrolled in CHIP who visited a primary care physician in the last federal fiscal year.

b. Increase/Decrease in the unduplicated number of Insure Oklahoma children enrolled at the baseline date (10/01/18) through (09/30/2021)

4. Numerator (total number)

118

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children of Hispanic ethnicity enrolled in CHIP in the last federal fiscal year.

b. The unduplicated number of Insure Oklahoma children enrolled at baseline (10/2018).

6. Denominator (total number)

190

Computed: 62.11%

7. What is the date range of your data?

Start

mm/yyyy

10 / 2021

End

mm/yyyy

09 / 2022

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

no change

10. What are you doing to continually make progress towards your goal?

At this time we are monitoring the increase/decrease and reporting trend of data for this SPA period to determine the best course of action for the next SPA period.

11. Anything else you'd like to tell us about this goal?

NA

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

You can edit the suggested objective to match what's in your CHIP State Plan.

Increase Medicaid Enrollment

1. Briefly describe your goal as it relates to this objective.

For example: In an effort to increase the use of preventive care in rural communities, our goal is to increase the number of rural children who receive one or more well child visits by 5% annually until relative utilization is equivalent to all other CHIP populations within the state.

a. Increase the number of SoonerCare enrolled Oklahoma children by 2% within 5 years beginning 10/1/18, under 19 years of age, under 186% FPL, converted to the MAGI-equivalent percent of FPL and applicable disregards.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of rural children who received one or more well child visits in the last federal fiscal year.

a. Increase in number of children enrolled in SoonerCare at the baseline date (10/01/18) through (09/30/2022)

4. Numerator (total number)

123401

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of rural children enrolled in CHIP.

a. Total number of children enrolled in SoonerCare at baseline date (10/2018).

6. Denominator (total number)

520151

Computed: 23.72%

7. What is the date range of your data?

Start

mm/yyyy

10 / 2021

End

mm/yyyy

09 / 2022

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

Numerator is a plus 32,588

10. What are you doing to continually make progress towards your goal?

At this time, we are monitoring the increase/decrease and reporting trend of data for this SPA period to determine the best course of action for the next SPA period.

11. Anything else you'd like to tell us about this goal?

NA

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal as it relates to this objective.

For example: In an effort to increase the use of preventive care in rural communities, our goal is to increase the number of rural children who receive one or more well child visits by 5% annually until relative utilization is equivalent to all other CHIP populations within the state.

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

2. What type of goal is it?

- ( ) New goal
- (•) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of rural children who received one or more well child visits in the last federal fiscal year.

b. Increase/Decrease in the unduplicated number of pregnant women enrolled in SoonerCare at the baseline date (10/01/18) through (09/30/2022)

4. Numerator (total number)

7402

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of rural children enrolled in CHIP.

b. The unduplicated number of pregnant women enrolled in SoonerCare at baseline (10/2018).

6. Denominator (total number)

22885

Computed: 32.34%

7. What is the date range of your data?

Start

mm/yyyy

10 / 2021

End

mm/yyyy

09 / 2022

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

Dominator remain the same this year

10. What are you doing to continually make progress towards your goal?

At this time, we are monitoring the increase/decrease and reporting trend of data for this SPA period to determine the best course of action for the next SPA period.

11. Anything else you'd like to tell us about this goal?

NA

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

Improving access to care

1. Briefly describe your goal as it relates to this objective.

a. Maintain the capacity of contracted SoonerCare primary care providers over a 2 year period beginning 10/01/18.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

a. Increase/Decrease in SoonerCare primary care provider capacity between 10/1/2018 and 9/30/2022

4. Numerator (total number)

346405

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

a. SoonerCare Primary Care Provider Capacity at the baseline (10/31/2018)

6. Denominator (total number)

1247538

Computed: 27.77%

7. What is the date range of your data?

Start

mm/yyyy

10 / 2021

End

mm/yyyy

09 / 2022

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

Numerator is a plus 151333

10. What are you doing to continually make progress towards your goal?

At this time we are monitoring the increase/decrease and reporting trend of data for this SPA period to determine the best course of action for the next SPA period.

11. Anything else you'd like to tell us about this goal?

NA

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal as it relates to this objective.

b. Maintain the capacity of contracted Insure Oklahoma primary care providers over a 2 year period beginning 10/01/18.

2. What type of goal is it?

- ○ New goal
- ○ Continuing goal
- ◉ Discontinued goal

2a. Why was this goal discontinued?

Goal 2.B Maintain Capacity of Contracted Insure Oklahoma Primary Care Providers was discontinued due to members in the Individual Plan portion of Insure Oklahoma being moved into Medicaid Expansion effective July 2021.

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

b. Increase/Decrease in Insure Oklahoma primary care provider capacity between 10/1/2018 and 9/30/2021

4. Numerator (total number)

0

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

b. Insure Oklahoma Primary Care Provider Capacity at the baseline (10/31/2018)

6. Denominator (total number)

459542

Computed: 0%

7. What is the date range of your data?

Start

mm/yyyy

10 / 2021

End

mm/yyyy

09 / 2022

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

no change

10. What are you doing to continually make progress towards your goal?

At this time we are monitoring the increase/decrease and reporting trend of data for this SPA period to determine the best course of action for the next SPA period.

11. Anything else you'd like to tell us about this goal?

NA

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal as it relates to this objective.

c. Increase the percentage of SoonerCare children, under 19 years of age, under 186% FPL, convert to the MAGI -equivalent percent of FPL and applicable disregards, who have selected a contracted SoonerCare primary care provider by 2% within 5 years beginning 10/1/18.

2. What type of goal is it?

- ( ) New goal
- (•) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

c. Increase/Decrease in SoonerCare Choice Children 10/1/2018 and 09/30/20212

4. Numerator (total number)

76550

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

c. Choice Children Enrollment data at the baseline (10/31/2018)

6. Denominator (total number)

442880

Computed: 17.28%

7. What is the date range of your data?

Start

mm/yyyy

10 / 2021

End

mm/yyyy

09 / 2022

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ○ Survey data
- ◉ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

Numerator no change Dominator no change

10. What are you doing to continually make progress towards your goal?

At this time we are monitoring the increase/decrease and reporting trend of data for this SPA period to determine the best course of action for the next SPA period.

11. Anything else you'd like to tell us about this goal?

NA

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

Increasing the use the use of preventative care

1. Briefly describe your goal as it relates to this objective.

a. Increase the percentage of SoonerCare well baby/child visits by age of birth through 18 years, by 2% within 5 years beginning 10/01/18.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

a. OHCA quality measures are calculated on a calendar year. Data reported for the Reporting Year 2019 (CY2018 data) will be used as a baseline for future comparisons. Well child visits data is broken down into age categories: • First 15 months • 3-6 years old • Adolescent

4. Numerator (total number)

0

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

a. No denominator includes CHIP XXI and Medicaid XIX

6. Denominator (total number)

Computed:

7. What is the date range of your data?

Start

mm/yyyy

10 / 2021

End

mm/yyyy

09 / 2022

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ○ Survey data
- ◉ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

no change

10. What are you doing to continually make progress towards your goal?

At this time, we are monitoring the increase/decrease and reporting trend of data for this SPA period to determine the best course of action for the next SPA period.

11. Anything else you'd like to tell us about this goal?

NA

12. Do you have any supporting documentation?
Optional

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Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal as it relates to this objective.

b. Participate with the state of Oklahoma to increase the immunization rates of all children, under 19 years of age, under 186% FPL, converted to the MAGI-equivalent percent of FPL and applicable disregards, by 2% within 5 years beginning 10/01/18.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

No numerator (CDC Combined 7 Vaccine Series Trend Report)

4. Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

No denominator includes CHIP XXI and Medicaid XIX

6. Denominator (total number)

Computed:

7. What is the date range of your data?

Start

mm/yyyy

10 / 2021

End

mm/yyyy

09 / 2022

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ○ Survey data
- ◉ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

no change

10. What are you doing to continually make progress towards your goal?

At this time, we are monitoring the increase/decrease and reporting trend of data for this SPA period to determine the best course of action for the next SPA period.

11. Anything else you'd like to tell us about this goal?

NA

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal as it relates to this objective.

c. Increase the number of SoonerCare pregnant women who sought prenatal care in the first trimester, by 2% within 5 years beginning 10/01/18.

2. What type of goal is it?

- ( ) New goal
- (•) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

c. No numerator (Trimester Breakdown SFY report that uses prenatal care claims.)

4. Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

c. No denominator includes CHIP XXI and Medicaid XIX

6. Denominator (total number)

Computed:

7. What is the date range of your data?

Start

mm/yyyy

10 / 2021

End

mm/yyyy

09 / 2022

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ○ Survey data
- ◉ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

No Change

10. What are you doing to continually make progress towards your goal?

At this time, we are monitoring the increase/decrease and reporting trend of data for this SPA period to determine the best course of action for the next SPA period.

11. Anything else you'd like to tell us about this goal?

a. OHCA quality measures are calculated on a calendar year. Data reported for the Reporting Year 2021 (CY2020 data) will be used as a baseline for future comparisons. Well-Child Visits data is broken down into age categories as follows: CY 21 OHCA Quality Measures Well-Child Visits (CY2020 data): Child Health Checkups in first 15 months (6 or more visits) = 59.4% Child Health Checkups 3-11 yrs (1 or more visits) = 40.7% Child Health Checkups adolescent (1 or more visits) = 29.8% OHCA Source "2022 - Quality of Care in the SoonerCare Program Report - Quality Measures (2021)": https://oklahoma.gov/ohca/research/data-and-reports.html b. For FFY2021, the rate reported refers to vaccination series 4:3:1:3:3:1:4 (Combined 7 vaccine series) which includes 4 doses of the DTP vaccine, 3 or more doses of the polio vaccine, 1 dose of MMR, 3 or more doses of Hib 3 or more doses of Hepatitis B vaccines, 1 dose of the varicella vaccine and 4 doses of PCV vaccine. The Oklahoma rate for CY2018 is 62.7% for age 24 Months and 69.1% for age 35 Months. This is the latest year available on CDC website when the site was accessed in Nov 2022. CDC Source: https://www.cdc.gov/vaccines/imz-managers/coverage/childvaxview/interactive-reports/index.html c. Number of deliveries with prenatal care beginning in the 1st trimester for SFY2021 was 16,781 (61.33%). The baseline year SFY2019 had 17,387 (61.95%).

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

Do you have another objective in your State Plan?

Optional

Part 2: Additional questions

1. Do you have other strategies for measuring and reporting on your performance goals? What are these strategies, and what information have you found through this research?

NA

2. Do you plan to add new strategies for measuring and reporting on your goals and objectives? What do you plan to do, and when will these data become available?

NA

3. Have you conducted any focused studies on your CHIP population? (For example: studies on adolescents, attention deficit disorder, substance use, behavioral health services access, health care equity, special health care needs, or other emerging health care needs.) What have you discovered through this research?

NA

4. Optional: Attach any additional documents here.
For example: studies, analyses, or any other documents that address your performance goals.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

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Tell us how much you spent on your CHIP program in FFY 2022, and how much you anticipate spending in FFY 2023 and 2024.

Part 1: Benefit Costs

Combine your costs for both Medicaid Expansion CHIP and Separate CHIP programs into one budget.

1. How much did you spend on Managed Care in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 269,018,245	**$** 276,012,720	**$** 282,085,000

2. How much did you spend on Fee for Service in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 29,112,655	**$** 30,365,009	**$** 31,033,039

3. How much did you spend on anything else related to benefit costs in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 0	**$** 0	**$** 0

4. How much did you receive in cost sharing from beneficiaries to offset your costs in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 0	**$** 0	**$** 0

Table 1: Benefits Costs
This table is auto-populated with the data you entered above.

	FFY 2022	FFY 2023	FFY 2024
Managed Care	269018245	276012720	282085000
Fee for Service	29112655	30365009	31033039
Other benefit costs	0	0	0
Cost sharing payments from beneficiaries	0	0	0
Total benefit costs	298130900	306377729	313118039

Part 2: Administrative Costs

1. How much did you spend on personnel in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?
This includes wages, salaries, and other employee costs.

2022	2023	2024
$ 2,837,568	**$** 2,916,060	**$** 2,980,213

2. How much did you spend on general administration in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 11,464,991	**$** 11,782,133	**$** 12,041,340

3. How much did you spend on contractors and brokers, such as enrollment contractors in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 0	**$** 0	**$** 0

4. How much did you spend on claims processing in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 0	**$** 0	**$** 0

5. How much did you spend on outreach and marketing in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 0	**$** 0	**$** 0

6. How much did you spend on your Health Services Initiatives (HSI) if you had any in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 1,250,257	**$** 2,218,232	**$** 2,218,232

7. How much did you spend on anything else related to administrative costs in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 2,006,200	**$** 2,061,695	**$** 2,107,052

Table 2: Administrative Costs
This table is auto-populated with the data you entered above.
Your total administrative costs cannot be more than 10% of your total CHIP program costs (the sum of your benefit and administrative costs). The 10% administrative cap is calculated by dividing the total benefit costs by 9.

	FFY 2022	FFY 2023	FFY 2024
Personnel	2837568	2916060	2980213
General administration	11464991	11782133	12041340
Contractors and brokers	0	0	0
Claims processing	0	0	0
Outreach and marketing	0	0	0
Health Services Initiatives (HSI)	1250257	2218232	2218232
Other administrative costs	2006200	2061695	2107052
Total administrative costs	17559016	18978120	19346837
10% administrative cap	33125655.56	34041969.89	34790893.22

Table 3: Federal and State Shares

CHIP is funded by federal and state budgets. The federal share of funding is calculated by multiplying your state's Federal Medical Assistance Percentage (eFMAP) by your total program costs (the sum of your benefit and administrative costs). The remaining amount of your total program costs is covered by your state share of funding.

This table is auto-calculated using the data you entered above. The federal and state shares for FFY 2022 will be calculated once the eFMAP rate for 2022 becomes available. In the meantime, these values will be blank.

	FFY 2022	**FFY 2023**	**FFY 2024**
Total program costs	315689916	325355849	332464876
eFMAP	77.82	77.15	77.82
Federal share	245669892.63	251012037.5	258724166.5
State share	70020023.37	74343811.5	73740709.5

8. What were your state funding sources in FFY 2022?
Select all that apply.

- [x] State appropriations
- [ ] County/local funds
- [ ] Employer contributions
- [ ] Foundation grants
- [x] Private donations
- [x] Tobacco settlement
- [ ] Other

9. Did you experience a shortfall in federal CHIP funds this year?

- ( ) Yes
- (•) No

Part 3: Managed Care Costs

Complete this section only if you have a managed care delivery system.

1. How many children were eligible for managed care in FFY 2022? How many do you anticipate will be eligible in FFY 2023 and 2024?

2022	2023	2024
$ 222,935	**$** 227,399	**$** 231,952

2. What was your per member per month (PMPM) cost based on the number of children eligible for managed care in FFY 2022? What is your projected PMPM cost for FFY 2023 and 2024?
Round to the nearest whole number.

2022	2023	2024
$ 196	**$** 200	**$** 202

	FFY 2022	FFY 2023	FFY 2024
PMPM cost	196	200	202

Part 4: Fee for Service Costs

Complete this section only if you have a fee for service delivery system.

1. How many children were eligible for fee for service in FFY 2022? How many do you anticipate will be eligible in FFY 2023 and 2024?

2022	2023	2024
$ 13,256	**$** 13,486	**$** 13,720

2. What was your per member per month (PMPM) cost based on the number of children eligible for fee for service in FFY 2022? What is your projected PMPM cost for FFY 2023 and 2024?
Round to the nearest whole number.

2022	2023	2024
$ 250	**$** 256	**$** 258

	FFY 2022	**FFY 2023**	**FFY 2024**
PMPM cost	250	256	258

1. Is there anything else you'd like to add about your program finances that wasn't already covered?

Assume additional FFCRA eFMAP 4.34% for CHIP will be extended thru end of FFY 2023.

2. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
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1. How has your state's political and fiscal environment affected your ability to provide healthcare to low-income children and families?

The State's ability to provide CHIP healthcare services to low-income children and families was not affected by the State's political and fiscal environment within federal fiscal year (FFY) 2022. State continues to see an increased enrollment in the expansion adult group since the State expanded on July 1, 2021. As of September 30, 2022 there were 335,174 new members enrolled under the new eligibility group; an increase of 149,725 members compared to September of 2021

2. What's the greatest challenge your CHIP program has faced in FFY 2022?

The COVID-19 global pandemic, from the declaration of the public health emergency on March 13, 2020 to present day, continues to impact the CHIP program. The State has received CMS-approval of 12 Title XIX Medicaid disaster relief state plan amendments (DRSPAs) and one Title XXI CHIP DRSPA. Of the 12 Title XIX DRSPAs, six helped to mitigate COVID-19 impacts to the Title XIX Medicaid and TXXI CHIP programs.

3. What are some of the greatest accomplishments your CHIP program has experienced in FFY 2022?

OHCA received CMS approval for the State Plan Amendment submitted in FFY 2020 that aligns the CHIP program with the Section 5022 of the SUPPORT Act of 2018. The state plan amendment updated coverage of mental health services, including behavioral health treatment, necessary to prevent, diagnose, and treat a broad range of mental health symptoms and disorders, including substance-use disorders, for eligible children and eligible pregnant women.

4. What changes have you made to your CHIP program in FFY 2022 or plan to make in FFY 2023? Why have you decided to make these changes?

No changes were made to the CHIP program during FFY 2022. The State continues to implement the CHIP COVID-19 disaster-relief state plan amendment approved June 4, 2020, by offering continuous eligibility to CHIP members. Further, the State has delayed acting on certain changes in circumstances for CHIP beneficiaries whom the state determines are impacted by COVID-19, such that processing the change in a timely manner is not feasible. For FFY 2023, the State is exploring two health service initiative (HSI) options for CHIP members: 1. The first HSI for consideration is aimed at increasing access to child and adolescent psychiatry expertise state-wide to decrease in psychotropic use in young children with Medicaid and reduce unnecessary psychiatric hospitalizations. Currently Oklahoma is categorized as a "severe shortage area in the nation" for child and adolescent psychiatrists with an average of 7 child and adolescent psychiatrists per 100,000 children. This program will provide consultation, medication review and education to PCPs statewide and thus better equip them to serve their patients with mental health needs. Existing programs have data that show: • PCPs report more knowledge and confidence in providing mental health care. • Children residing in states with statewide CPAPs were more likely to receive mental health services than children in states without a CPAP. • A decrease in psychotropic use in young children with Medicaid • A reduction in unnecessary psychiatric hospitalizations. 2. The second HSI is to reimburse primary care physicians for the application of fluoride varnish as well as provide dental hygiene education to youth. Currently, less than 45% of children under age five years receive any dental preventive care from any provider type, and often this preventive care is provided once the child has extensive dental decay, as parents may not bring a child to the dentist until there is a problem. Only 13% of children under five years of age receive fluoride varnish from any provider, dentist or non-dentist. Children in this age group are more likely to see a PCP than a dentist. This is especially true in Oklahoma, where there is severe shortage of pediatric dentists. Unfortunately, only 7% of SoonerCare contracted non-dentist providers are applying fluoride varnish, and fewer than 4% of children in this age group enrolled in SoonerCare are receiving this care from their PCPs. Fluoride Varnish is highly effective and has a high margin of safety in children under the age of six years. It has been shown to reduce dental caries by 30-35% when applied twice a year. It is the standard of care. The United States Preventive Services Task Force (USPSTF) recommends that

the PCP apply fluoride varnish to the teeth of all infants and children, starting with the appearance of the first primary tooth, at least every 6 months through five years of age. For this project the State is planning to implement a program called Brush, Book, Bed, an American Academy of Pediatrics (AAP) initiative, which incorporates oral health and bedtime routines with ROR. Providers start at the 12 months visit with a book centered around oral health, a toothbrush, and toothpaste. This prompts the provider to discuss oral health and provide fluoride varnish. Results from the AAP pilot showed a 20% increase in pediatricians talking about oral health, a 40% increase in fluoride varnish applications, and a 10% increase in parents reporting that they brush their children's teeth. Reach Out and Read (ROR) is a well-established model. In Oklahoma, the State has successfully utilized a HSI linking ROR with developmental screening. This project has been effective with Medicaid billing data showing higher rates of both well child visits and developmental screening rates in ROR clinics. Our finding was published in Journal of Investigative Medicine in 2021.

5. Is there anything else you'd like to add about your state's challenges and accomplishments?

NA

6. Optional: Attach any additional documents here.

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