Table of Contents

State/Territory Name: Oklahoma

State Plan Amendment (SPA) #: 23-0007

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS Form 179
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

September 14, 2023

Traylor Rains
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

Re: Oklahoma State Plan Amendment (SPA) 23-0007

Dear Mr. Rains:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 23-0007. This amendment updates the State's Alternative Benefit Plan (ABP) to add managed care organizations (MCO) and prepaid ambulatory health plans (PAHP) for expansion adults.

We conducted our review of your submittal according to statutory requirements in Title XIX Section 1937 of the Social Security Act, and CFR Part 440, Subpart C. This letter is to inform you that Oklahoma Medicaid SPA 23-0007 was approved on September 14, 2023, with an effective date of February 1, 2024.

If you have any questions, please contact Stacey Steiner at (469) 904-1068 or via email at Stacey.Steiner@cms.hhs.gov .

Sincerely,

[redacted]

James G. Scott, Director
Division of Program Operations

Enclosures

cc: Sandra Puebla
Kasie McCarty
Heather Cox

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name: **Oklahoma**

Transmittal Number:

Enter the Transmittal Number (TN), including dashes, in the format SS-YY-NNNN or SS-YY-NNNN-xxxx (with xxxx being optional to specific SPA types), where SS = 2-character state abbreviation, YY = last 2 digits of submission year, NNNN = 4-digit number with leading zeros, and xxxx = OPTIONAL, 1- to 4-character alpha/numeric suffix.

OK-23-0007

Proposed Effective Date

02/01/2024 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

Section 1937 of the Social Security Act; 42 CFR Part 440, Subpart C

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2024	$ 0.00
Second Year	2025	$ 0.00

Subject of Amendment

ABP update to add managed care organizations (MCOs) and prepaid ambulatory health plans (PAHP) for expansion adults receiving services via the alternative benefit plan (ABP).

Governor's Office Review

- ○ **Governor's office reported no comment**
- ○ **Comments of Governor's office received**

  Describe:

- ○ **No reply received within 45 days of submittal**
- ◉ **Other, as specified**

  Describe:

  The Governor's office does not review State Plan amendments.

Signature of State Agency Official

Submitted By:	**Kasie McCarty**
Last Revision Date:	**Sep 13, 2023**
Submit Date:	**Jun 30, 2023**

Alternative Benefit Plan

State Name: Oklahoma Attachment 3.1-L- OMB Control Number: 09381148

Transmittal Number: OK - 21 - 0002

Alternative Benefit Plan Populations — ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name: Adult Expansion Alternative Benefit Plan (ABP)

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

Add	Eligibility Group:	Enrollment is mandatory or voluntary?	Remove
Add	Adult Group	Mandatory	Remove

Enrollment is available for all individuals in these eligibility group(s). Yes

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory. Yes

Any other information the state/territory wishes to provide about the population (optional)

PRA Disclosure Statement

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. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20181119

Alternative Benefit Plan

State Name: Oklahoma Attachment 3.1-L- OMB Control Number: 09381148

Transmittal Number: OK - 21 - 0002

Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act	**ABP2a**
The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan.	Yes

Explain how the state has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements.

The benefits offered within Oklahoma's Alternative Benefit Plan are equal to or greater than the benefits offered via the approved Oklahoma Medicaid State Plan; therefore and per CMS guidance, the benefit packages are considered to be in alignment. For this eligibility group, the state will cover additional habilitative and comprehensive preventive services as described in ABP5.

PRA Disclosure Statement

V.20160722

Alternative Benefit Plan

State Name: Oklahoma Attachment 3.1-L- OMB Control Number: 0938-1148

Transmittal Number: OK - 21 - 0002

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package ABP3.1

Select one of the following:

- ○ The state/territory is amending one existing benefit package for the population defined in Section 1.
- ◉ The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package: Adult Expansion Alternative Benefit Plan (ABP)

Selection of EHB-Benchmark Plan

P SEP The state/territory must select an EHB-benchmark plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

EHB-benchmark plan name: BCBS of Oklahoma/Blue Options Gold 002 plan

The EHB-benchmark plan is the same as the Section 1937 Coverage option: No

Indicate the EHB-benchmark option as described at 45 CFR 156.111(b)(2)(B) the state/territory will use as its EHB-benchmark plan:

State/Territory is selecting one of the below options to design an EHB package that complies with the requirements for the individual insurance market under 45 CFR 156.100 through 156.125.

- ◉ State/Territory is selecting the EHB-benchmark plan used by the state/territory for the 2017 plan year.
- ○ State/Territory is selecting one of the EHB-benchmark plans used for the 2017 plan year by another state/territory.
- ○ State/ Territory selects the following EHB-benchmark plan used for the 2017 plan year but will replace coverage of one or more of the categories of EHB with coverage of the same category from the 2017 EHB-benchmark plan of one or more other states
- ○ Select a set of benefits consistent with the 10 EHB categories to become the new EHB-benchmark plan. (Complete and submit the ABP5: Benefits Description form to describe the set of benefits.)

Type of EHB-benchmark plan:

- ◉ Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- ○ Any of the largest three state employee health benefit plans by enrollment.
- ○ Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- ○ Largest insured commercial non-Medicaid HMO.

Alternative Benefit Plan

Assurances

☑ The state/territory assures the EHB plan meets the scope of benefits standards at 45 CFR 156.111(b), does not exceed generosity of most generous among a set of comparison plans, provides appropriate balance of coverage among 10 EHB categories, and the scope of benefits is equal to, or greater than, the scope of benefits provided under a typical employer plan as defined at 45 CFR 156.111(b)(2).

☑ The state/territory assures that all services in the EHB-benchmark plan have been accounted for throughout the benefit chart found in ABP 5.

☑ The state/territory assures the accuracy of all information in ABP5 depicting amount, duration and scope parameters of services authorized in the currently approved Medicaid State Plan.

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

◉ Benchmark Benefit Package.

○ Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

○ The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).

○ State employee coverage that is offered and generally available to state employees (State Employee Coverage):

○ A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):

◉ Secretary-Approved Coverage.

◉ The state/territory offers benefits based on the approved state plan.

○ The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.

◉ The state/territory offers the benefits provided in the approved state plan.

○ Benefits include all those provided in the approved state plan plus additional benefits.

○ Benefits are the same as provided in the approved state plan but in a different amount, duration and/or scope.

○ The state/territory offers only a partial list of benefits provided in the approved state plan.

○ The state/territory offers a partial list of benefits provided in the approved state plan plus additional benefits.

Please briefly identify the benefits, the source of benefits and any limitations:

Please refer to ABP 5 for description of services

Other Information Related to Selection of the Section 1937 Coverage Option and the EHB-Benchmark Plan (optional):

The Alternative Benefit Plan will include the same services that are traditionally available in through the State's approved State Plan. In addition, the ABP will offer habilitative services as defined in ABP5

PRA Disclosure Statement

Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) for the purpose of standardizing data. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. 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 0938-1188. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20190813

Alternative Benefit Plan

State Name: Oklahoma Attachment 3.1-L- [ ] OMB Control Number: 09381148

Transmittal Number: OK - 21 - 0002

Alternative Benefit Plan Cost-Sharing	ABP4

☑ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A. No

Other Information Related to Cost Sharing Requirements (optional):

PRA Disclosure Statement

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. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722

Alternative Benefit Plan

State Name: Oklahoma

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: OK - 22 - 0004

Benefits Description ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Blue Cross Blue Shield of Oklahoma/Blue Options Gold 002 plan

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary-approved

Alternative Benefit Plan

■ 1. Essential Health Benefit: Ambulatory patient services Collapse All ☐

Benefit Provided: Primary Care Visits to Treat Injury or Illness
Source: State Plan 1905(a)
Remove

Authorization: Authorization required in excess of limitation
Provider Qualifications: Medicaid State Plan

Amount Limit: 4 visits/month
Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-A, section 5.
Amount limits can be exceeded based on medical necessity.

Benefit Provided: Specialty Visits
Source: State Plan 1905(a)
Remove

Authorization: Authorization required in excess of limitation
Provider Qualifications: Medicaid State Plan

Amount Limit: 4 visits/month
Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-A, section 5.
Amount limits can be exceeded based on medical necessity.

Benefit Provided: Other Practitioner Office Visits
Source: State Plan 1905(a)
Remove

Authorization: Authorization required in excess of limitation
Provider Qualifications: Medicaid State Plan

Amount Limit: 4 visits/month for PA and APRN visits
Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-A, section 6.d.

Amount limits can be exceeded based on medical necessity.

Benefit Provided: Outpatient Facility (ambulatory surgery ctr)
Source: State Plan 1905(a)
Remove

Authorization: No
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-A, section 2.a.

Benefit Provided: Dialysis
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-A, section 2.a.

Benefit Provided: Allergy Testing
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: 60 tests/3 years
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 5
Reference approved State Plan, Attachment 3.1-A, section 6.d.
Amount limits can be exceeded based on medical necessity.

Remove

Benefit Provided: Chemotherapy

Source: State Plan 1905(a)

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 2.a.

Remove

Benefit Provided: Radiation

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 2.a.

Remove

Benefit Provided: Outpatient Surgery Physician/Surgical Services

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 2.a.

Benefit Provided:

Hospice

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

See “other information" box

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Hospice care in accordance with section 1905(o) of the Social Security Act

Hospice services are provided as a comprehensive, holistic program of palliative and/or comfort care and support for terminally ill members and his/her families when a physician certifies that the member has a terminal illness and has a life expectancy of six months or less. The hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional, and spiritual stresses which are experienced during the final stages of illness and death. Hospice services must be related to the palliation and management of the member's illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills.

Hospice services are performed under the direction of the physician as per the member’s plan of care and in an approved hospital hospice facility, in-home hospice program, or nursing facility. A participating hospice provider must meet Medicare’s conditions of participation for hospices and have a valid provider agreement with the State Medicaid Agency.

A. Election periods
Hospice care is initially available for two 90-day certification periods then for an unlimited number of 60-day certification periods during the remainder of the member's lifetime.

Prior authorization
Each certification period requires a new prior authorization.

B. Election statement
The form must be completed, dated, and signed by the member or legal representative. The election of benefits stays in effect as long as the participant remains in hospice, does not revoke the election, and is not discharged from hospice for other reasons. Reasons for discharge may include: the participant is no longer considered terminally ill, the participant transfers to another hospice, the participant moves out of the hospice service area, or the participant is not receiving the required or expected care from the hospice provider.

The election statement waives a member's right to other Medicaid benefits, except for care not related to the terminal illness and care provided by the attending physician.

Expansion adults under age 21 who elect hospice care will receive it concurrently with curative care for the terminal condition/illness, in accordance with section 2302 of the Affordable Care Act.

An individual or representative may revoke the election of hospice care at any time. Upon revoking the election of Medicaid coverage of hospice care for a particular election period, an individual resumes Medicaid coverage of the benefits waived when hospice care was elected. An individual may at any time elect to receive hospice coverage for any other hospice election periods for which he or she is eligible.

C. Requirements for coverage for each certification period

Certification of terminal illness
Certification of terminal illness is and includes a medical prognosis with a life expectancy of 6 months or less if the illness runs its normal course. The certificate of terminal illness is completed by the member's attending physician or the medical director of an interdisciplinary group and is supported by clinical information and other documentation in the medical record. The nurse practitioners serving as the attending physician may not certify the terminal illness.

Plan of care
A plan of care developed by the hospice interdisciplinary team must be established before services are provided. To be covered, services must be consistent with the plan of care. The plan of care should be submitted with the prior authorization request.

Re-evaluation for continuation for services
Re-evaluation by physician or nurse practitioner is required for continuation of services for each subsequent 90-day and/or 60-day certification periods. The hospice physician or nurse practitioner must have a face-to-face encounter with the member to determine if the member's terminal illness necessitates continuing hospice care services. The encounter must take place prior to the 180th day recertification and each subsequent recertification thereafter.

D. Covered Services
Hospice care includes nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide services; personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. Services must be prior authorized. Bereavement counseling services are required but are not reimbursable.

Levels of Care

1. Routine hospice care
Member is at home and is not receiving continuous care

2. Continuous Home Care
Member is not in an inpatient facility and receives hospice on a continuous basis at home (consists primarily of nursing care to achieve palliation and management of acute medical symptoms during a brief period of crisis only as necessary to maintain the terminally ill patient at home.) If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine hospice care.

3. Inpatient respite care

Member receives care in an approved facility on a short-term basis for respite. Inpatient respite care is not provided to individuals residing in a nursing home."

4. General inpatient care
Member receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management that cannot be managed at home. In this situation, at home can mean a member's personal home, an assisted living facility, or a nursing home.

TN-21-0018, effective 10/01/21

Benefit Provided:

Source:

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

☑ 2. Essential Health Benefit: Emergency services Collapse All ☐

Benefit Provided: Emergency Room Services
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-A, section 2.a.

Benefit Provided: Emergency Transportation/Ambulance
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-D.

Benefit Provided: Urgent Care Center
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 9.

Add

Alternative Benefit Plan

☑ 3. Essential Health Benefit: Hospitalization Collapse All ☐

Benefit Provided: Inpatient Hospital Services (Inpatient Stay)
Source: State Plan 1905(a)
Remove

Authorization: No
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-A, section 1.

Benefit Provided: Inpatient Physician & Surgical Services
Source: State Plan 1905(a)
Remove

Authorization: Authorization required in excess of limitation
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit:
Inpatient physician services: one visit per day per physician.
Inpatient surgical services: no limit.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-A, section 5.
Reference approved State Plan, Attachment 3.1-A, section 1.
Amount limits can be exceeded based on medical necessity.

Benefit Provided: Organ Transplants
Source: State Plan 1905(a)
Remove

Authorization: Authorization required in excess of limitation
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: All transplantation services, except kidney and cornea, must be prior authorized.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-E.

Benefit Provided: Reconstructive Surgery

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Non-cosmetic; breast reconstruction/implantation/removal is covered only when it is a direct result of a mastectomy which is medically necessary.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 1.

Benefit Provided:

Source:

Remove

Authorization: Other

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

☑ 4. Essential Health Benefit: Maternity and newborn care — Collapse All ☐

Benefit Provided: Prenatal & Postnatal care
Source: State Plan 1905(a)
Remove

Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 3.
Reference approved State Plan, Attachment 3.1-A, section 5.
Reference approved State Plan, Attachment 3.1-A, section 6.d.
Reference approved State Plan, Attachment 3.1-A, section 17.
Reference approved State Plan, Attachment 3.1-A, section 20 and section 21.

Benefit Provided: Delivery & Inpatient Services for Maternity Care
Source: State Plan 1905(a)
Remove

Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 1.
Reference approved State Plan, Attachment 3.1-A, section 3.
Reference approved State Plan, Attachment 3.1-A, section 5.
Reference approved State Plan, Attachment 3.1-A, section 6.d.
Reference approved State Plan, Attachment 3.1-A, section 17.
Reference approved State Plan, Attachment 3.1-A, section 20.

Benefit Provided:
Source:
Remove

Authorization: No
Provider Qualifications:
Amount Limit:
Duration Limit:

Alternative Benefit Plan

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Source:

Remove

Authorization:

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

Collapse All ☐

☑ 5. Essential Health Benefit: Mental health and substance use disorder services including behavioral health treatment

☑ The state/territory assures that it does not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

Remove

Benefit Provided: Mental/Behavioral Health Outpatient Services

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 13.d.1.
Amount limits can be exceeded based on medical necessity.

Remove

Benefit Provided: Mental/Behavioral Health Inpatient Services

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 1.
Amount limits can be exceeded based on medical necessity.

Remove

Benefit Provided: Substance Use Disorder Outpatient Services

Source: State Plan 1905(a)

Authorization: No

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 13.d.1.
Amount limits can be exceeded based on medical necessity.
Revised within TN-21-0014, effective 07/01/21

Remove

Benefit Provided:

Substance Use Disorder Inpatient Services

Source:

State Plan 1905(a)

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 13.d.5.
Revised within TN-21-0014, effective 07/01/21

Remove

Benefit Provided:

Source:

Authorization:

Other

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

■ 6. Essential Health Benefit: Prescription drugs

☑ The state/territory assures that the ABP prescription drug benefit plan is the same as under the approved Medicaid State Plan for prescribed drugs.

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
☒ Limit on days supply	No	State licensed
☒ Limit on number of prescriptions		
☒ Limit on brand drugs		
☐ Other coverage limits		
☒ Preferred drug list		

Coverage that exceeds the minimum requirements or other:

The state's ABP prescription drug benefit is the same as the approved Medicaid state plan for prescribed drugs.

Alternative Benefit Plan

■ 7. Essential Health Benefit: Rehabilitative and habilitative services and devices — Collapse All ☐

☑ The state/territory assures that it is not imposing limits on habilitative services and devices that are more stringent than limits on rehabilitative services (45 CFR 156.115(a)(5)(ii)). Further, the state/territory understands that separate coverage limits must also be established for rehabilitative and habilitative services and devices. Combined rehabilitative and habilitative limits are allowed, if these limits can be exceeded based on medical necessity.

Remove

Benefit Provided: Outpatient Rehabilitation Services

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: 15 visits/year for each OT, PT, & ST

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 2.a.
The benefit amount limits exceed the quantity limits within the base benchmark.

Remove

Benefit Provided: Home Health

Source: State Plan 1905(a)

Authorization: No

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Provided by Home Health agencies

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 7.

Remove

Benefit Provided: Durable Medical Equipment

Source: State Plan 1905(a)

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Some items may require prior authorization.
Reference approved State Plan, Attachment 3.1-A, section 12.c.
Reference approved State Plan, Attachment 3.1-A, section 7.

Remove

Benefit Provided:

Prosthetic Devices

Source:

State Plan 1905(a)

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Some items may require prior authorization.
Reference approved State Plan, Attachment 3.1-A, section 12.c.

Remove

Benefit Provided:

Orthotic Devices

Source:

State Plan 1905(a)

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Some items may require prior authorization.
Reference approved State Plan, Attachment 3.1-A, section 12.c.

Remove

Benefit Provided:

Habilitation Services

Source:

State Plan 1905(a)

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Alternative Benefit Plan

Amount Limit:
15 visits/year for each OT, PT, & ST

Duration Limit:
None

Scope Limit:
Provided only in outpatient hospitals

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-A, section 2.a.
The benefit amount limits exceed the quantity limits within the base benchmark.

Benefit Provided:
Inpatient Rehab Hospital

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
90 days per individual per State Fiscal Year (SFY)

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-A, section 1.
Amount limits can be exceeded based on medical necessity. Revised within TN-22-0004, effective 01/01/22.

Benefit Provided:

Source:

Remove

Authorization:
Authorization required in excess of limitation

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

☑ 8. Essential Health Benefit: Laboratory services Collapse All ☐

Benefit Provided: Imaging (CT/PET scans, MRIs)
Source: State Plan 1905(a)
Remove

Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-A, section 2.a.
Reference approved State Plan, Attachment 3.1-A, section 3.

Benefit Provided: Laboratory Outpatient & Professional Services
Source: State Plan 1905(a)
Remove

Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-A, section 2.a.
Reference approved State Plan, Attachment 3.1-A, section 3.

Benefit Provided: X-rays & Diagnostic Imaging
Source: State Plan 1905(a)
Remove

Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-A, section 2.a.

Alternative Benefit Plan

Reference approved State Plan, Attachment 3.1-A, section 3.

Add

Alternative Benefit Plan

■ 9. Essential Health Benefit: Preventive and wellness services and chronic disease management Collapse All ☐

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided: Diabetes Education

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: 10 hours/first year; 2 hours/subsequent year

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 6.d.
Amount limits can be exceeded based on medical necessity.

Benefit Provided: Preventive Care/Screening/Immunization

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 5.
Reference approved State Plan, Attachment 3.1-A, section 6.d.

Benefit Provided: Nutritional Services

Source: State Plan 1905(a)

Remove

Authorization: No

Provider Qualifications: Medicaid State Plan

Amount Limit: 6 hours/year

Duration Limit: None

Alternative Benefit Plan

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 6.d.
Amount limits can be exceeded based on medical necessity.

Benefit Provided:

Source:

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

☑ 10. Essential Health Benefit: Pediatric services including oral and vision care — Collapse All ☐

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-A, section 4.b.

Add

☐ 11. Other Covered Benefits from Base Benchmark Collapse All ☐

Alternative Benefit Plan

☒ 12. Base Benchmark Benefits Not Covered due to Substitution or Duplication Collapse All ☐

Base Benchmark Benefit that was Substituted: Hospice - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Hospice services are a base benchmark benefit covered within EHB 1, Ambulatory patient services. Services are for expansion adults only.
Revised within TN-21-0018, effective 10/01/21

Base Benchmark Benefit that was Substituted: Private Duty Nursing (PDN) - Substitution
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

PDN services are a base benchmark benefit substituted with skilled nursing under the home health services benefit covered under the State Plan, Attachment 3.1-A, section 7 and are within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted: Chiropractic Services - Substitution
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Chiropractic services are a base benchmark benefit substituted with rehabilitation occupational therapy, physical therapy, and speech therapy services in the outpatient hospital setting covered under the State Plan, Attachment 3.1-A, section 2.a. and are within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted: Substance Use Disorder Outpatient Services - Dup
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substance use disorder outpatient services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 13.d.1. and are within EHB 5, mental health and substance use disorder services including behavioral health treatment.

Base Benchmark Benefit that was Substituted: Substance Use Disorder Inpatient Services - Dup
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substance use disorder inpatient services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 13.d.5. and are within EHB 5, mental health and substance use disorder services including behavioral health treatment.

Base Benchmark Benefit that was Substituted: Accidental Dental - substitution
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Accidental Dental is a base benchmark benefit substituted with medically necessary extractions covered under the State Plan, Attachment 3.1-A, section 10 and are within 14, other 1937 covered benefits that are not essential health benefits.

Base Benchmark Benefit that was Substituted: Primary Care Visit to Treat Injury/Illness - Dup
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Primary care visits to treat injury or illness are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 5 and are within EHB 1, ambulatory patient services.

Base Benchmark Benefit that was Substituted: Specialist Visits - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Specialty visits are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 5 and are within EHB 1, ambulatory patient services.

Base Benchmark Benefit that was Substituted: Other Practitioner Office Visits - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Other practitioner office visits are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 6.d. and are within EHB 1, ambulatory patient services.

Base Benchmark Benefit that was Substituted: Outpatient Facility (Ambulatory Surgery Ctr) - Dup
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Outpatient facility fee (e.g., ambulatory surgery center) services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. and are within EHB 1, ambulatory patient services.

Base Benchmark Benefit that was Substituted: Outpatient Surgery Physician/Surgical - Dup
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Outpatient surgery physician/surgical services are a base benchmark benefit covered under the State Plan,

Attachment 3.1-A, Section 2.a. and are within EHB 1, ambulatory patient services.

Base Benchmark Benefit that was Substituted: Urgent Care Centers or Facilities - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Urgent care centers or facilities services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 9 and are within EHB 2, emergency services.

Base Benchmark Benefit that was Substituted: Home Health Care Services - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Home health care services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 7 and are within EHB 7, rehabilitation and habilitative services and devices.

Base Benchmark Benefit that was Substituted: Emergency Room Services - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Emergency room services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. and are within EHB 2, emergency services.

Base Benchmark Benefit that was Substituted: Emergency Transportation/Ambulance - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Emergency transportation/ambulance services are a base benchmark benefit covered under the State Plan, Attachment 3.1-D and are within EHB 2, emergency services.

Base Benchmark Benefit that was Substituted: Inpatient Hospital Services - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Inpatient hospital services (inpatient stay) are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 1 and are within EHB 3, hospitalization.

Base Benchmark Benefit that was Substituted: Inpatient Physician & Surgical Services - Dup
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Inpatient physician & surgical services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 1 & section 5 and are within EHB 3, hospitalization.

Base Benchmark Benefit that was Substituted: Inpatient Rehab - Dup

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Inpatient rehab services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 1 and are within EHB 7, rehabilitative and habilitative services and devices. Revised within TN-22-0004, effective 01/01/22.

Base Benchmark Benefit that was Substituted: Prenatal and Postnatal Care - Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Prenatal and postnatal care is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 3, section 5, section 6.d., section 17, section 20, & section 21 and is within EHB 4, maternity and newborn care.

Base Benchmark Benefit that was Substituted: Delivery & Inpatient Services for Maternity - Dup

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Delivery & all inpatient services for maternity care is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 1, section 3, section 5, section 6.d., section 17, & section 20 and is within EHB 4, maternity and newborn care.

Base Benchmark Benefit that was Substituted: Mental/Behavioral Health Outpatient Services - Dup

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Mental/behavioral health outpatient services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 13.d.1. and are within EHB 5, mental health and substance use disorder services including behavioral health treatment.

Base Benchmark Benefit that was Substituted: Mental/Behavioral Health Inpatient Services - Dup

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Mental/behavioral health inpatient services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 1. and are within EHB 5, mental health and substance use disorder services

including behavioral health treatment.

Base Benchmark Benefit that was Substituted: Habilitation Services - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Habilitation services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. and are within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted: Durable Medical Equipment - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Durable medical equipment is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 12.c. & section 7 and is within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted: Hearing Aids for Children - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Hearing aids for children are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 4.b. and are within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted: Imaging (CT/PET Scans, MRIs) - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Imaging (CT/PET Scans, MRIs) services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. & section 3 and are within EHB 8, laboratory services.

Base Benchmark Benefit that was Substituted: Preventive Care/Screening/Immunization - Dup
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Preventive care/screening/immunization services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 5 & section 6.d. and are within EHB 9, preventive and wellness services and chronic disease management.

Base Benchmark Benefit that was Substituted: Routine Eye Exam for Children - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Routine eye exams for children are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 4.b. and are within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted: Eye Glasses for Children - Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Eye glasses for children are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 4.b. and are within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted: Dental Check-Up for Children - Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Dental check-up for children are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 4.b. and are within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted: Well Baby Visits and Care - Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Well baby visits and care are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 4.b. and are within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted: Lab Outpatient & Professional Services - Dup

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Laboratory outpatient & professional services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. & section 3 and are within EHB 8, laboratory services.

Base Benchmark Benefit that was Substituted: X-rays and Diagnostic Imaging - Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

X-rays and diagnostic imaging services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. & section 3 and are within EHB 8, laboratory services.

Base Benchmark Benefit that was Substituted: Basic Dental Care – Child - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 4.b. and are within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted: Orthodontia – Child - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Basic dental care for children is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 4.b. and is within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted: Major Dental Care – Child - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Major dental care for children is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 4.b. and is within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted: Transplant - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Transplant services are a base benchmark benefit covered under the State Plan, Attachment 3.1-E and are within EHB 3, hospitalization.

Base Benchmark Benefit that was Substituted: Dialysis - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Dialysis is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. and is within EHB 1, ambulatory services.

Base Benchmark Benefit that was Substituted: Allergy Testing - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Allergy testing is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 5 & section 6.d. and is within EHB 1, ambulatory services.

Base Benchmark Benefit that was Substituted: Chemotherapy - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Chemotherapy is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. and is within EHB 1, ambulatory services.

Base Benchmark Benefit that was Substituted: Radiation - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Radiation is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. and is within EHB 1, ambulatory services.

Base Benchmark Benefit that was Substituted: Diabetes Education - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Diabetes education is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 6.d. and is within EHB 9, preventive and wellness services and chronic disease management.

Base Benchmark Benefit that was Substituted: Prosthetic Devices - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Prosthetic devices is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 12.c. and is within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted: Nutritional Counseling - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Nutritional counseling is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 6.d. and is within EHB 9, preventive and wellness services and chronic disease management.

Base Benchmark Benefit that was Substituted: Reconstructive Surgery - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Reconstructive surgery is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 1 and is within EHB 3, hospitalization.

Base Benchmark Benefit that was Substituted: Rehabilitation Speech Therapy - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Rehabilitation speech therapy services are a base benchmark benefit duplicated with outpatient rehabilitation services covered under the State Plan, Attachment 3.1-A, section 2.a. and are within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted: Rehab Occupational & Physical Therapy - Dup
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Rehabilitation occupational and physical therapy services are a base benchmark benefit duplicated with outpatient rehabilitation services covered under the State Plan, Attachment 3.1-A, section 2.a. and are within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted: Outpatient Rehabilitation Services - Dup
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Outpatient rehabilitation services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. and are within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted: Orthotic Devices - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Orthotic devices is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 12.c. and is within EHB 7, rehabilitative and habilitative services and devices.

Add

Alternative Benefit Plan

☒ 13. Other Base Benchmark Benefits Not Covered Collapse All ☐

Base Benchmark Benefit not Included in the Alternative Benefit Plan: Orthodontia - Adult

Source: Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit: It is not a mandatory benefit

Add

☒ 14. Other 1937 Covered Benefits that are not Essential Health Benefits Collapse All ☐

Other 1937 Benefit Provided: Nursing facility services
Source: Section 1937 Coverage Option Benchmark Benefit Package
Remove
Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other: Reference approved State Plan, Attachment 3.1-A, section 4.a.
Revised within TN-21-0014, effective 07/01/21.

Other 1937 Benefit Provided: Medically Necessary Extractions - Adult
Source: Section 1937 Coverage Option Benchmark Benefit Package
Remove
Authorization: No
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other: Reference approved State Plan, Attachment 3.1-A, section 10.

Other 1937 Benefit Provided: Family planning
Source: Section 1937 Coverage Option Benchmark Benefit Package
Remove
Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: See below
Duration Limit: None
Scope Limit: None
Other: Reference approved State Plan, Attachment 3.1-A, section 4.c.

Other 1937 Benefit Provided:
Bariatric Surgery

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Bariatric surgery is not covered for the treatment of obesity alone.

Other:
Reference approved State Plan, Attachment 3.1-A, section 1.
Reference approved State Plan, Attachment 3.1-A, section 5.

Other 1937 Benefit Provided:
Non-emergency transportation

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:

Other:
Reference approved State Plan, Attachment 3.1-A, section 24a.
Reference approved State Plan, Attachment 3.1-D .

Other 1937 Benefit Provided:
Podiatric services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
4 office visits/month

Duration Limit:
None

Scope Limit:
None

Other:
Reference approved State Plan, Attachment 3.1-A, section 6.a.

Other 1937 Benefit Provided:
Eye care to treat a medical or surgical condition

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Authorization required in excess of limitation

Provider Qualifications:
Medicaid State Plan

Amount Limit:
4 office visits/month

Duration Limit:
None

Scope Limit:
Services are to treat to treat a medical or surgical condition only.

Other:
Reference approved State Plan, Attachment 3.1-A, section 6.b.

Other 1937 Benefit Provided:
Meals and Lodging

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Authorization required in excess of limitation

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Payment for lodging and/or meals assistance for an eligible member and an approved medical escort, if needed, is provided only when medically necessary in connection with transportation to and from SoonerCare compensable services.

Other:
Reference approved State Plan, Attachment 4.19-B, transportation, section C, meals and lodging.

Other 1937 Benefit Provided:
Personal Care Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Reference approved State Plan, Attachment 3.1-A, section 24.f.

Other 1937 Benefit Provided:
Medication-Assisted Treatment Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Reference approved State Plan, Attachment 3.1-A, section 29.
Revised within TN-21-0014, effective 07/01/21

Other 1937 Benefit Provided:
Infusion Therapy

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Reference approved State Plan, Attachment 3.1-A, section 2.a. and section 5.
Revised within TN-21-0014, effective 07/01/21

Other 1937 Benefit Provided:
Diagnostic Dental - Adult

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Reference approved State Plan, Attachment 3.1-A, section 10.
Revised within TN-21-0014, effective 07/01/21

Other 1937 Benefit Provided:
Preventive Dental - Adult

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Reference approved State Plan, Attachment 3.1-A, section 10.
Revised within TN-21-0014, effective 07/01/21

Other 1937 Benefit Provided:
Restorative Dental - Adult

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Reference approved State Plan, Attachment 3.1-A, section 10.
Revised within TN-21-0014, effective 07/01/21

Other 1937 Benefit Provided:
Non-surgical Periodontal Therapy - Adult

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Reference approved State Plan, Attachment 3.1-A, section 10.
Revised within TN-21-0014, effective 07/01/21

Other 1937 Benefit Provided:
Removable Prosthetics Dental - Adult

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Reference approved State Plan, Attachment 3.1-A, section 10.
Revised within TN-21-0014, effective 07/01/21

Other 1937 Benefit Provided:
PCCM/PCMH Service Delivery Model

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
The Primary Care Case Management (PCCM)/ Patient Centered providers Medical Home (PCMH) is a service delivery model in which the State contracts directly with primary care providers (PCPs) throughout the state to provide basic health care services. The PCCM is a managed care service delivery system and follows managed care rules. As part of the SoonerCare Choice coordinated care delivery service system, eligible members select a PCMH for primary care and care coordination. Providers are eligible to receive a per month (PMPM) care coordination payment for each enrolled beneficiary, based upon the services provided at the medical home.

American Indian/Alaskan Native (AI/AN) individuals eligible as Expansion Adult members who do not opt-in to the SoonerSelect managed care program may elect to enroll the in the PCCM with a SoonerCare Choice provider, or an Indian Health Services (IHS), tribal, or urban Indian (I/T/U) clinic SoonerCare Choice provider as their primary care provider. Additionally, these members are eligible to receive Health Management Program (HMP) and Health Access Network (HAN) support based on their health status and coordinated care needs.

Eligible members are enrolled into the PCCM other than during a period of presumptive eligibility.

Revised within TN-21-0031, effective 07/01/21
Revised within TN-23-0007, effective 02/01/24

Other 1937 Benefit Provided: ICF/IID services

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other: Reference approved State Plan Section 3.1-A, section 15. Revised within TN-22-0004, effective 01/01/22.

Other 1937 Benefit Provided: Alternative Treatment for Pain Management

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: 48 units for PT; 12 visits for chiropractic

Duration Limit: None

Scope Limit: None

Other: Reference approved State Plan, Attachment 3.1-A, section 13.d.6.
Amount limits can be exceeded based on medical necessity. Revised within TN-22-0004, effective 01/01/22.

Other 1937 Benefit Provided: Routine Patient Cost in Qualifying Clinical Trials

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Alternative Benefit Plan

Authorization:
Authorization required in excess of limitation

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Reference approved State Plan, Attachment 3.1-A, section 30.
Revised within TN-22-0004, effective 01/01/22.

Other 1937 Benefit Provided:

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

Other:

Add

☐ 15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.) Collapse All ☐

PRA Disclosure Statement

Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) for the purpose of standardizing data. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. 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 0938-1188. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20190808

Alternative Benefit Plan

State Name: Oklahoma Attachment 3.1-L- [ ] OMB Control Number: 09381148

Transmittal Number: OK - 21 - 0002

Benefits Assurances — ABP7

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. Yes

☑ The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

☑ The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

○ Through an Alternative Benefit Plan.

◉ Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Per 42 CFR 440.345, please describe how the additional benefits will be provided, how access to additional benefits will be coordinated and how beneficiaries and providers will be informed of these processes in order to ensure individuals have access to the full EPSDT benefit.

Indicate whether additional EPSDT benefits will be provided through fee-for-service or contracts with a provider:

◉ State/territory provides additional EPSDT benefits through fee-for-service.

○ State/territory contracts with a provider for additional EPSDT services.

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age (optional):

Prescription Drug Coverage Assurances

☑ The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

☑ The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.

☑ The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.

☑ The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Alternative Benefit Plan

Other Benefit Assurances

- ☑ The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.
- ☑ The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.
- ☑ The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.
- ☑ The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.
- ☑ The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.
- ☑ The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.
- ☑ The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.
- ☑ The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: “A” and “B” services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

Alternative Benefit Plan

State Name: Oklahoma Attachment 3.1-L- [ ] OMB Control Number: 09381148

Transmittal Number: OK - 23 - 0007

Service Delivery Systems — ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

- [x] Managed care.
  - [x] Managed Care Organizations (MCO).
  - [ ] Prepaid Inpatient Health Plans (PIHP).
  - [x] Prepaid Ambulatory Health Plans (PAHP).
  - [x] Primary Care Case Management (PCCM).
- [x] Fee-for-service.
- [ ] Other service delivery system.

Managed Care Options

Managed Care Assurance

- [x] The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

The OHCA began a 14-day expedited tribal and public notice process on June 16 2021 and concluded the process on June 30, 2021. ITU notice 2021-10 informed tribal partners of the proposal on June 16, 2021; the State also posted a public notice on the public website on June 16, 2021. A copy of the public notice and instructions about the public comment process is available at oklahoma.gov/ohca/policies-and-rules/public-notices. Further discussions with ITUs within the state will occur on July 6, 2021 at the bimonthly consultation.

Revised within TN-21-0031, effective 07/01/21

The State engaged stakeholders as part of its planning process for the new managed care delivery system, SoonerSelect Medical. The transition to a medical managed care delivery system was discussed at stakeholder meetings held on June 20, 2022, August 31, 2022, September 15, 2022, September 20, 2022, September 22, 2022, September 29, 2022, October 5, 2022, October 26, 2022, October 27, 2022, and November 5, 2022. Additional press conferences took place on June 23, 2022, July 26, 2022, August 31, 2022.

The State's SoonerSelect Medical and Children's Specialty RFPs were drafted in accordance with state procurement policies and the SoonerSelect MCE RFP was released on the State's Office of Management & Enterprise Services public website on November 10, 2022 with opportunities for managed care entities (MCEs) to submit bids through February 8, 2023.

The Agency conducted formal tribal consultation during the bi-monthly meeting on January 3, 2023; the State also posted a public notice on the public website on May 11, 2023. A copy of the public notice and instructions about the public comment process is

available at oklahoma.gov/ohca/policies-and-rules/public-notices.

Revised within TN-23-0007, effective 04/01/24

MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program. No

☐ The Alternative Benefit Plan will be provided through primary care case management (PCCM) consistent with applicable managed care requirements (42 CFR Part 438, section 1903(m) of the Social Security Act, and section 1932 of the Social Security Act).

#type# Procurement or Selection Method

Indicate the method used to select #type#s:

◉ Competitive procurement method (RFP, RFA).

○ Other procurement/selection method.

Describe the method used by the state/territory to procure or select the MCOs:

Other MCO-Based Service Delivery System Characteristics

One or more of the Alternative Benefit Plan benefits or services will be provided apart from the managed care organization. Yes

List the benefits or services that will be provided apart from the #type#, and explain how they will be provided. Add as many rows as needed.

Add	Name	Description	Remove
Add	Orthodontia – Child	Dental PAHP or Traditional State-Managed Fee-For-Service (FFS)	Remove
Add	Major Dental Care – Child	Dental PAHP or Traditional State-Managed FFS	Remove
Add	Tobacco Cessation 5-As Counseling 5-As Counseling – Child	Dental PAHP or Traditional State-Managed FFS	Remove
Add	Medically Necessary Extractions – Adult	Dental PAHP or Traditional State-Managed FFS	Remove
Add	Diagnostic Dental – Adult	Dental PAHP or Traditional State-Managed FFS	Remove
Add	Preventive Dental – Adult	Dental PAHP or Traditional State-Managed FFS	Remove
Add	Restorative Dental – Adult	Dental PAHP or Traditional State-Managed FFS	Remove
Add	Non-surgical Periodontal Therapy – Adult	Dental PAHP or Traditional State-Managed FFS	Remove
Add	Removable Prosthetics Dental – Adult	Dental PAHP or Traditional State-Managed FFS	Remove
Add	Outpatient Surgery Dentist/Surgical Services – Adult	Dental PAHP or Traditional State-Managed FFS	Remove

Add	Tobacco Cessation 5-As Counseling 5-As Counseling – Adult	Dental PAHP or Traditional State-Managed FFS	Remove
Add	PCCM/PCMH Service Delivery Model	Traditional State-Managed FFS	Remove

MCO service delivery is provided on less than a statewide basis. No

#type# Participation Exclusions

Individuals are excluded from MCO participation in the Alternative Benefit Plan: Yes

Select all that apply:

- ☐ Individuals with other medical insurance.
- ☐ Individuals eligible for less than three months.
- ☐ Individuals in a retroactive period of Medicaid eligibility.
- ☒ Other:

General #type# Participation Requirements

Indicate if participation in the managed care is mandatory or voluntary:

- ◉ Mandatory participation.
- ○ Voluntary participation. Indicate the method for effectuating enrollment:

Describe method of enrollment in MCOs:

Expansion adults will be mandatorily enrolled with a medical MCE; however, American Indian/Alaskan Native (AI/AN) expansion adults will have the option to voluntarily enroll in the SoonerSelect Medical program through an opt-in process.

Expansion adults will have sixty (60) days to select a medical MCE prior to the start of coverage under the SoonerSelect Medical program. Subsequent to program implementation, expansion adults will have an opportunity to select a medical MCE on their application. Expansion adults who do not make an election within the allowed timeframe will be automatically assigned to a medical MCE.

Expansion adults who apply within the first (1st) day of the month through the fifteenth (15th) day of the month will be enrolled effective on the first (1st) day of the following month. Expansion adults who select or are assigned to a dental PAHP on the sixteenth (16th) day of the month through the last day of the month will be enrolled effective on the first day of the second following month.

Expansion adults may change their assigned medical MCE within ninety (90) days of enrollment or ninety (90) days within receiving notification of enrollment, whichever is later and may also change their medical MCE during the annual open enrollment period.

A medical MCE may not refuse an assignment or seek to disenroll an enrollee or otherwise discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and may not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin, sex, sexual orientation, gender identity, or disability. A medical MCE may not discriminate against an enrollee in enrollment, disenrollment, or re-enrollment on the basis of expectations that the individual will require frequent or high-cost care, or on the basis of health status or need for health care services or due to an adverse change in the individual's health.

Individuals during a period of presumptive eligibility are excluded from MCO enrollment.

Individuals that remain enrolled due to the continuous enrollment and maintenance of effort (MOE) requirement of Section 6008(b)(3) of the Families First Coronavirus Response Act (FFCRA) are excluded from MCO enrollment.

Populations excluded from this ABP and MCO enrollment include: Medicare dual eligible individuals; Individuals enrolled in the Medicare Savings Program; individuals determined eligible for Medicaid on the basis of age, blindness, or disability; Medicaid beneficiaries who reside in nursing facilities (NF) or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), with the exception of beneficiaries with a pending level of care determination; participants of a in Home and Community Based Services (HCBS) Waiver program; individuals infected with tuberculosis eligible for tuberculosis-related services under 42 C.F.R. § 435.21; individuals determined eligible for SoonerCare on the basis of needing treatment for breast or cervical cancer under 42 C.F.R. § 435.213; undocumented persons eligible for Emergency Services only in accordance with 42 C.F.R. § 435.139; Insure Oklahoma Employee Sponsored Insurance (ESI) dependent Children in accordance with the Oklahoma Title XXI Children's Health Insurance Program (CHIP) State Plan; and Individuals within the Title XIX Soon-to-be-Sooners Separate CHIP (STBS S-CHIP) program.

Revised within TN-23-0007, effective 04/01/24

Additional Information: #type# (Optional)

Provide any additional details regarding this service delivery system (optional):

PAHP: Prepaid Ambulatory Health Plan

The managed care delivery system is the same as an already approved managed care program. No

☐ The Alternative Benefit Plan will be provided through primary care case management (PCCM) consistent with applicable managed care requirements (42 CFR Part 438, section 1903(m) of the Social Security Act, and section 1932 of the Social Security Act).

#type# Procurement or Selection Method

Indicate the method used to select #type#s:

◉ Competitive procurement method (RFP, RFA).

○ Other procurement/selection method.

Describe the method used by the state/territory to procure or select the PAHPs:

Other PAHP-Based Service Delivery System Characteristics

One or more of the Alternative Benefit Plan benefits or services will be provided apart from the PAHP. Yes

List the benefits or services that will be provided apart from the #type#, and explain how they will be provided. Add as many rows as needed.

Add	Name	Description	Remove
Add	Primary Care Visits to Treat Injury or Illness	MCO or Traditional State-Managed FFS	Remove
Add	Specialty Visits	MCO or Traditional State-Managed FFS	Remove
Add	Other Practitioner Office Visits	MCO or Traditional State-Managed FFS	Remove

Add	Outpatient Facility (ambulatory surgery ctr)	MCO or Traditional State-Managed FFS	Remove
Add	Dialysis	MCO or Traditional State-Managed FFS	Remove
Add	Allergy Testing	MCO or Traditional State-Managed FFS	Remove
Add	Chemotherapy	MCO or Traditional State-Managed FFS	Remove
Add	Radiation	MCO or Traditional State-Managed FFS	Remove
Add	Outpatient Surgery Physician/Surgical Services	MCO or Traditional State-Managed FFS	Remove
Add	Hospice	MCO or Traditional State-Managed FFS	Remove
Add	Emergency Room Services	MCO or Traditional State-Managed FFS	Remove
Add	Emergency Transportation/Ambulance	MCO or Traditional State-Managed FFS	Remove
Add	Urgent Care Center	MCO or Traditional State-Managed FFS	Remove
Add	Inpatient Hospital Services (Inpatient Stay)	MCO or Traditional State-Managed FFS	Remove
Add	Inpatient Physician & Surgical Services	MCO or Traditional State-Managed FFS	Remove
Add	Organ Transplants	MCO or Traditional State-Managed FFS	Remove
Add	Reconstructive Surgery	MCO or Traditional State-Managed FFS	Remove
Add	Prenatal & Postnatal care	MCO or Traditional State-Managed FFS	Remove
Add	Delivery & Inpatient Services for Maternity Care	MCO or Traditional State-Managed FFS	Remove
Add	Mental/Behavioral Health Outpatient Services	MCO or Traditional State-Managed FFS	Remove
Add	Mental/Behavioral Health Inpatient Services	MCO or Traditional State-Managed FFS	Remove
Add	Substance Use Disorder Outpatient Services	MCO or Traditional State-Managed FFS	Remove
Add	Substance Use Disorder Inpatient Services	MCO or Traditional State-Managed FFS	Remove
Add	Prescription drugs	MCO or Traditional State-Managed FFS	Remove
Add	Outpatient Rehabilitation Services	MCO or Traditional State-Managed FFS	Remove

Add	Home Health	MCO or Traditional State-Managed FFS	Remove
Add	Durable Medical Equipment	MCO or Traditional State-Managed FFS	Remove
Add	Prosthetic Devices	MCO or Traditional State-Managed FFS	Remove
Add	Orthotic Devices	MCO or Traditional State-Managed FFS	Remove
Add	Habilitation Services	MCO or Traditional State-Managed FFS	Remove
Add	Inpatient Rehab Hospital	MCO or Traditional State-Managed FFS	Remove
Add	Imaging (CT/PET scans, MRIs)	MCO or Traditional State-Managed FFS	Remove
Add	Laboratory Outpatient & Professional Services	MCO or Traditional State-Managed FFS	Remove
Add	X-rays & Diagnostic Imaging	MCO or Traditional State-Managed FFS	Remove
Add	Diabetes Education	MCO or Traditional State-Managed FFS	Remove
Add	Preventive Care/Screening/Immunization	MCO or Traditional State-Managed FFS	Remove
Add	Nutritional Services	MCO or Traditional State-Managed FFS	Remove
Add	State Plan EPSDT Benefits	MCO or Traditional State-Managed FFS	Remove
Add	Nursing facility services	MCO (for up to 60 days pending a level of care determination) or Traditional State-Managed FFS	Remove
Add	Family planning	MCO or Traditional State-Managed FFS	Remove
Add	Bariatric Surgery	MCO or Traditional State-Managed FFS	Remove
Add	Non-emergency transportation	MCO or Traditional State-Managed FFS	Remove
Add	Podiatric services	MCO or Traditional State-Managed FFS	Remove
Add	Eye care to treat a medical or surgical condition	MCO or Traditional State-Managed FFS	Remove
Add	Meals and Lodging	MCO or Traditional State-Managed FFS	Remove
Add	Personal Care Services	MCO or Traditional State-Managed FFS	Remove
Add	Medication-Assisted Treatment Services	MCO or Traditional State-Managed FFS	Remove

Add	Infusion Therapy	MCO or Traditional State-Managed FFS	Remove
Add	PCCM/PCMH Service Delivery Model	MCO or Traditional State-Managed FFS	Remove
Add	ICF/IID services	MCO (for up to 60 days pending a level of care determination) or Traditional State-Managed FFS	Remove
Add	Alternative Treatment for Pain Management	MCO or Traditional State-Managed FFS	Remove
Add	Routine Patient Cost in Qualifying Clinical Trials	MCO or Traditional State-Managed FFS	Remove

PAHP service delivery is provided on less than a statewide basis. No

#type# Participation Exclusions

Individuals are excluded from PAHP participation in the Alternative Benefit Plan: Yes

Select all that apply:

☐ Individuals with other medical insurance.

☐ Individuals eligible for less than three months.

☐ Individuals in a retroactive period of Medicaid eligibility.

☒ Other:

General #type# Participation Requirements

Indicate if participation in the managed care is mandatory or voluntary:

◉ Mandatory participation.

○ Voluntary participation. Indicate the method for effectuating enrollment:

Describe method of enrollment in PAHPs:

Expansion adults will be mandatorily enrolled with a dental PAHP; however, American Indian/Alaskan Native (AI/AN) expansion adults will have the option to voluntarily enroll in the SoonerSelect Dental program through an opt-in process.

Expansion adults will have sixty (60) days to select a dental PAHP prior to the start of coverage under the SoonerSelect Dental program. Subsequent to program implementation, expansion adults will have an opportunity to select a CE on their application. Expansion adults who do not make an election within the allowed timeframe will be automatically assigned to a dental PAHP.

Expansion adults who applies within the first (1st) day of the month through the fifteenth (15th) day of the month will be enrolled effective on the first (1st) day of the following month. Expansion adults who select or are assigned to a dental PAHP on the sixteenth (16th) day of the month through the last day of the month will be enrolled effective on the first day of the second following month.

Expansion adults may change their assigned dental PAHP within ninety (90) days of enrollment or ninety (90) days within receiving notification of enrollment, whichever is later and may also change their dental PAHP during the annual open enrollment period.

A dental PAHP may not refuse an assignment or seek to disenroll an enrollee or otherwise discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and may not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin, sex, sexual orientation, gender identity, or disability. A dental PAHP may not discriminate against an enrollee in enrollment, disenrollment, or re-enrollment on the basis of

expectations that the individual will require frequent or high-cost care, or on the basis of health status or need for health care services or due to an adverse change in the individual's health.

Individuals during a period of presumptive eligibility are excluded from PAHP enrollment.

Individuals that remain enrolled due to the continuous enrollment and maintenance of effort (MOE) requirement of Section 6008(b)(3) of the Families First Coronavirus Response Act (FFCRA) are excluded from PAHP enrollment.

Populations excluded from this ABP and PAHP enrollment include: Medicare dual eligible individuals; Individuals enrolled in the Medicare Savings Program; individuals determined eligible for Medicaid on the basis of age, blindness, or disability; Medicaid beneficiaries who reside in nursing facilities (NF) or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), with the exception of beneficiaries with a pending level of care determination; participants of a in Home and Community Based Services (HCBS) Waiver program; individuals infected with tuberculosis eligible for tuberculosis-related services under 42 C.F.R. § 435.21; individuals determined eligible for SoonerCare on the basis of needing treatment for breast or cervical cancer under 42 C.F.R. § 435.213; undocumented persons eligible for Emergency Services only in accordance with 42 C.F.R. § 435.139; Insure Oklahoma Employee Sponsored Insurance (ESI) dependent Children in accordance with the Oklahoma Title XXI Children's Health Insurance Program (CHIP) State Plan; and Individuals within the Title XIX Soon-to-be-Sooners Separate CHIP (STBS S-CHIP) program.

Revised within TN-23-0007, effective 02/01/24

Additional Information: #type# (Optional)

Provide any additional details regarding this service delivery system (optional):

The State is seeking to establish the PAHP delivery model for the provision of dental services. Medical services will continue to be provided via the traditional state-managed fee-for-service delivery system.

Revised within TN-23-0007, effective 02/01/24

PCCM: Primary Care Case Management

The PCCM delivery system is the same as an already approved PCCM program. No

☑ The Alternative Benefit Plan will be provided through primary care case management (PCCM) consistent with applicable managed care requirements (42 CFR Part 438, section 1903(m) of the Social Security Act, and section 1932 of the Social Security Act).

#type# Procurement or Selection Method

Indicate the method used to select #type#s:

○ Competitive procurement method (RFP, RFA).

◉ Other procurement/selection method.

Describe the method used by the state/territory to procure or select the PCCMs:

Primary care case managers (PCCM) contract directly with the State as primary care providers to furnish case management services to AI/AN expansion adult members who do not opt-in to managed care.

Revised within TN-23-0007, effective 02/01/24

Other PCCM-Based Service Delivery System Characteristics

One or more of the Alternative Benefit Plan benefits or services will be provided apart from the PCCM. Yes

List the benefits or services that will be provided apart from the #type#, and explain how they will be provided. Add as many rows as needed.

Add	Name	Description	Remove
Add	Primary Care Visits to Treat Injury or Illness	MCO or Traditional State-Managed FFS	Remove
Add	Specialty Visits	MCO or Traditional State-Managed FFS	Remove
Add	Other Practitioner Office Visits	MCO or Traditional State-Managed FFS	Remove
Add	Outpatient Facility (ambulatory surgery ctr)	MCO or Traditional State-Managed FFS	Remove
Add	Dialysis	MCO or Traditional State-Managed FFS	Remove
Add	Allergy Testing	MCO or Traditional State-Managed FFS	Remove
Add	Chemotherapy	MCO or Traditional State-Managed FFS	Remove
Add	Radiation	MCO or Traditional State-Managed FFS	Remove
Add	Outpatient Surgery Physician/Surgical Services	MCO or Traditional State-Managed FFS	Remove
Add	Hospice	MCO or Traditional State-Managed FFS	Remove
Add	Emergency Room Services	MCO or Traditional State-Managed FFS	Remove
Add	Emergency Transportation/Ambulance	MCO or Traditional State-Managed FFS	Remove
Add	Urgent Care Center	MCO or Traditional State-Managed FFS	Remove
Add	Inpatient Hospital Services (Inpatient Stay)	MCO or Traditional State-Managed FFS	Remove
Add	Inpatient Physician & Surgical Services	MCO or Traditional State-Managed FFS	Remove
Add	Organ Transplants	MCO or Traditional State-Managed FFS	Remove
Add	Reconstructive Surgery	MCO or Traditional State-Managed FFS	Remove
Add	Prenatal & Postnatal care	MCO or Traditional State-Managed FFS	Remove
Add	Delivery & Inpatient Services for Maternity Care	MCO or Traditional State-Managed FFS	Remove
Add	Mental/Behavioral Health Outpatient Services	MCO or Traditional State-Managed FFS	Remove

Add	Mental/Behavioral Health Inpatient Services	MCO or Traditional State-Managed FFS	Remove
Add	Substance Use Disorder Outpatient Services	MCO or Traditional State-Managed FFS	Remove
Add	Substance Use Disorder Inpatient Services	MCO or Traditional State-Managed FFS	Remove
Add	Prescription drugs	MCO or Traditional State-Managed FFS	Remove
Add	Outpatient Rehabilitation Services	MCO or Traditional State-Managed FFS	Remove
Add	Home Health	MCO or Traditional State-Managed FFS	Remove
Add	Durable Medical Equipment	MCO or Traditional State-Managed FFS	Remove
Add	Prosthetic Devices	MCO or Traditional State-Managed FFS	Remove
Add	Orthotic Devices	MCO or Traditional State-Managed FFS	Remove
Add	Habilitation Services	MCO or Traditional State-Managed FFS	Remove
Add	Inpatient Rehab Hospital	MCO or Traditional State-Managed FFS	Remove
Add	Imaging (CT/PET scans, MRIs)	MCO or Traditional State-Managed FFS	Remove
Add	Laboratory Outpatient & Professional Services	MCO or Traditional State-Managed FFS	Remove
Add	X-rays & Diagnostic Imaging	MCO or Traditional State-Managed FFS	Remove
Add	Diabetes Education	MCO or Traditional State-Managed FFS	Remove
Add	Preventive Care/Screening/Immunization	MCO or Traditional State-Managed FFS	Remove
Add	Nutritional Services	MCO or Traditional State-Managed FFS	Remove
Add	State Plan EPSDT Benefits	MCO or Traditional State-Managed FFS	Remove
Add	Nursing facility services	MCO (for up to 60 days pending a level of care determination) or Traditional State-Managed Fee-For-Service	Remove
Add	Family planning	MCO or Traditional State-Managed FFS	Remove
Add	Bariatric Surgery	MCO or Traditional State-Managed FFS	Remove
Add	Non-emergency transportation	MCO or Traditional State-Managed FFS	Remove

Add	Podiatric services	MCO or Traditional State-Managed FFS	Remove
Add	Eye care to treat a medical or surgical condition	MCO or Traditional State-Managed FFS	Remove
Add	Meals and Lodging	MCO or Traditional State-Managed FFS	Remove
Add	Personal Care Services	MCO or Traditional State-Managed FFS	Remove
Add	Medication-Assisted Treatment Services	MCO or Traditional State-Managed FFS	Remove
Add	Infusion Therapy	MCO or Traditional State-Managed FFS	Remove
Add	ICF/IID services	MCO (for up to 60 days pending a level of care determination) or Traditional State-Managed Fee-For-Service	Remove
Add	Alternative Treatment for Pain Management	MCO or Traditional State-Managed FFS	Remove
Add	Routine Patient Cost in Qualifying Clinical Trials	MCO or Traditional State-Managed FFS	Remove
Add	Orthodontia – Child	Dental PAHP or Traditional State-Managed FFS	Remove
Add	Major Dental Care – Child	Dental PAHP or Traditional State-Managed FFS	Remove
Add	Tobacco Cessation 5-As Counseling 5-As Counseling – Child	Dental PAHP or Traditional State-Managed FFS	Remove
Add	Medically Necessary Extractions – Adult	Dental PAHP or Traditional State-Managed FFS	Remove
Add	Diagnostic Dental – Adult	Dental PAHP or Traditional State-Managed FFS	Remove
Add	Preventive Dental – Adult	Dental PAHP or Traditional State-Managed FFS	Remove
Add	Restorative Dental – Adult	Dental PAHP or Traditional State-Managed FFS	Remove
Add	Non-surgical Periodontal Therapy – Adult	Dental PAHP or Traditional State-Managed FFS	Remove
Add	Removable Prosthetics Dental – Adult	Dental PAHP or Traditional State-Managed FFS	Remove
Add	Outpatient Surgery Dentist/Surgical Services – Adult	Dental PAHP or Traditional State-Managed FFS	Remove
Add	Tobacco Cessation 5-As Counseling 5-As Counseling – Adult	Dental PAHP or Traditional State-Managed FFS	Remove

PCCM service delivery is provided on less than a statewide basis. No

PCCM Payments

Specify how payment for services is handled:

- (•) Per member/per month case management fee paid to PCCM provider.
- ( ) Other:

Additional Information: #type# (Optional)

Provide any additional details regarding this service delivery system (optional):

Fee-For-Service Options

Indicate whether the state/territory offers traditional fee-for-service and/or services managed under an administrative services organization:

- (•) Traditional state-managed fee-for-service
- ( ) Services managed under an administrative services organization (ASO) arrangement

Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, fee-for-service care management models/non-risk, contractual incentives as well as the population served via this delivery system.

With the exception of medical services provided by medical MCOs and dental services provided by dental PAHPs, the services provided under the ABP are provided under the Medicaid State Plan and are paid in the same manner as those services provided in the Medicaid state plan, Attachment 4.19.

Revised within TN-23-0007, effective 02/01/24

Additional Information: Fee-For-Service (Optional)

Provide any additional details regarding this service delivery system (optional):

Alternative Benefit Plan

State Name: Oklahoma Attachment 3.1-L- OMB Control Number: 09381148

Transmittal Number: OK - 21 - 0002

Employer Sponsored Insurance and Payment of Premiums	ABP9
The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package.	No
The state/territory otherwise provides for payment of premiums.	No

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

PRA Disclosure Statement

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. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722

Alternative Benefit Plan

State Name: Oklahoma Attachment 3.1-L- [ ] OMB Control Number: 09381148

Transmittal Number: OK - 21 - 0002

General Assurances — ABP10

Economy and Efficiency of Plans

☑ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services. Yes

Compliance with the Law

☑ The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.

☑ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).

☑ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

PRA Disclosure Statement

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. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722

Alternative Benefit Plan

State Name: Oklahoma Attachment 3.1-L- [ ] OMB Control Number: 09381148

Transmittal Number: OK - 21 - 0002

Payment Methodology	ABP11

Alternative Benefit Plans - Payment Methodologies

☑ The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

PRA Disclosure Statement

V.20160722