



Our Mission Statement

To purchase state and federally funded health care in the most efficient and comprehensive manner possible and to study and recommend strategies for optimizing the accessibility and quality of health care.

Our Vision

Our vision is for Oklahomans to enjoy optimal health status through having access to quality healthcare regardless of their ability to pay.

Our Values and Behaviors

- ☞ OHCA staff will operate as members of the same team, with a common mission, and each with a unique contribution to make our success.**
- ☞ OHCA will be open to new ways of working together.**
- ☞ OHCA will use qualitative and quantitative data to guide and evaluate our actions and improve our performance in a purposeful way over time.**

Governor of Oklahoma



Frank Keating

EXECUTIVE
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Lieutenant Governor, Mary Fallin
Cabinet Secretary, Jerry Regier

LEGISLATIVE
47th Legislature
State Senate President Pro Tempore, Stratton Taylor
House of Representatives Speaker, Loyd Benson

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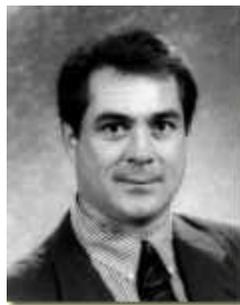
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From the Chief Executive Officer...



Mike Fogarty

State fiscal year 2000 was the high point of a five-year plan to totally change the way Oklahoma administers Medicaid. It was truly a year marked by struggle and triumph for an agency driven to provide access to quality health care to all Oklahomans regardless of their ability to pay.

The Oklahoma Health Care Authority serves more Oklahomans than ever, more than 400,000 individuals (approximately 12 percent of the state's population), including 260,000 children and 150,000 adults.

We are very proud of the efficiency and effectiveness of our Medicaid program. In a recent *Kaiser Commission Study on Medicaid and the Uninsured*, Oklahoma was identified as being one of just a few states that have experienced constant, positive enrollment growth during the past two years. It is very gratifying that we are becoming nationally recognized as a state moving in a positive direction.

However, our successes came only after we struggled with many challenges, especially in this fiscal year. It was against a backdrop of serving more Oklahomans than ever that we experienced serious financial difficulties. Facing a FY2000 state appropriations shortfall, the Board of Directors and agency staff made difficult decisions of recommending cuts to the Medically Needy and Behavioral Health programs. At one point provider payments had to be delayed.

The Oklahoma Health Care Authority was determined to build on our success and keep the program on track. We rolled up our sleeves and worked harder. All divisions pulled together to pursue available revenues and to cut costs without cutting more programs, while continuing to reach out and serve more Oklahomans.

External support for the agency and the Medicaid program began to form. Governor Keating made improvements in rural health care a priority in his legislative agenda. A coalition called Partners for Health Investment began to promote increased funding for all areas of Medicaid expenditures. The coalition included nearly 20 professional health care organizations with a common goal to ensure better access to health care for working Oklahomans.

Hard work was rewarded with increased support for Oklahomans in need of health care. State fiscal year 2000 will always be remembered for the passage of a historic piece of state legislation called Oklahoma 2001 Healthcare Initiative. This initiative gave us the tools to offer more services to participants; to pay providers better reimbursements for services and to ensure nursing facilities are accountable and have the tools they need to care for elderly Oklahomans.

Now more than ever, Oklahomans, young and old, have access to quality health care. Individual participants have better access to preventive and primary care. Participants have a direct relationship with a medical professional to provide and manage health care services. Participants are no longer left to fend for their own health care needs and find Medicaid providers alone.

In this annual report, you will find more information about the foundations of our programs and the financial and statistical data that marked our progress. This year is also highlighted by accomplishments in transportation services called **SoonerRide**, more school participation in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program and high participant satisfaction ratings for the **SoonerCare** Choice program.

As we enter our sixth year, we will strive to improve our health care programs for the benefit of individual Oklahoma participants, providers and others concerned about health care in Oklahoma. I invite you to join us in this worthwhile effort.

A handwritten signature in black ink that reads "Mike Fogarty". The signature is written in a cursive, flowing style.

Mike Fogarty
Chief Executive Officer

From the State Medicaid Director...

Commitment and dedication to our patients continues to be the priority of the Oklahoma Health Care Authority. In state fiscal year 2000, our staff's primary effort focused on providing access to quality health care for all individuals in Medicaid, whether managed care or fee-for-service.

This effort would not be possible if it weren't for the dedication of the providers who share this commitment to care for all individuals who need health care. We have very special people who are health care professionals from many different and important fields serving the needs of Oklahomans who cannot afford medical care.

We thank the many providers who stood with this agency through the many good times and the few lean times. It truly takes a collaborative effort with willing providers to care for all individuals who need help. Together, we had many accomplishments in state fiscal year 2000 and I will highlight a few of our successes.

The transition of Aged, Blind and Disabled (ABD) Medicaid individuals from the fee-for-service program to Oklahoma's managed care program was completed. This allows more people access to enhanced benefits, case management and care coordination.

A study released in January, conducted by the Oklahoma State Department of Health, indicated the childhood immunization rates of Oklahoma Medicaid children age 2 or younger improved 75 percent from 1995 to 1998. Also, Early Periodic Screening, Diagnosis and Treatment (EPSDT) screening ratios increased 12 points to 52 percent in SFY2000. EPSDT is Oklahoma's basic package of comprehensive and preventive child health services to Medicaid-eligible children.

This dedication to improving the quality of health care and the quality of life for individuals in Oklahoma's Medicaid program earned a commitment from Governor Keating and the legislature with the passage of the Oklahoma 2001 Healthcare Initiative.

This legislation allowed OHCA to fulfill a commitment to pursuing increased reimbursement for our providers. Oklahoma's Medicaid reimbursement rates for all health care providers and facilities have been among the lowest in the nation. This successful budget increase will allow the Oklahoma Health Care Authority to provide a more realistic reimbursement for costs.

Ultimately, our desire is to attract and retain more providers that will continue to offer access to Oklahomans in need of health care. This allows the Oklahoma Health Care Authority to fulfill its commitment and dedication to our patients. Your comments and suggestions are appreciated. We welcome your input and invite you to share your ideas about continuing on this positive path with us. Thank you for your effort and continued assistance in this important endeavor.



Lynn Mitchell, MD, MPH

A handwritten signature in cursive script that reads "Lynn Mitchell". The ink is dark and the signature is fluid and legible.

Lynn Mitchell, MD, MPH
State Medicaid Director

Contents

CONTENTS 1

FIGURES.....2

OHCA’S STATE FISCAL YEAR 2000 ACCOMPLISHMENTS.....3

OKLAHOMA MEDICAID7

 WHAT IS MEDICAID?..... 7

 WHO IS ELIGIBLE FOR MEDICAID? 7

 HOW IS MEDICAID FINANCED? 10

 WHERE ARE THE MEDICAID DOLLARS GOING?..... 11

 AGENCY HISTORY 13

 FOUNDATIONS FOR THE FUTURE..... 13

OKLAHOMA MEDICAID SERVICES..... 15

 WHAT IS A WAIVER? 15

 OKLAHOMA MANAGED CARE -**SOONERCARE** PLUS..... 17

 OKLAHOMA MANAGED CARE -**SOONERCARE** CHOICE..... 18

 COVERING MORE KIDS - - TITLE XIX EXPANSION AND THE STATE CHILDREN’S HEALTH INSURANCE PROGRAM (SCHIP) 19

 BEHAVIORAL HEALTH SERVICES 20

 GRADUATE MEDICAL EDUCATION (GME) 20

 HOSPITALS 21

 LONG TERM CARE 22

 MEDICARE “BUY-IN” PROGRAM..... 23

 PHARMACY PROGRAM..... 24

 PHYSICIANS AND OTHER PRACTITIONERS..... 24

 SCHOOL BASED SERVICES 25

SOONERRIDE (NON-EMERGENCY TRANSPORTATION)..... 26

STATEWIDE SFY2000 FIGURES..... 29

CORE FUNCTION SUMMARY 36

 EXECUTIVE OFFICE SUPPORT..... 36

 MEDICAID OPERATIONS..... 36

 INFORMATION SERVICES DIVISION 38

 FINANCE DIVISION..... 39

 MANAGEMENT AND AUDIT SERVICES..... 40

 LEGAL SERVICES 40

GLOSSARY OF TERMS 41

SERVICE EFFORTS AND ACCOMPLISHMENTS42

 SERVICE EFFORTS AND ACCOMPLISHMENTS (SEA) DEFINITION..... 43

 SERVICE EFFORTS AND ACCOMPLISHMENTS (SEA) HIGHLIGHTS..... 44

 SERVICE EFFORTS AND ACCOMPLISHMENTS (SEA)- SPECIFIC DETAIL 50

IMPORTANT TELEPHONE NUMBERS 80

Figures

Figure 1	General Age Breakdown of Medicaid Eligibles (as of June 2000).....	8
Figure 2	Breakdown of Medicaid Eligibles by Aid Category (as of June 2000)	8
Figure 3	State of Oklahoma Population by Race.....	9
Figure 4	Oklahoma Medicaid Population by Race	9
Figure 5	Condensed Summary of OHCA Revenues	10
Figure 6	Federal and State Share Expenditures–Oklahoma Medicaid.....	10
Figure 7	Historical Federal Medical Assistance Percentage (FMAP)	11
Figure 8	Oklahoma Medicaid Actual Expenditures SFY2000.....	11
Figure 9	Condensed Summary of OHCA Expenditures SFY2000	12
Figure 10	SoonerCare Plus Catchment Areas.....	17
Figure 11	SoonerCare Choice Catchment Areas	18
Figure 12	Oklahoma Medicaid Breakout of SoonerCare and Fee for Service (June 2000)	18
Figure 13	Increased Enrollment of Children Since Implementing Expansion Programs	19
Figure 14	Medicaid Programs- Comparison of Benefits (as of June 2000)	27
Figure 15	Percent of Oklahoma Population Enrolled in Medicaid (as of June 30, 2000)	29
Figure 16	Average Dollars Spent per Medicaid Eligible per Month	30
Figure 17	Statewide Medicaid Figures	31
Figure 18	OHCA's Organizational Chart	35
Figure 19	Technical Notes	41



OHCA's State Fiscal Year 2000 Accomplishments

Aged, Blind and Disabled Enroll In *SoonerCare*

On July 1, 1999, the Oklahoma Health Care Authority began to fulfill its 1993 legislative mandate to transition persons categorized as Aged, Blind and Disabled (ABD) from the fee-for-service Medicaid program to ***SoonerCare***, Oklahoma's Medicaid managed care program. Oklahoma became one of nearly twenty states that have instituted some form of managed care within their respective ABD populations.

Under ***SoonerCare*** Plus, health benefits and services, including case management, have been enhanced. For example, there are specific health services that are now offered to adults that were not present under the fee-for-service program. Persons living outside of the ***SoonerCare*** Plus areas were enrolled into ***SoonerCare*** Choice beginning in October 1999. The total number of ABD eligibles in the Medicaid program remained constant from the end of State Fiscal Year 1999 from 99,300 to 98,600 at the end of State Fiscal Year 2000. For additional information refer to pages 50, 65 and 66 of the Service Efforts and Accomplishments section.

Comprehensive Health Care Package Approved During the Second Session of the 47th Legislative

The Oklahoma State Legislature and the Governor approved a \$400 million health care initiative for needy Oklahomans, coupled with a package of reforms to broaden and strengthen regulation and inspection of nursing homes. The "Oklahoma 2001 Healthcare Initiative," House Bill 2019, provides benefits to Oklahomans of all ages, infants to elderly, in urban and rural areas alike, and will create safeguards for residents of every nursing home in this state.

The Oklahoma 2001 Healthcare Initiative proposes various public health benefit increases and health care provider rate increases, including higher hospital reimbursement rates for maternity care, neo natal services and ambulance services; an initiative to broaden availability of dental care to needy Oklahomans; pay increases for minimum-wage social-service providers; longer hospital stays; and extending state disability services to more children. The Healthcare Initiative also provides Medicaid services, including prescriptions to Qualified Medicare Beneficiaries. For more information regarding the Qualified Medicare Beneficiaries (QMB) see page 23.

Accomplishments (Continued)

Childhood Immunization Rates and Early Periodic Screening, Diagnosis and Treatment (EPSDT) Ratios Improve

More parents and caretakers are seeking preventive care for children, rather than waiting for a crisis, then seeking emergency care. A study published in the January 2000 issue of the Oklahoma State Medical Association Journal indicates the childhood immunization rates of Oklahoma Medicaid children age 2 or younger improved from 27.6 percent to 48.2 percent. This reflects an increase of 75 percent from 1995 to 1998. Also, Early Periodic Screening, Diagnosis and Treatment (EPSDT) screening ratios increased 12 points to 52 percent in State Fiscal Year 2000. EPSDT is Oklahoma's basic package of comprehensive and preventive child health services to Medicaid-eligible children. School-based health care, such as EPSDT services, is an effective method of providing access to health care for children. In SFY2000, there were 294 active school-based contracts compared to 136 in SFY1999. For more information please refer to page 25 and the Service Efforts and Accomplishments on page 59.

McKesson HBOC ClaimCheck? And ClaimReview? Claim Auditing System Implemented

The McKesson HBOC ClaimCheck? And ClaimReview? Claim Auditing System was implemented by OHCA in June of 2000. The ClaimCheck? and ClaimReview? product is a fully automated claim auditing system that verifies the coding accuracy of professional claims. This allows for systematic identification of the appropriate coding of procedures eligible for reimbursement. During this process, ClaimCheck? and ClaimReview? analyze the current and historical procedure codes billed on a single and/or multiple dates of service. In the past, detecting inaccuracies required manual review by OHCA staff. Automation expedites processing, enhances payment consistency and allows for more efficient monitoring.

Medicaid Management Information System Reprocurement Process In Full Swing

The goal of this procurement is for the State of Oklahoma to competitively acquire the services of a qualified contractor to transfer, design and develop, implement, operate and maintain a new state-owned Oklahoma Medicaid Management Information System (OKMMIS). With the assistance of a contracted consultant firm, representatives from throughout the agency were selected to develop the requirements for an MMIS system that would meet or exceed all system requirements set forth in the Federal Code of Regulations (CFR), be eligible for federal certification and meet all of the functional requirements of the agency. In May 2000, the Oklahoma Health Care Authority released a Request for Proposal (RFP) for the OKMMIS. This 736-page Request for Proposal document describes the Administrative Overview, Oklahoma Medicaid Program, Scope of Work, Proposal Submission Requirements, Evaluation Methodology, and Contract Terms and Conditions. Bids were due July 26, 2000. After the evaluation and approval process, work is scheduled to begin on the new system in October of 2000 and the final system product should be implemented in January 2003.

Accomplishments (Continued)

National Recognition Follows Enrollment Increases

Increasing access and reducing barriers to quality Medicaid health care for low-income families continues to result in phenomenal increases in the total number of Medicaid eligibles in State Fiscal Year 2000. One outcome of the aggressive outreach efforts and an efficient eligibility process is the Oklahoma Health Care Authority received national recognition for the program's positive growth. State Medicaid Director, Dr. Lynn Mitchell, testified on the efforts of the Oklahoma Medicaid program to a United States House of Representatives' Committee on Ways and Means, Subcommittee on Human Resources in May 2000.

Additionally, in a recent *Kaiser Commission Study on Medicaid and the Uninsured*, Oklahoma was identified as being one of just a few states that have experienced constant, positive enrollment growth during the past two years. Pushed by an increase in the number of children, the total number of Medicaid eligibles rose from 383,884 in July 1999 to 416,785 in June 2000.

Product Based Prior Authorization Cost Avoidance

A Product Based Prior Authorization program was implemented on January 4, 2000 and the program has experienced \$1.66 million in cost avoidance or savings while reporting no official patient or physician grievances. The goal of the Product Based Prior Authorization program is to optimize each patient's medical therapy with medication that best treats the patient's condition given his or her unique health status and circumstances. The program focuses on two therapeutic classes, Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) and H2 Antagonists/Proton Pump Inhibitors or anti-inflammatory and ulcer medications. Each class of medication has two tiers with Tier 2 medications requiring Prior Authorization. The OHCA wants to stress those patients with clinical exceptions or patients that have not tolerated or did not achieve a clinical success with a Tier 1 product previously can obtain a Tier 2 medication via the Prior Authorization Process. For more information regarding OHCA's pharmacy program go to page 24, as well as page 62 of the Service Efforts and Accomplishments.

Satisfied Recipients / Providers

Providers and participants in the Oklahoma Medicaid program have many rights and responsibilities. The Oklahoma Health Care Authority prides itself in addressing questions and solving problems in a timely manner. Based upon the low number of formal appeals filed by recipients and providers, it appears that both the recipients of services, as well as the providers of services understand and are satisfied with the Oklahoma Medicaid program. Formal appeals for both were less than 1/4 of one percent (<1/4 of 1%) for State Fiscal Year 2000. Please refer to the Service Efforts and Accomplishments, page 53, for more details.

Accomplishments (Continued)

SoonerCare Choice Earns High Satisfaction Marks

A survey to track the health and satisfaction of Medicaid participants enrolled in managed care plans resulted in high marks for the Oklahoma Health Care Authority's **SoonerCare** Choice program. The Oklahoma Foundation for Medical Quality (OFMQ) conducted the annual QISMC (Quality Improvement System for Managed Care) review for the contract year July 1999 through June 2000. The QISMC review results show that the **SoonerCare** Choice program was in full compliance in the areas that involved Quality Assessment and Performance Improvement (QAPI) and delegation and were in significant compliance with health services management and enrollee rights. For further information concerning the Quality Assurance Reform Initiative (QARI) reviews refer to page 78 of the Service Efforts and Accomplishments.

SoonerRide Program Spans All 77 Counties

SoonerRide, which kicked off in June 1999, expanded to all 77 counties by May 2000. This program provides non-emergency, medically necessary transportation to Medicaid clients in the state. The transportation providers are required to have liability insurance, driver training and proper vehicle maintenance giving greater assurances for the safety of the Medicaid clients, as well as raising the accessibility in the rural areas. For more information on the **SoonerRide** program, refer to the Non-Emergency Transportation section under Medicaid Services and the Service Efforts and Accomplishments on page 54.

Website Production Increases with New Information Monthly

The Oklahoma Health Care Authority website at www.ohca.state.ok.us continues to evolve into a vital communication and information tool for the agency and its operations. Many new features are being added monthly to better serve consumers, providers and other stakeholders. In addition to general Medicaid information such as eligibility guidelines, specific program information, and agency information, the site features forms for providers, State Medicaid letters, fee schedules, press releases and monthly statistical information. As the website expands, computer users will find more and more resources available to allow the Oklahoma Medicaid program to become more efficient and effective. OHCA plans to implement a secure website for contracted Medicaid providers in early 2001.



Oklahoma Medicaid

What is Medicaid?

Most people know Medicaid as the country's funding source to provide health care to low-income Americans. But most don't realize that Medicaid also serves as the nation's primary source of funding for nursing home care. Additionally, Medicaid reimbursements also largely fund hospitals which serve as the cornerstone for a network of other health care providers that include primary care physicians, specialists, pharmacies, vision services, transportation, dental services and etc.

Medicaid is three programs in one:

- A health insurance program for low-income parents (mostly mothers), pregnant women and children,
- A long term care program for the elderly,
- A funding source for services to people with disabilities.

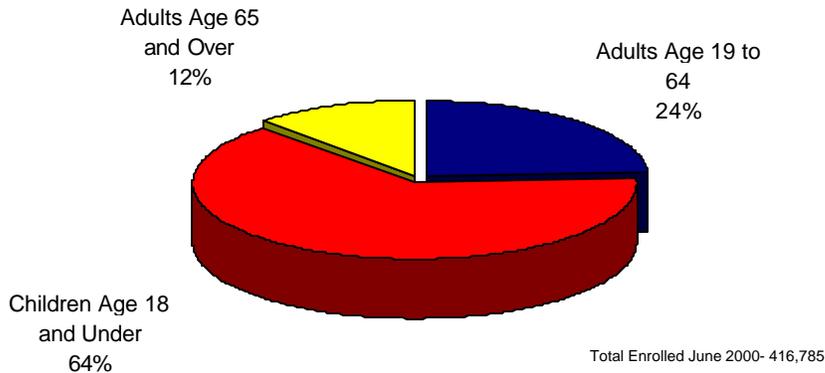
Created as Title XIX of the Social Security Act in 1965, Medicaid is a federal / state program administered by the state and funded from federal, state and in some cases, local revenues. At the federal level the program is administered by the Health Care Financing Administration (HCFA) within the Department of Health and Human Services (HHS); at the state level Medicaid must be administered by a "single state agency". The federal government establishes and monitors certain requirements concerning funding, eligibility standards, and quality and scope of medical services. States have the flexibility to determine certain aspects of their own programs in the areas of eligibility, reimbursement rates, benefits and service delivery. For over 30 years, Medicaid has operated as an entitlement program for individuals; that is, anyone who meets specified eligibility criteria is "entitled" to Medicaid services.

Who is Eligible for Medicaid?

As required by State law, Oklahoma's eligibility is determined at each of the 77 county Department of Human Services offices. Each is governed by federal and state eligibility criteria. Most Medicaid eligibility criteria related to income levels are determined by federal poverty guidelines established by the U.S. Department of Health and Human Services. Medicaid serves as an insurance plan for many Oklahoma women of childbearing age and children. Women and children qualify for Medicaid based on income, resources and "categorical" status, that is, they are in a certain category such as TANF-related or low income pregnant women, hereafter referred to as the Temporary Assistance for Needy Families (TANF/AFDC) population. The bulk of their service needs are for preventative and primary care and other acute services. As of the end of the June 2000, children age 18 and under alone comprised 64 percent (64%) of the total 416,785 Oklahoma Medicaid population.

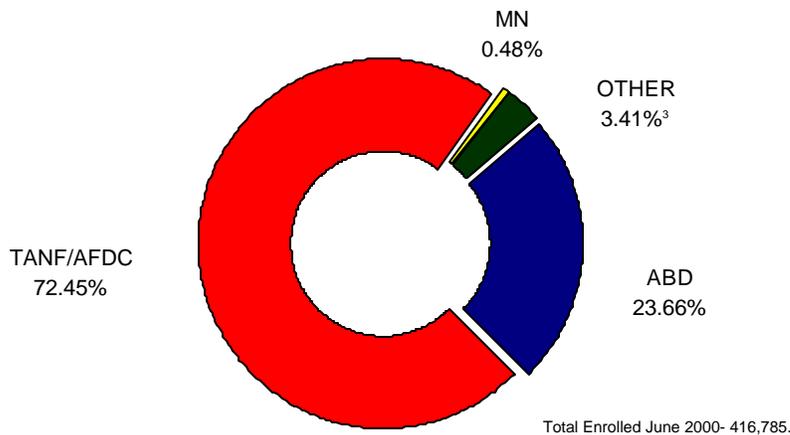
Who is Eligible for Medicaid? (continued)

Figure 1 General Age Breakdown of Medicaid Eligibles (as of June 2000)¹



Some people qualify for Medicaid based on blindness or another disability regardless of age group. Serious health problems are commonly treated by private insurance markets as “pre-existing conditions”, making it difficult for people to obtain private insurance. Without private insurance, most people with disabilities and chronic conditions cannot afford to pay for the health care services they need. Medicaid has become a major source of funding for the health, health-related support services, and long-term care for these Oklahomans. These recipients are also referred to as the Aged, Blind and Disabled (ABD) population.

Figure 2 Breakdown of Medicaid Eligibles by Aid Category (as of June 2000)²



¹ Source: June 2000 data extracted from recipient eligibility files on July 12, 2000. Numbers frequently change due to retro-certifications and other factors. This figure is based on data within the system prior to 7/12/2000.

² Source: June 2000 data extracted from recipient eligibility files on July 12, 2000. Numbers frequently change due to retro-certifications and other factors. This figure is based on data within the system prior to 7/12/2000.

³ OTHER Eligibility group encompasses tuberculosis patients, Qualified Medicare Beneficiaries, Special Low Income Medicare Beneficiaries, Refugees and Developmentally Disabled Supported Living.

Who is Eligible for Medicaid? (continued)

Figure 3 State of Oklahoma Population by Race⁴

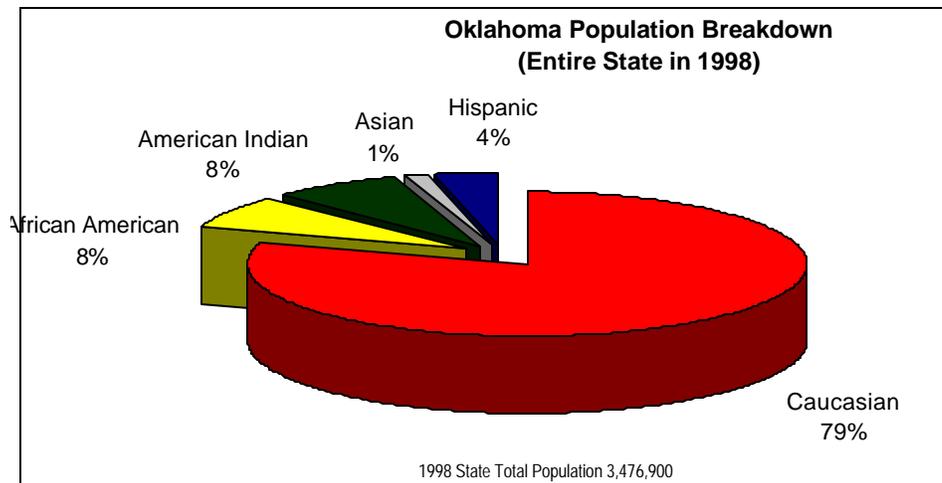
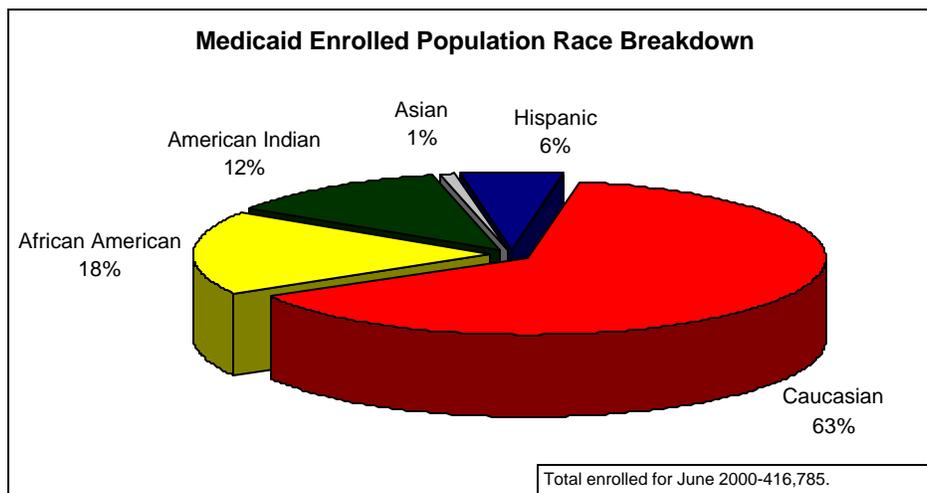


Figure 4 Oklahoma Medicaid Population by Race⁵



Changes (Increases / Decreases) in Medicaid Enrollment (June 97 – June 99)⁶

Total monthly enrollment in the Medicaid program, for the entire nation, fell from 23.2 million in June 1997 to 22.9 million in June 1999. All but three (Arkansas, Massachusetts and Oklahoma) of the twenty-one (21) states studied by the *Kaiser Commission on Medicaid and the Uninsured* experienced an enrollment decrease between June 1997 and June 1999.

Oklahoma	25.7% Increase
21 State Average	(1.3%) Decrease

⁴ Source: Oklahoma Department of Commerce- Population by Race 1998 (Totals may not sum due to rounding.)

⁵ Data extracted from recipient eligibility files on July 12, 2000. Numbers frequently change due to retro-certifications and other factors. This figure is based on data within the system prior to 7/12/2000.

⁶ Source: Compiled by Health Management Associates from State Medicaid enrollment reports. Presented by Kaiser Commission on Medicaid and the Uninsured – Report Release Date: April 12, 2000.

How is Medicaid Financed?

The federal and state governments share Medicaid costs. For program administration costs, the federal government contributes 50 percent (50%) for each state with enhanced funding provided for some administrative activities such as fiscal agent operations. For medical services provided under the program, the federal matching rate varies between states. Each year the federal matching rate, known as the "federal medical assistance percentage" (FMAP), is adjusted. States having lower per capita incomes receive a higher federal match. As an entitlement program for individuals who meet eligibility criteria, Medicaid's federal funding is open-ended. Oklahoma contributes general fund appropriations as their Medicaid match. Oklahoma's estimated Medicaid expenditures as a percentage of total state expenditures for State fiscal year (SFY) 2000 were 13 percent (13%).⁷

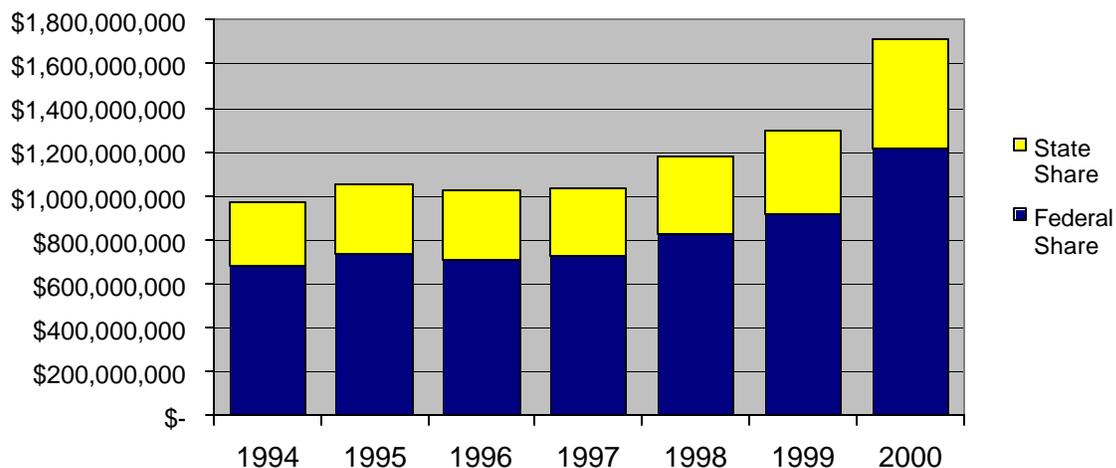
Figure 5 Condensed Summary of OHCA Revenues⁸

As of July 2000

REVENUES	FY00 Budget YTD	FY00 Actual YTD	% Over/ (Under)
State Appropriations	\$ 343,124,518	\$ 343,124,518	0.0%
Federal Funds - OHCA	917,848,854	930,667,689	1.4%
Federal Funds for Other State Agencies	247,400,672	258,288,585	4.4%
Refunds from Other State Agencies	121,464,325	121,534,394	0.1%
Prior Year Carryover	500,000	2,958,458	491.7%
Other Revenue	49,697,428	57,197,565	15.1%
TOTAL REVENUES	\$ 1,680,035,797	\$ 1,713,771,209	2.0%

Figure 6 Federal and State Share Expenditures—Oklahoma Medicaid⁹

Medicaid Expenditures SFY94 through SFY00



⁷ Source: National Association of State Budget Officers, 1999 State Expenditure Report, June 2000.

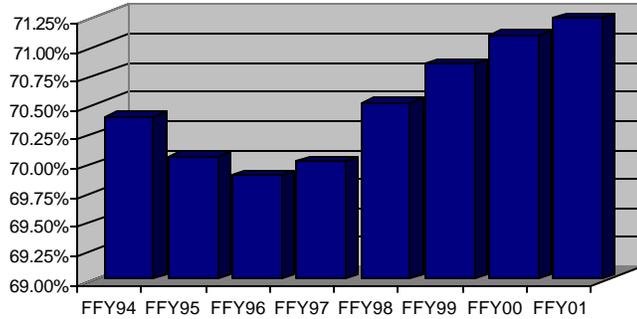
⁸ Source: OHCA Finance Division (07/2000)

⁹ Source: OHCA Finance Division (07/2000)

How is Medicaid Financed? (Continued)

Figure 7 Historical Federal Medical Assistance Percentage (FMAP)¹⁰

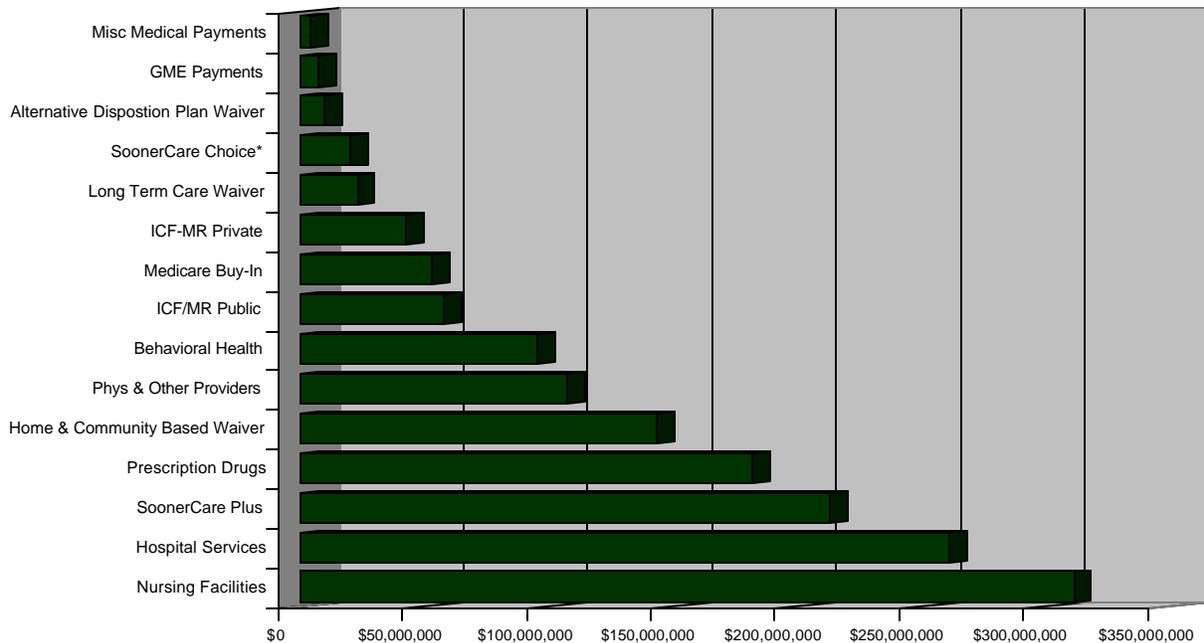
<u>Federal Fiscal Year</u>	<u>FMAP Rate</u>	<u>SCHIP[‡]</u>
FFY94	70.39%	
FFY95	70.05%	
FFY96	69.89%	
FFY97	70.01%	
FFY98	70.51%	79.36%
FFY99	70.84%	79.59%
FFY00	71.09%	79.76%
FFY01	71.24%	79.87%



(The Federal Fiscal Year is October 1st through September 30th.)

Where are the Medicaid Dollars Going?

Figure 8 Oklahoma Medicaid Actual Expenditures SFY2000



¹⁰ Source: OHCA Finance Division (11/1999)

[‡] SCHIP: State Children's Health Insurance Program, see additional information on Page 19.

***SoonerCare** Choice expenditure figures represent capitated payments only. Noncapitated services are not included in this amount.

Oklahoma Health Care Authority Annual Report SFY2000

Where are the Medicaid Dollars Going? (Continued)

Figure 9 Condensed Summary of OHCA Expenditures SFY2000¹¹

As of 7/2000

EXPENDITURES	Budget FY00	Actual FY00	% (Over) / Under
ADMINISTRATION	\$ 50,377,796	\$ 42,968,497	14.7%
OHCA MEDICAID PROGRAMS			
<u>Managed Care:</u>			
SoonerCare Plus	208,069,600	213,238,980	(2.5)%
SoonerCare Choice*	19,370,764	20,560,792	(6.1)%
Graduate Medical Education Payments	9,685,793	7,259,764	0.0%
<u>Acute Fee for Service Payments:</u>			
Hospital Services	241,241,178	261,440,317	(8.4)%
Behavioral Health	88,043,479	95,745,141	(8.7)%
Physicians & Other Providers	107,638,878	107,305,664	0.3%
Prescription Drugs	174,681,196	181,872,762	(4.1)%
Miscellaneous Medical Payments	3,633,774	4,021,406	(10.7)%
<u>Other Payments:</u>			
Nursing Facilities	317,275,670	311,680,199	1.8%
ICF-MR Private	42,591,839	42,735,603	(0.3)%
Medicare Buy-In	57,073,232	53,239,760	6.7%
Total OHCA Medicaid Programs	\$ 1,269,305,403	\$ 1,299,100,388	(2.3)%
OTHER OHCA MEDICAL PROGRAMS	\$ 4,792,465	\$ 5,382,852	(12.3)%
Total OHCA	\$ 1,324,475,664	\$ 1,347,451,737	(1.7)%
OTHER STATE AGENCY PROGRAMS			
Non-Medicaid Programs	\$ 20,485,710	\$ 14,286,213	30.3%
Dept. of Human Serv. Medicaid (DHS)	291,272,196	312,116,613	(7.2)%
Okla. State Dept. of Health (OSDH)	3,000,000	1,964,826	34.5%
Office of Juvenile Affairs Medicaid (OJA)	8,338,045	10,196,496	(22.3)%
Dept. of Mental Health Medicaid	24,064,182	16,789,672	30.2%
Department of Health Medicaid (OSDH)	1,900,000	1,024,076	46.1%
Dept. of Education Medicaid (DOE)	6,500,000	10,140,219	(56.0)%
Total Other State Agency Programs	\$ 355,560,133	\$ 366,518,115	(3.1)%
TOTAL ALL EXPENDITURES	\$ 1,680,035,797	\$ 1,713,969,852	(2.0)%

¹¹ Source: OHCA Finance Division (07/2000)

***SoonerCare** Choice expenditure figures represent capitated payments only. Noncapitated services are not included in this amount.

Agency History

In 1992, as an attempt to curb the steady growth of Medicaid, reductions in rates and specific services available to Oklahoma's Medicaid population were made. Physicians and other practitioners saw a 5 percent (5%) reduction in their rates and adult recipients saw limits placed on office visits and hospitalization. Further, the state was also forced to completely eliminate adult dental services.

In an effort to avoid additional dramatic cuts in services and reductions in eligible populations, the Governor and Legislature placed health care reform near the top of their legislative agendas. From 1992 through 1993, Oklahoma's leadership formed citizen's committees. These groups were directed to study access and cost-containment problems within the existing system and to propose meaningful reforms. Recommendations were made for Oklahoma to begin the transition of its traditional fee-for-service Medicaid program to a coordinated system of managed care – focusing on primary care, prevention and increased access. This served as a catalyst for the Legislature in 1993 to establish the Oklahoma Health Care Authority as the single state Medicaid agency effective January 1, 1995.

Also mandated at that time, was the conversion of the Oklahoma Medicaid program from fee-for-service to a statewide comprehensive system of managed care delivery. Oklahoma has chosen to develop and implement two distinct managed care delivery systems: **SoonerCare** Plus and **SoonerCare** Choice. **SoonerCare** Plus was designed to allow for prepaid fully-capitated health plan arrangements. **SoonerCare** Choice is the primary care case management system in areas that could not support the fully capitated approach.

Foundations for the Future

The end of the twentieth century presents a time of unparalleled change in our nation's health care system. As new models of health care delivery systems continually evolve and rapid advances in technology and communications revolutionize the provision of health care, so too must Oklahoma's Medicaid program adapt. In carrying out our responsibilities, OHCA strives to be a leader in improving the delivery of cost-effective, appropriate, high quality health care for all of our participants, promoting and preserving beneficiary rights and protections, and in meeting the highest standards of administrative performance.

As OHCA plans for the future, we must be ever mindful of the following:

FOCUS ON PARTICIPANTS...

Part of serving participants effectively is knowing their characteristics and needs, both now and in the future. While the Medicaid population in Oklahoma is diverse, it is predominately comprised of children and their families, while the elderly and disabled on Medicaid account for a greater percentage of program expenditures.

Participants eligible for Medicaid comprise one of the most vulnerable populations; these individuals are low income and include a disproportionate share of the frail elderly and non-elderly individuals with severe mental and physical disabilities.

The State Children's Health Insurance Program (SCHIP) allowed Oklahoma to expand Medicaid to cover more uninsured, low-income children. Many of these children have working parents who earn too much to qualify for Medicaid, but too little to afford private insurance.

Foundations for the Future (Continued)

PUBLIC PURCHASER...

OHCA's interdependence with a changing health care environment presents both challenges and opportunities with respect to the achievement of the agency's strategic goals and objectives. As a government agency, OHCA operates in a framework that differs from private sector purchasers of health care. While OHCA strives to purchase the best value health care for participants, the fact that we must operate within current statutory authorities means that some shifts towards this direction may take longer or require a change in underlying statutes. OHCA must develop purchasing strategies for both fee-for-service and managed care environments.

OHCA AND ITS PARTNERS...

OHCA accomplishes its work by working with and through others - - not in isolation. OHCA employees are only a small portion of a large, complex network that makes our programs work successfully. OHCA employees, HCFA employees, other State agencies, tribes, providers of care, beneficiary and consumer organizations, accrediting bodies, researchers, and others work together to help ensure that our participants have access to high quality health care.

OHCA's reliance on partners is one of its defining characteristics. Working in partnership leverages OHCA resources, which is ultimately in the participants' best interest. Interdependence means working together to establish and accomplish mutual goals.

PROGRAM INTEGRITY...

The size and scope of OHCA's programs, measured both in dollars and in the numbers of persons served, necessitate an emphasis on prevention and detection of waste, fraud and abuse that divert program dollars from their otherwise intended purposes. OHCA must take effective measures to prevent improper or fraudulent claims, which strain the fiscal and personnel resources of the programs. While ensuring that program dollars are appropriately expended, OHCA must also ensure that pursuit of efficiency and cost-effectiveness does not compromise access or health care quality.

TECHNOLOGICAL ADVANCES...

Technological advances are often spectacular in their character and speed of diffusion. No doubt, advances in transplants, laser technology, nuclear medicine and genetically-based treatments will change the nature of health care. New technologies also raise coverage, payment and quality issues. OHCA has a responsibility, within the limits of the law and regulations, to ensure that participants have access to new technologies as they emerge and are supported by authoritative scientific evidence.

Technological advances are one of the primary reasons health care costs have risen faster than the general consumer price index over the last three (3) decades. OHCA has a responsibility to ensure that new technologies covered by Oklahoma's Medicaid program are reasonable and necessary.

DEMOGRAPHIC CHANGES...

The demographic changes that will occur as the post World War II "baby boom" generation ages are well known. Past variation in birth rates, together with steady improvement in life expectancy, are expected to result in major increases in the number of older persons relative to those of working age beginning in 2010.¹² A larger number of elderly participants has implications for Medicaid because of Medicaid's role in financing long-term care services.

¹² Source: Kaiser Commission on *Medicaid and the Uninsured*, November 1999.

Oklahoma Medicaid Services



What is a Waiver?

Before Oklahoma could transition its Medicaid program to one of managed care, the state had to request a waiver from the federal Health Care Financing Administration (HCFA).

States apply for waivers of Medicaid rules to test innovative approaches to benefits, services, eligibility, program payments, and service delivery. The federal government allows states to request waivers specifically to “waive” certain federal requirements of the program. State demonstration projects are frequently aimed at saving money or extending Medicaid coverage to additional low-income and uninsured people. The Federal government currently grants two kinds of Medicaid managed care waivers: Section 1915(b) “Freedom of Choice” waivers and Section 1115(a) “Research and Demonstration” waivers.

Section 1915(b) waivers permit states to require participants to enroll in managed care plans. To receive such a waiver, states must prove that these plans have the capacity to serve Medicaid participants who will be enrolled in the program. The purpose of freedom of choice waivers is to improve beneficiary access to care through enrollment in a guaranteed provider network that operates in a cost efficient manner. Such waivers also facilitate the monitoring of beneficiary quality of care. They frequently place participants in delivery systems in which there is greater emphasis on health education and preventive medicine.

Section 1115(a) demonstrations allow states to test new approaches to benefits, services, eligibility, program payments, and service delivery, often on a statewide basis. These approaches are frequently aimed at saving money to allow states to extend Medicaid coverage to additional low-income and uninsured people. Research and demonstration waiver authority can normally be granted for up to five years at a time. This permits states to try out a far greater range of policies than would otherwise be permissible in ordinary freedom of choice waiver programs.

HCFA waivers allow for some state flexibility in the design of its managed care delivery system; and, managed care models can vary based on available community resources, geographic location and experience in managed care practices. Oklahoma initially implemented its Medicaid managed care program under a Section 1915(b) waiver in 1995 but transitioned to a Section 1115(a) waiver on July 1, 1996. Under its current waiver, Oklahoma has chosen to develop and implement two, distinct managed care delivery systems within its Medicaid program: **SoonerCare** Plus and **SoonerCare** Choice.

What is a Waiver? (Continued)

Home and Community Based Services (HCBS) Waivers

Medicaid Home and Community-Based Service (HCBS) waivers afford states the flexibility to develop and implement creative alternatives to placing Medicaid-eligible individuals in hospitals, nursing facilities or intermediate care facilities for persons with mental retardation (ICF/MR). The HCBS waiver program recognizes that many individuals at risk of being placed in these facilities can be cared for in their own homes and communities, preserving their independence and ties to family and friends at a cost no higher than that of institutional care. Initial waivers are approved by the Health Care Financing Administration (HCFA) to operate for three years. Waiver renewals are for periods of five years. The State of Oklahoma operates four Home and Community Based Services waivers (HCBS). Three waivers serve the mentally retarded and related conditions populace and one serves the frail elderly and adult disabled.

The Home and Community Based Service waivers Oklahoma operates under are as follows:

- EE* ICF/MR Waiver: Serves approximately twenty seven hundred (2,700) recipients with mental retardation or related conditions. The waiver expenditures are tested to determine that the costs incurred are below those of the institutionalized recipients.
- EE* In-Home Support Waiver for Adults: This waiver began in July of 1999 and is designed to assist the state in moving adult individuals with mental retardation or related conditions from the ICF/MR waiver waiting list. This waiver has an annual post eligibility spending cap of \$15,000 per year per recipient for waiver services.
- EE* In Home Support Waiver for Children: Designed to assist the state in moving children ages 6 through 17 with mental retardation or related conditions from the ICF/MR waiver waiting list. This waiver has an annual post eligibility spending cap of \$10,000 per recipient per year for waiver services. The reason for the lower cap for the In Home Support Waiver for Children is that children are also entitled EPSDT services with a generally broader scope, amount and duration than are provided to adults under Oklahoma Medicaid.
- EE* ADvantage waiver: Serves older Oklahomans and adults with physical disabilities that can choose to stay home, instead of going into a nursing home. Eighty percent (80%) of the waiver population are physically disabled on-or-after their 22nd birthday and do not suffer cognitive impairment.

Services through these waivers are available to individuals when the cost of waiver services are less than the costs of nursing home services and when the recipient can be served safely in the home. Waiver services available, depending on each person's needs and wishes, are skilled nursing, prescription drugs, adult day care services, specialized equipment and supplies, home delivered meals, comprehensive home health care, personal care, respite care, environmental modifications and therapies. Individuals receiving waiver services are either classified as being "diverted", having been diverted into the waiver rather than placed in an institution, or "de-institutionalized", having been in an institution then placed back into the community through the waiver.

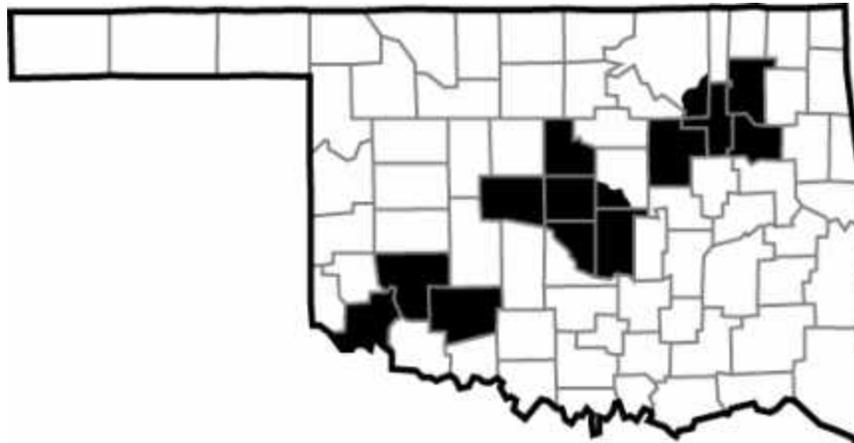
Oklahoma Managed Care-*SoonerCare* Plus

Under *SoonerCare* Plus, OHCA contracts directly with Health Maintenance Organizations (HMOs) to provide all medically necessary services to recipients residing in Oklahoma City, Tulsa, Lawton and the counties immediately surrounding these urban centers.

The “Plus” in *SoonerCare* Plus refers to the enhanced benefit package created through the removal of limitations of hospital days, prescriptions and office visits for adults, all of which are present under the traditional fee-for-service program. Persons within the *SoonerCare* Plus program select a primary care physician (PCP); this PCP is responsible for coordinating most of the recipient’s health care, including a majority of specialty care and referrals. The PCP becomes a “Medical Home” for people who have traditionally navigated a fragmented health care delivery system through use of yellow pages and numerous phone calls to determine if providers accepted Medicaid as payment for services.

Figure 10 *SoonerCare* Plus Catchment Areas¹³

(Darkened Areas)



Specifically, the counties that are considered urban and are serviced by *SoonerCare* Plus, are;

Southwest	Central	Northeast
Comanche	Canadian	Creek
Jackson	Cleveland	Rogers
Kiowa	Logan	Tulsa
	Oklahoma	Wagoner
	Pottawatomie	Osage

SFY2000 Specific Information...

- The \$213,238,980 *SoonerCare* Plus dollars accounted for sixteen percent (16%) of the total Medicaid dollars expended in SFY2000.
- As of June 30, 2000, the *SoonerCare* Plus program had 142,527 persons enrolled.
- For additional information on the *SoonerCare* Plus program, refer to the Service Efforts and Accomplishments on page 48 and pages 65 through 72.

¹³ Source: OHCA *SoonerCare* Operations Division

Oklahoma Managed Care-SoonerCare Choice

SoonerCare Choice is a Primary Care Case Management (PCCM) program where the state contracts directly with primary care providers throughout the state to provide basic health care services. The **SoonerCare** Choice program is partially capitated in that, providers are paid a monthly capitated rate for a fixed set of services with non-capitated services remaining compensable on a fee-for-service basis.

The word "Choice" in the **SoonerCare** Choice program name refers to the recipient's ability to change health care providers up to four times per year. Recipients enrolled in **SoonerCare** Choice are not "locked in" with a primary care physician / case manager (PCP/CM) like their counterparts in the **SoonerCare** Plus delivery system. This is an important facet to the program that allows providers to be added in rural areas of Oklahoma on a continuous basis- especially in areas of the state that may be historically under-served or be limited on the types of available providers.

Figure 11 SoonerCare Choice Catchment Areas¹⁴

(Darkened Areas)

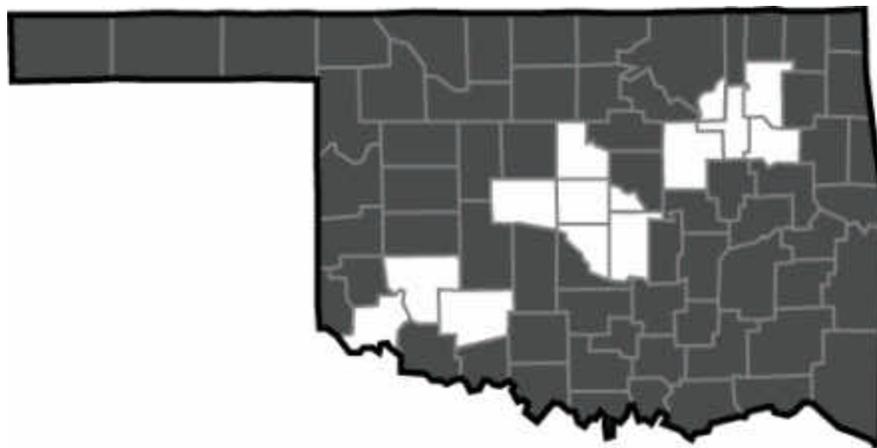
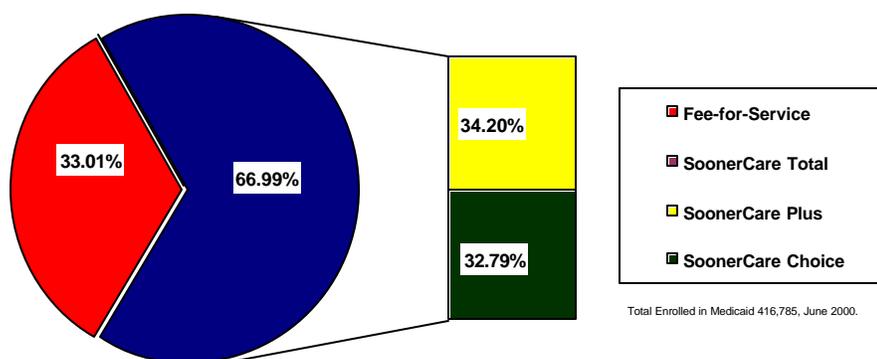


Figure 12 Oklahoma Medicaid Breakout of SoonerCare and Fee for Service (June 2000)¹⁵



SFY2000 Specific Information...

- The \$20,560,792 **SoonerCare** Choice dollars accounted for two percent (2%) of the total Medicaid dollars expended in SFY2000.
- As of June 30, 2000, the **SoonerCare** Choice program had 136,678 persons enrolled.
- For additional information on the **SoonerCare** Choice program, refer to the Service Efforts and Accomplishments on page 49 and pages 73 through 79.

¹⁴ Source: OHCA **SoonerCare** Operations Division

¹⁵ Source: OHCA **SoonerCare** Operations Division. Percents may not sum due to rounding.

Covering More Kids - - Title XIX Expansion and the State Children's Health Insurance Program (SCHIP)

First Came the Title XIX Expansion...

Recognizing the growing concern for the health and welfare of Oklahoma's children, the state legislature took action in 1997 by passing a Title XIX expansion. This legislation raised the eligibility level to 185% of the federal poverty level for children. This expansion included children under 18 and pregnant women regardless of age. The Title XIX expansion also included these qualifying individuals even if they had other types of insurance coverage (third party liabilities).

And Then Came SCHIP...

Subsequently, the Federal Budget Act of 1997 made numerous Medicaid changes and also created the State Children's Health Insurance Program (SCHIP). The optional program, referred to as SCHIP or Title XXI, is designed to help states cover additional uninsured low-income children with a higher federal match assistance percentage (See Figure 7 Historical Federal Medical Assistance Percentage, Page 11).

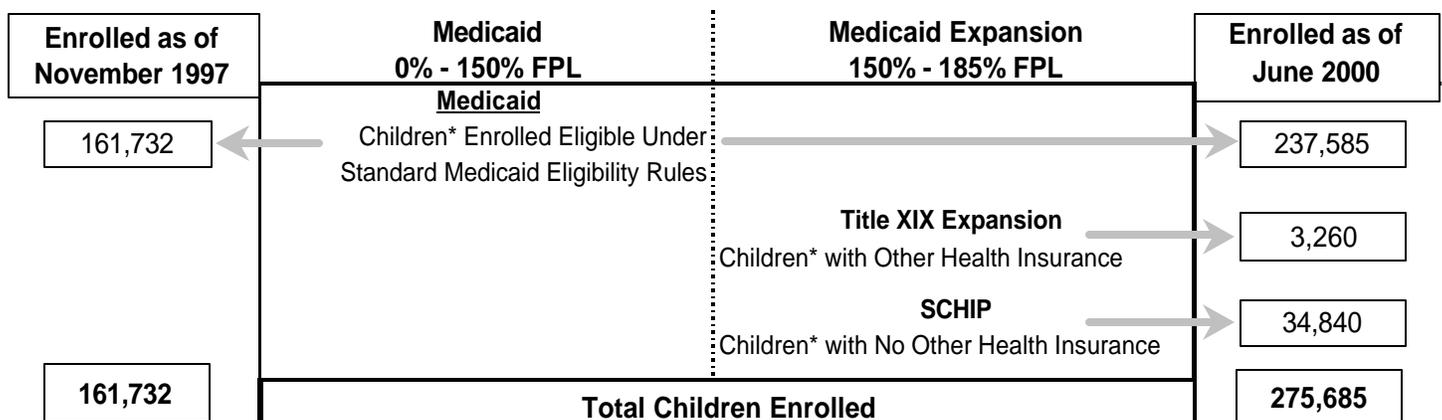
Oklahoma SCHIP defines eligibility for "targeted low-income children," as children who meet all of the following criteria:

- Have no creditable insurance;
- Family income below 185 percent (185%) of federal poverty guidelines;
- Under age 18; and
- Not eligible for Medicaid under eligibility criteria in effect prior to November 1997 or any other federal health insurance program. Uninsured children who meet previous eligibility standards must be enrolled in Medicaid, not SCHIP.

With SCHIP, the federal poverty guidelines for Oklahoma children were raised from 150% to 185%. This increased the allowable monthly income from \$1,735 monthly gross to the current \$2,181 monthly gross (both based on a family size of three).

With the inception of the Title XIX expansion and SCHIP, coupled with an aggressive outreach program, Oklahoma experienced a significant increase in the number of children covered by Medicaid (overall increase of seventy percent (70%) between November 1997 and June 2000). The collaborative outreach initiative provided an opportunity to reach, not only the children in the expansion, but also those who had previously been eligible under the Medicaid eligibility standards prior to 1997.

Figure 13 Increased Enrollment of Children Since Implementing Expansion Programs



* Children as defined above are only enrolled children under the age of 21.

Covering More Kids - - Title XIX Expansion and the State Children's Health Insurance Program (SCHIP) (Continued)

Most Federal SCHIP Dollars Unattainable for Oklahoma...

States do not get the higher, enhanced SCHIP reimbursement dollars for children who are already Medicaid-eligible. The problem lies in the allocation formula from the initial federal legislation. The "uninsured" number from prior to November 1997 was used by HCFA in their determination of the amount of SCHIP dollars allocated to Oklahoma; however, Oklahoma is only allowed to claim against the SCHIP dollars for those children between 150% and 185% of the federal poverty level who had no other type of health insurance. The formula did not take into account the number of kids who were uninsured *and* already Medicaid-eligible. Oklahoma has a small percentage of "SCHIP-eligible" kids, so only a small percentage of the enhanced SCHIP appropriation for reimbursement can be drawn down. Thus, leaving some appropriated money unused each federal fiscal year of the SCHIP program.

SFY2000 Specific Information...

- ✍ Expenditures made on behalf of persons eligible under the SCHIP program totaled \$33,217,109 and \$5,155,395 for persons in the Title XIX expansion program.
- ✍ The 34,840 enrolled in SCHIP as of June 2000, is eighty-five percent (85%) of target enrollment.

Behavioral Health Services

Behavioral Health Care Services represent a significant portion of the healthcare services purchased by the Oklahoma Health Care Authority on behalf of Medicaid recipients. Mental health treatment benefits for those enrolled in the fee for service, **SoonerCare** Choice and **SoonerCare** Plus programs include, inpatient acute care, crisis stabilization and emergency care. Additionally residential treatment (children only), psychiatric outpatient services (including pharmacological services) and a variety of outpatient counseling and rehabilitative services are included benefits. Treatment for alcohol and other drug disorders include hospital based medical detoxification, and a range of outpatient treatment services.

Over the past three years, the OHCA has increased contracting, accreditation, credentialing and quality assurance requirements for many of the behavioral health care using our available resources as efficiency as possible will continue over the next several years. Efforts will also include the development of new purchasing arrangements and increased collaborative efforts with other state agencies.

Graduate Medical Education (GME)

Graduate medical education refers to the residency training that doctors receive after completing medical school. Most residency programs are set up in teaching hospitals across the United States. GME derives funding from a variety of sources. Funding sources include patient care dollars and university funding, but the bulk of the money for GME comes from public, tax-supported sources: Medicare, Medicaid, the Department of Defense and Veterans' Affairs.

Specific SFY2000 Information...

- ✍ Graduate medical education payments, under the **SoonerCare** program, totaled \$7,259,764; this accounted for three percent (3%) of the SFY2000 **SoonerCare** expenditures.
- ✍ GME payments were made to the following: University of Oklahoma College of Medicine, both Oklahoma City and Tulsa locations, and OSU's School of Osteopathy.

Hospitals

Local hospitals serve as the cornerstone for a network of care providers that include such economic staples as primary care physicians, specialists, nutritionists, etc.

Disproportionate Share Hospital (DSH) Payments

Hospitals provide healthcare to the poor and uninsured in the form of uncompensated care, defined as the sum of charity care and bad debt charges. Uncompensated care has always been unevenly distributed - - urban safety net hospitals have had to assume a disproportionate burden of care for the under and uninsured.

The Medicaid DSH payment adjustment was born in a clause in the Omnibus Budget Reconciliation Act of 1981 (OBRA '81) that required state Medicaid agencies to make allowances when determining reimbursement rates for hospitals that served a disproportionate number of Medicaid or low-income patients.

Direct Medical Education (DME)

Effective July 1, 1999, in-state hospitals that qualified as teaching hospitals received a supplemental payment adjustment for direct medical education (DME) expenses. These payments were made in order to encourage training in rural hospital and primary care settings and to recognize the loss of support for GME due to the advent of Managed Care capitation programs.

In order to qualify as a teaching hospital and be deemed eligible for DME supplemental incentive payment adjustments, the hospital must:

- ☒ Be licensed in the State of Oklahoma;
- ☒ Have a medical residency program; and
- ☒ Apply for certification by the OHCA prior to receiving payments for any quarter;
- ☒ Have a contract with OHCA to provide Medicaid Services;
- ☒ Belong to the Council of Teaching Hospitals or show proof of affiliation with an approved Medical Education Program.

SFY2000 Specific Information...

- ☒ Hospital expenditures, \$261,440,317, accounted for sixteen percent (16%) of Oklahoma's total Medicaid Expenditures.
- ☒ During SFY2000, the Oklahoma Medicaid program had individual contracts with 529 hospitals.
- ☒ Disproportionate Share Hospital (DSH) payments for SFY2000 were \$22,304,780; this represents eight percent (8%) of total Medicaid expenditures for hospital services.
- ☒ Disproportionate Share Hospital (DSH) payments were made to fifteen (15) hospitals during SFY2000.
- ☒ Direct Medical Education (DME) payments totaling \$27,612,774 were made to sixteen (16) Oklahoma hospitals; this accounted for ten percent (10%) of the total Medicaid expenditures for hospital services.

Long Term Care

Medicaid is the only public program that provides substantial coverage for long-term care. Medicaid is the nation's safety net provider of long-term care services not only for the poor, but for the middle class as well. However, Medicaid pays for care for those with middle incomes only once they have exhausted their own financial resources; consequently, many of the elderly are at considerable risk of catastrophic long-term care expenditures. Because of their greater likelihood of needing long-term care and their limited ability to pay, the low-income elderly are especially at risk.

While much is being said about the future consequences of an aging population on society, Medicaid programs are facing significant long-term health care challenges today. The elderly growth rate is predicted to remain steady until 2010; however, by 2030 one in five Americans will be elderly. More significantly, the oldest population (85 years and over) is predicted to double between 1990 and 2010, and more than double again by 2040.¹⁶ Because Medicaid is a major payer of long-term care services, states will face a much greater financial burden than they do today.

SFY2000 Specific Information...

- Expenditures for nursing facilities (NF) serving adults were \$311,680,199; expenditures for intermediate care facilities for the mentally retarded (ICF/MR) were \$42,735,603.
- Total long term care expenditures accounted for twenty-percent (20%) of the total Oklahoma Medicaid expenditures.
- Medicaid recipients living in long term care facilities represented an estimated six percent (6%) of total Medicaid recipients.
- Medicaid funded 6,329,957 long-term care facility bed days; this represents seventy percent (70%) of the total actual bed days for SFY99 (last reported cost report data).

Facility Type:	NF-Aids	NF-Adults	ICF-MR	ICF-MR (16 Bed or Less)
Medicaid Bed Days:	8,361	5,733,389	513,431	74,776
Medicaid as a % of Total Bed Days:	96%	68%	98%	97%

- Medicaid payments were made to 423 long-term care facilities.
- For additional information refer to pages 63 and 64 of the Service Efforts and Accomplishments.

¹⁶ Source: Kaiser Commission on *Medicaid and the Uninsured*, November 1999.

Medicare “Buy-In” Program

In order to help protect low-income Medicare beneficiaries from the Medicare program's cost-sharing requirements, Congress has enacted several programs. Under the Medicare Catastrophic Coverage Act (MCCA) of 1988, Congress required each state's Medicaid program to “buy-in” to Medicare for low-income beneficiaries and persons with disabilities by paying for Medicare premiums, deductibles and coinsurance. Medicare is made up of two parts, hospital insurance (Part A) and supplementary medical insurance (Part B). For hospital insurance expenses, Medicaid pays the coinsurance and deductible fees for hospital services and skilled nursing services for eligible persons. The deductible and coinsurance fees are also paid for supplementary medical insurance expenses that are primarily physician services.

Subsequent legislation was passed in order to cover individuals with slightly higher income levels. Individuals eligible for both Medicare and Medicaid coverage through any of the Medicare assistance programs are collectively known as the dual eligible populations, or “dual eligibles”.

There are several programs (often called “buy-in” programs) that assist low-income beneficiaries with potentially high out-of-pocket health care costs:

1. Qualified Medicare Beneficiary (QMB)

☞ For Medicare beneficiaries with incomes below 100% of the federal poverty level who have limited financial resources.

☞ Pays for Medicare beneficiaries' share of Medicare Part A.

2. Specified Low-income Medicare Beneficiary (SLMB)

☞ For Medicare beneficiaries whose incomes are at least 100%, but less than 120% of the federal poverty level who have limited financial resources.

☞ Pays for beneficiaries' share of Medicare Part B premiums.

3. Qualifying Individuals (QI)

QI-1's (Qualifying Individual Group 1):

☞ For Medicare beneficiaries whose incomes are at least 120%, but less than 135% of the federal poverty level who have limited financial resources.

☞ Pays the Medicare Part B premiums for beneficiaries who are not otherwise eligible for Medicaid.

QI-2's (Qualifying Individual Group 2):

☞ For Medicare beneficiaries whose incomes are at least 135%, but less than 175% of the federal poverty level who have limited financial resources.

☞ Pays for a portion of the Medicare Part B premiums for beneficiaries who are not otherwise eligible for Medicaid.

SFY2000 Specific Information...

☞ Medicare “Buy-In” expenditures accounted for three percent (3%) of the total Medicaid expenditures.

☞ “Buy-In” expenditures totaled \$53,239,760; this represented a two percent (2.17%) increase compared to SFY1999 “Buy-In” expenditures.

☞ 45,020 Part A premiums and 784,582 Part B premiums were paid for with Medicaid funding.

Pharmacy Program

Prescription drugs are currently covered by every state's Medicaid program, although coverage is optional under federal law. All states have opted to cover pharmaceuticals because use of medications often provides an alternative to expensive surgery, results in shorter hospital stays and prevents illness. Nevertheless, prescriptions drugs can be costly. Federal law governing Medicaid prescription drug reimbursements seeks to contain costs through limits on pharmacy reimbursement and mandatory rebates on pharmaceutical products.

Seeking additional pharmacy cost controls, the Oklahoma Health Care Authority implemented a Product Based Prior Authorization program, effective January 4, 2000. The goal of the Product Based Prior Authorization program is to optimize each patient's medical therapy with medication that best treats the patient's condition given his or her unique health status and circumstances. The program focuses on two therapeutic classes, Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) and H2 Antagonists/Proton Pump Inhibitors or anti-inflammatory and ulcer medications. Each class of medication has two tiers with Tier 2 medications requiring Prior Authorization. Patients with clinical exceptions or patients that have not tolerated or did not achieve a clinical success with a Tier 1 product previously can obtain a Tier 2 medication via the Prior Authorization Process. For additional information on the Product Based Prior Authorization refer to the Service Efforts and Accomplishments on page 62.

A Drug Utilization Review (DUR) Board also works to monitor medication therapies and to advise the OHCA on program policies to achieve appropriate and optimal use of pharmaceuticals for Oklahoma Medicaid recipients. The primary goal of the DUR is to enhance and improve the quality of pharmaceutical care and patient outcomes by encouraging optimal medication use. This goal is accomplished primarily by educating physicians and pharmacists to ensure medication therapies are appropriate, safe and effective.

SFY2000 Specific Information...

- Prescription drug program expenditures accounted for \$181,872,762 or ten percent (10%) of the total Oklahoma Medicaid expenditures.
- The average cost per prescription funded by Medicaid was \$43.96.
- The average prescription cost per patient funded by Medicaid was \$153.42.
- Product Based Prior Authorization saved \$1.6 million while reporting no official patient grievances.
- 36 million dollars were collected through the Drug Rebate program.
- For additional information, see page 62.

Physicians and Other Practitioners

Oklahoma Medicaid includes both private and public providers such as physicians, nurse practitioners, physician assistants and other health care professionals. Oklahoma pays medical providers to deliver Medicaid services and provide access to enrolled individuals. Oklahoma reimburses providers for services at state-determined rates from annual state and federal appropriations.

Participating providers are the cornerstone of the Medicaid program coordinating and providing the health care needs of individuals in the Oklahoma Medicaid program. For additional information on Physicians and Other Practitioners, refer to the Service Efforts and Accomplishments on Page 56.

SFY2000 Specific Information...

- Fee for Service expenditures for Physicians and Other Practitioners accounted for \$107,305,664 or six percent (6.26%) of Oklahoma's total Medicaid expenditures.

School Based Services

Health care is a vital foundation for families wanting to ensure their children are ready to learn at school. We know that children without health insurance are absent more frequently than their classmates; and they suffer more from asthma, ear infections and vision problems. These conditions, with treatment, can improve classroom attendance and participation.

OHCA is focusing an outreach initiative on places where we know we can find uninsured children such as schools. Parents rely on school systems to communicate important information about their children. This line of communication allows schools to become our partners in identifying and enrolling eligible children as well as contracting with OHCA to provide services by qualified health care professionals.

Many school systems across Oklahoma are taking advantage of this beneficial program. With Medicaid program assistance, many schools can now afford to employ nurses and health programs to help keep children healthy and productive.

One of the greatest challenges to the success of the programs and the prevention and detection of childhood illnesses is reaching children early and informing families about available comprehensive health services. This package of enhanced health care services for children is known as EPSDT or Early Periodic Screening, Diagnosis and Treatment. This program includes a broad range of services beyond the general Medicaid program such as comprehensive screenings, immunizations and dental services. The main goal is to help parents receive preventive care for their children rather than just rely on emergency care. This program allows families to identify potential health problems early.

SFY2000 Specific Information...

- EE* School-based contracts more than doubled compared to SFY1999. In SFY2000, there were 294 active contracts compared to 136 in SFY1999.
- EE* Expenditures also more than doubled compared to SFY1999. In SFY2000, expenditures were \$10,543,157 compared to \$4,043,949 in SFY1999.
- EE* Out of a total of 77 counties in Oklahoma, schools in 65 counties are participating.
- EE* For additional information refer to page 59 of the Service Efforts and Accomplishment section.

SoonerRide (Non-Emergency Transportation)

Non-emergency transportation has been part of the Medicaid program since 1969 when federal regulations mandated that states ensure the service for all Medicaid recipients. The purpose was clear, without transportation many of the very persons Medicaid was designed to aid would not get to the services needed. States are given a considerable amount of flexibility in the Medicaid regulations, including setting reimbursement rates and transportation modes.

Currently, the OHCA is responsible for reimbursement or payment for transportation for recipients in both the fee-for-service (FFS) program and the **SoonerCare** Choice program. The health maintenance organizations (HMO's) are responsible, by contract, for the transportation of recipients enrolled in the **SoonerCare** Plus program.

In an effort to provide budget predictability and increased accountability of the non-emergency transportation program under Oklahoma's fee-for-service Medicaid program, the Authority moved in early 1999 to institute a transportation brokerage system of reimbursement for mileage paid to clients outside the fully-capitated **SoonerCare** Plus program. Similar to a managed care health care delivery system, the contracted transportation broker is reimbursed on a per-member-per-month (PM/PM) basis.

By the end of SFY2000, all counties in Oklahoma had been phased into the new transportation system.

During SFY2000, the non-emergency transportation program for the fee-for-service and **SoonerCare** Choice program received an administrative Medicaid match of fifty percent (50%). At year end, OHCA was in the process of preparing a waiver for submission to HCFA that would allow OHCA to draw a higher program match for these expenditures.

Specific SFY2000 Information...

- ✂✂ The non-emergency transportation program cost \$5,092,598; this represented less than one percent (>1%) of the total Oklahoma Medicaid expenditures.
- ✂✂ Non-emergency transportation expenditures increased by nineteen percent (19%) from SFY1999 to SFY2000.
- ✂✂ For more information, refer to page 54 of the Service Efforts and Accomplishments.

Oklahoma Health Care Authority Annual Report SFY2000

Figure 14 Medicaid Programs- Comparison of Benefits (as of June 2000)

Fee-For-Service Program	SoonerCare CHOICE (Rural)	SoonerCare Plus (Urban)
? Assistive Technology (Children Only)	? Assistive Technology (Children Only)	? Assistive Technology (includes cognitive and developmental aids and augmentative and communication aids)
? Behavioral health services	? Behavioral health services	? Behavioral health services
? Case management services	? Case management services	? Case management services
? Dental services (adults are not covered except for reconstructive surgery and emergency extractions only)	? Dental services (adults are not covered except for reconstructive surgery and emergency extractions only)	? Dental services (adults are not covered except for reconstructive surgery and emergency extractions only - ABD adult members limited to emergency dental care, extractions, and dentures).
? Durable medical equipment including oxygen, oxygen concentrators, respirators, and ventilators (adults limited to one month each year)	? Durable medical equipment including oxygen, oxygen concentrators, respirators, and ventilators (adults limited to one month each year)	? Durable medical equipment including medical supplies (includes aids for daily living and personal care, mobility and positioning aids, standing and walking aids, hearing aids and listening aids, and visual aids)
? Early and Periodic Screening, Diagnostic & Treatment* (EPSDT) for children	? Early and Periodic Screening, Diagnostic & Treatment* (EPSDT) for children	? Early and Periodic Screening, Diagnostic & Treatment (EPSDT) for children
? Family planning services	? Family planning services	? Educational Classes
? Home health care services, limited to 36 visits per calendar year	? Home health care services, limited to 36 visits per calendar year	? Exceptional Needs Coordinator for ABD members
? Inpatient hospital services (12 days per fiscal year for adults)	? Inpatient hospital services (12 days per year for adults)	? Family planning services
? Laboratory and X-ray for children (anticipated coverage for adults in FY 2000)	? Laboratory and X-ray for children (limited adult coverage through PCP/CM)	? Home health care services
? Long-term care	? Maternity services	? Inpatient hospital services unlimited
? Maternity services	? Nurse midwife services and birthing center services	? Laboratory and X-ray unlimited
? Nurse midwife services and birthing center services	? Outpatient hospital services	? Maternity services
? Outpatient hospital services	? Outpatient surgery	? Nurse midwife services and birthing center services
? Outpatient surgery	? Over-the-Counter Contraceptives	? Outpatient hospital services
? Over-the-Counter Contraceptives	? Podiatry services (limited)	? Outpatient surgery
? Podiatry services (limited)	? Prescription drugs (3 per month for adults)	? Over-the-Counter Contraceptives
? Prescription drugs (3 per month for adults)	? Provider/Clinic office visits (unlimited with PCP/CM, specialty visits limited to 2 per month for adults)	? Podiatry services
? Provider/Clinic office visits (2 office visits per month for adults)	? Therapy Services (Occupation Therapy, Physical Therapy, and Speech for children)	? Prescription drugs (unlimited)
? Therapy Services (Occupation Therapy, Physical Therapy, Speech for children)	? Transportation related to covered Medicaid services	? Provider/Clinic office visits unlimited
? Transportation related to covered Medicaid services	? Vision services (adults are not covered except for treatment of eye diseases or eye injuries only)	? Therapy Services (Occupation Therapy, Physical Therapy, and Speech Therapy)
? Vision services (adults are not covered except for treatment of eye diseases or eye injuries only)	? Nurse Advice Line	? Transportation to covered services
		? Vision services (adults are not covered except for treatment of eye diseases or eye injuries only - ABD adults 21-45 - one routine eye exam plus one pair of glasses each 24 months - ABD adults 46 or older - one routine eye exam and one pair of glasses each 12 month)

Children = Birth up through age 21 Adult = age 21 and older

*Early Periodic Screening, Diagnosis and Treatment (EPSDT) = 6 visits before age 1- 2 visits between ages 1 and 2 - 1 yearly visit for ages 2-5 - 1 visit every other year for ages 6-20. **Includes:** Physical exam, eye and hearing exam, dental exam, nutritional review, lead screening, lab tests, speech screening, visit for mental health and substance abuse problems.



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Oklahoma Health Care Authority Annual Report SFY2000

Figure 17 Statewide Medicaid Figures

County	Population Proj. 2000 Census ²¹	Rank	Eligibles ²²	Rank	Pop.Covered by Medicaid	Rank
ADAIR	21,400	38	4,408	31	20.60%	6
ALFALFA	6,300	70	422	71	6.70%	76
ATOKA	13,750	47	2,545	43	18.51%	15
BEAVER	6,400	67	363	73	5.67%	77
BECKHAM	20,150	40	3,003	38	14.90%	30
BLAINE	12,400	50	1,615	57	13.02%	42
BRYAN	33,650	27	5,620	22	16.70%	25
CADDO	32,250	30	5,976	17	18.53%	14
CANADIAN	83,350	5	5,985	16	7.18%	73
CARTER	46,100	16	7,925	8	17.19%	20
CHEROKEE	37,200	23	7,011	13	18.85%	13
CHOCTAW	16,750	43	3,875	34	23.13%	1
CIMARRON	3,550	77	266	77	7.49%	71
CLEVELAND	191,050	3	14,037	4	7.35%	72
COAL	6,350	69	1,295	60	20.39%	7
COMANCHE	127,100	4	14,274	3	11.23%	52
COTTON	6,850	66	939	66	13.71%	39
CRAIG	14,800	45	2,344	46	15.84%	27
CREEK	66,300	7	7,632	10	11.51%	49
CUSTER	29,000	33	2,999	39	10.34%	53
DELAWARE	28,950	34	5,847	19	20.20%	9
DEWEY	5,850	71	409	72	6.99%	74
ELLIS	4,550	73	362	74	7.96%	68
GARFIELD	60,750	11	7,189	12	11.83%	47
GARVIN	27,700	35	3,802	35	13.73%	38
GRADY	45,200	17	5,618	23	12.43%	44
GRANT	5,850	71	456	70	7.79%	69
GREER	6,400	67	967	65	15.11%	29
HARMON	3,850	76	759	68	19.71%	11
HARPER	4,100	75	277	76	6.76%	75
HASKELL	11,050	57	2,367	45	21.42%	5
HUGHES	13,500	48	2,744	41	20.33%	8
JACKSON	32,800	28	4,076	32	12.43%	45
JEFFERSON	7,050	65	1,244	61	17.65%	18
JOHNSTON	10,450	60	1,845	51	17.66%	17
KAY	51,150	13	5,854	18	11.44%	50
KINGFISHER	14,200	46	1,184	63	8.34%	66
KIOWA	11,650	53	1,629	56	13.98%	37
LATIMER	11,100	56	2,417	44	21.77%	4
LEFLORE	47,050	15	7,874	9	16.74%	24
LINCOLN	31,250	31	3,603	36	11.53%	48
LOGAN	30,550	32	3,061	37	10.02%	55
LOVE	8,850	63	1,200	62	13.56%	40
MCCLAIN	24,900	37	2,301	47	9.24%	59
MCCURTAIN	37,400	22	8,474	7	22.66%	3

Oklahoma Health Care Authority Annual Report SFY2000

Figure 17 Statewide Medicaid Figures (continued)

County	Total Annual Expenditures	Rank	Annual Per Capita	Rank	Monthly Per Eligible	Rank
ADAIR	\$12,651,807.84	36	\$591.21	27	\$239.27	67
ALFALFA	\$1,908,202.97	72	\$302.89	67	\$373.80	13
ATOKA	\$8,735,649.53	45	\$635.32	19	\$283.90	44
BEAVER	\$1,012,513.10	76	\$158.21	76	\$236.55	69
BECKHAM	\$11,911,145.05	38	\$591.12	28	\$329.25	23
BLAINE	\$6,156,959.62	56	\$496.53	38	\$318.46	28
BRYAN	\$21,130,795.63	22	\$627.96	21	\$314.96	31
CADDO	\$15,852,936.60	30	\$491.56	39	\$220.73	73
CANADIAN	\$22,690,812.73	19	\$272.24	71	\$317.58	29
CARTER	\$26,891,073.36	11	\$583.32	31	\$282.25	47
CHEROKEE	\$26,944,307.69	10	\$724.31	9	\$319.31	26
CHOCTAW	\$12,903,248.45	35	\$770.34	8	\$277.99	51
CIMARRON	\$560,994.50	77	\$158.03	77	\$175.65	76
CLEVELAND	\$47,847,262.83	4	\$250.44	73	\$286.22	46
COAL	\$4,369,904.72	62	\$688.17	13	\$282.12	48
COMANCHE	\$37,114,731.56	7	\$292.01	68	\$221.21	74
COTTON	\$2,440,168.16	67	\$356.23	57	\$217.24	75
CRAIG	\$15,680,613.34	31	\$1,059.50	2	\$582.21	3
CREEK	\$33,331,195.74	8	\$502.73	37	\$365.19	14
CUSTER	\$10,398,773.00	42	\$358.58	56	\$288.28	40
DELAWARE	\$16,978,595.04	27	\$586.48	29	\$242.72	65
DEWEY	\$2,141,565.53	71	\$366.08	53	\$435.65	6
ELLIS	\$1,566,090.64	73	\$344.20	61	\$360.53	15
GARFIELD	\$60,196,845.79	3	\$990.89	4	\$699.66	2
GARVIN	\$45,204,784.94	6	\$1,631.94	1	\$992.16	1
GRADY	\$16,370,989.07	28	\$362.19	54	\$242.06	64
GRANT	\$2,341,539.82	68	\$400.26	46	\$430.47	7
GREER	\$3,140,115.88	65	\$490.64	41	\$272.24	53
HARMON	\$2,328,177.91	69	\$604.72	26	\$253.11	60
HARPER	\$1,560,760.40	74	\$380.67	50	\$465.48	5
HASKELL	\$7,607,398.34	48	\$688.45	12	\$267.18	56
HUGHES	\$13,400,269.37	33	\$992.61	3	\$411.51	8
JACKSON	\$11,783,364.37	39	\$359.25	55	\$239.95	66
JEFFERSON	\$5,083,428.31	60	\$721.05	10	\$339.27	18
JOHNSTON	\$6,412,720.93	53	\$613.66	23	\$289.51	39
KAY	\$16,098,459.16	29	\$314.73	62	\$228.98	72
KINGFISHER	\$4,463,737.12	61	\$314.35	63	\$306.52	30
KIOWA	\$7,723,889.68	47	\$662.99	17	\$394.63	10
LATIMER	\$7,812,921.32	46	\$703.87	11	\$276.90	54
LEFLORE	\$25,409,880.42	13	\$540.06	34	\$268.39	55
LINCOLN	\$10,853,898.78	41	\$347.32	58	\$250.95	62
LOGAN	\$12,539,949.24	37	\$410.47	45	\$340.54	17
LOVE	\$3,326,465.36	64	\$375.87	51	\$230.70	70
MCCLAIN	\$7,134,915.78	50	\$286.54	69	\$258.90	58
MCCURTAIN	\$23,735,457.48	16	\$634.64	20	\$233.30	68

Oklahoma Health Care Authority Annual Report SFY2000

Figure 17 Statewide Medicaid Figures (Continued)

County	Population Proj. 2000 Census ²¹	Rank	Eligibles ²²	Rank	Pop.Covered by Medicaid	Rank
MCINTOSH	16,850	42	2,867	40	17.01%	21
MAJOR	8,200	64	675	69	8.23%	67
MARSHALL	11,000	58	1,843	52	16.75%	23
MAYES	35,750	26	5,129	26	14.35%	34
MURRAY	12,500	49	1,793	53	14.34%	35
MUSKOGEE	74,500	6	11,625	5	15.60%	28
NOBLE	11,650	53	1,095	64	9.40%	57
NOWATA	10,150	61	1,467	59	14.45%	33
OKFUSKEE	12,350	51	2,082	49	16.86%	22
OKLAHOMA	659,650	1	78,524	1	11.90%	46
OKMULGEE	39,100	21	7,552	11	19.31%	12
OSAGE	44,600	18	4,045	33	9.07%	61
OTTAWA	32,450	29	5,701	21	17.57%	19
PAWNEE	16,500	44	1,859	50	11.27%	51
PAYNE	65,650	8	5,714	20	8.70%	64
PITTSBURG	42,700	20	6,876	14	16.10%	26
PONTOTOC	35,800	25	4,852	29	13.55%	41
POTTAWATOMIE	63,150	9	9,023	6	14.29%	36
PUSHMATAHA	11,250	55	2,559	42	22.75%	2
ROGER MILLS	4,300	74	328	75	7.63%	70
ROGERS	61,400	10	5,127	27	8.35%	65
SEMINOLE	26,900	36	5,344	25	19.87%	10
SEQUOYAH	36,850	24	6,734	15	18.27%	16
STEPHENS	44,600	18	5,607	24	12.57%	43
TEXAS	18,150	41	1,699	55	9.36%	58
TILLMAN	10,900	59	1,588	58	14.57%	32
TULSA	559,750	2	50,669	2	9.05%	62
WAGONER	52,400	12	4,832	30	9.22%	60
WASHINGTON	50,950	14	4,951	28	9.72%	56
WASHITA	11,900	52	1,743	54	14.65%	31
WOODS	9,000	62	797	67	8.86%	63
WOODWARD	20,500	39	2,117	48	10.33%	54

²¹ County Population Projections were downloaded from the Oklahoma Department of Commerce website. (www.odoc.state.ok.us)

²² Eligibles listed above represent an unduplicated count of individuals that were enrolled in Medicaid for the month of June 2000. The data does not represent the number of individuals eligible within the quarter or the year.

Oklahoma Health Care Authority Annual Report SFY2000

Figure 17 Statewide Medicaid Figures (Continued)

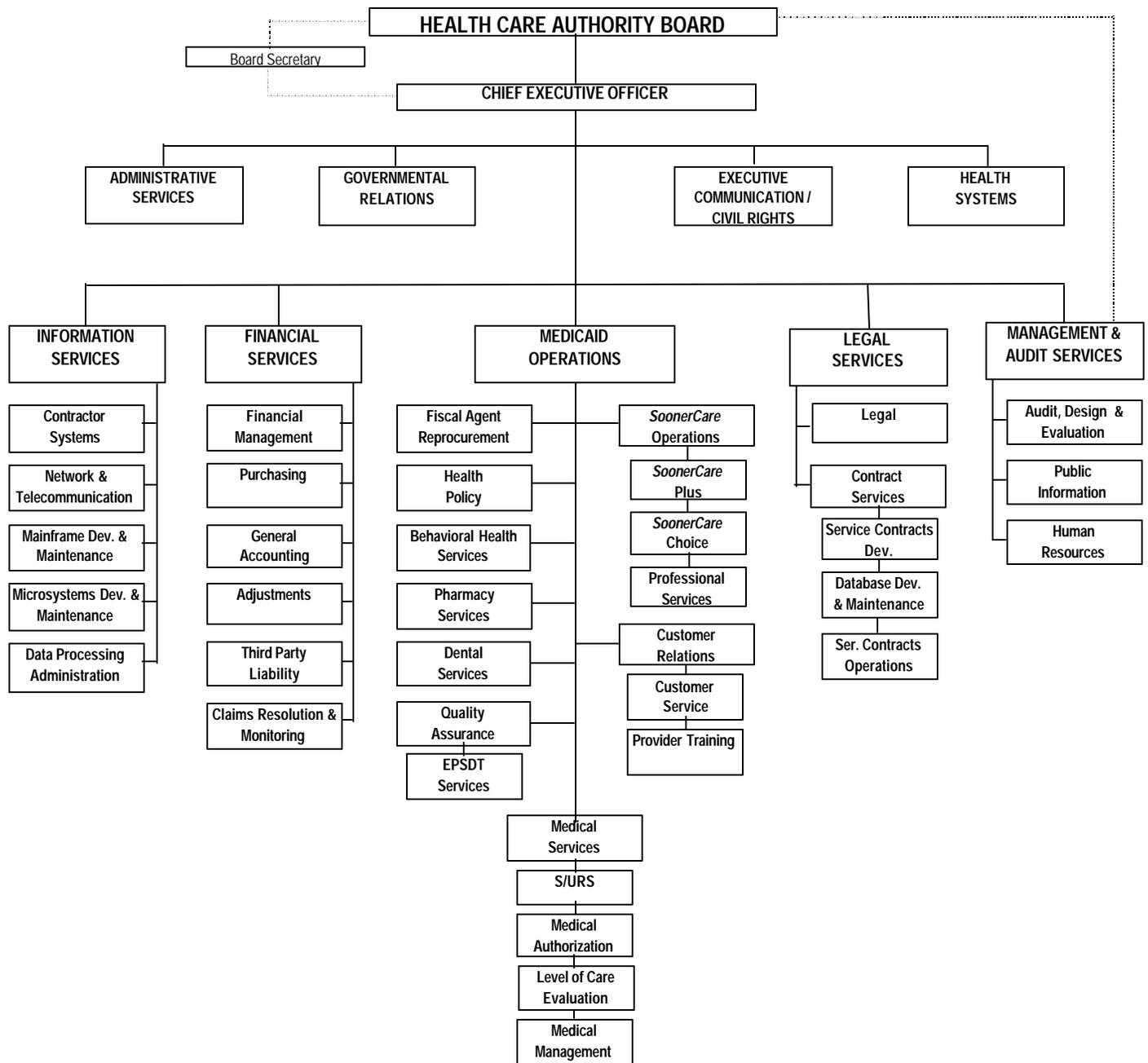
County	Total Annual Expenditures	Rank	Annual Per Capita	Rank	Monthly Per Eligible	Rank
MCINTOSH	\$11,427,282.29	40	\$678.18	14	\$331.63	22
MAJOR	\$2,324,513.97	70	\$283.48	70	\$285.92	43
MARSHALL	\$7,420,349.14	49	\$674.58	15	\$336.22	20
MAYES	\$17,560,632.15	26	\$491.21	40	\$285.37	45
MURRAY	\$6,391,305.64	54	\$511.30	35	\$296.73	34
MUSKOGEE	\$45,666,798.28	5	\$612.98	24	\$326.19	24
NOBLE	\$6,797,094.88	51	\$583.44	30	\$516.66	4
NOWATA	\$5,618,306.58	57	\$553.53	33	\$319.24	27
OKFUSKEE	\$9,986,949.67	43	\$808.66	6	\$402.60	9
OKLAHOMA	\$242,962,298.13	1	\$368.32	52	\$313.81	59
OKMULGEE	\$26,118,378.86	12	\$667.99	16	\$289.18	42
OSAGE	\$13,582,153.77	32	\$304.53	65	\$279.72	49
OTTAWA	\$19,818,470.07	23	\$610.74	25	\$289.12	38
PAWNEE	\$6,584,910.26	52	\$399.09	47	\$294.64	35
PAYNE	\$22,784,669.14	17	\$347.06	59	\$332.28	21
PITTSBURG	\$23,946,212.53	14	\$560.80	32	\$289.50	37
PONTOTOC	\$22,388,234.41	20	\$625.37	22	\$384.22	11
POTTAWATOMIE	\$30,183,354.16	9	\$477.96	42	\$278.64	50
PUSHMATAHA	\$9,504,087.72	44	\$844.81	5	\$308.91	32
ROGER MILLS	\$1,065,209.80	75	\$247.72	74	\$271.50	52
ROGERS	\$18,875,562.92	24	\$307.42	64	\$306.34	33
SEMINOLE	\$21,699,979.46	21	\$806.69	7	\$339.61	19
SEQUOYAH	\$23,822,150.83	15	\$646.46	18	\$294.42	36
STEPHENS	\$17,662,644.47	25	\$396.02	48	\$261.61	57
TEXAS	\$3,568,420.91	63	\$196.61	75	\$175.17	77
TILLMAN	\$5,493,385.90	58	\$503.98	36	\$288.02	41
TULSA	\$217,080,079.19	2	\$387.82	49	\$374.81	16
WAGONER	\$13,339,297.67	34	\$254.57	72	\$229.51	71
WASHINGTON	\$22,760,162.01	18	\$446.72	43	\$383.38	12
WASHITA	\$5,261,444.70	59	\$442.14	44	\$251.40	61
WOODS	\$3,120,189.41	66	\$346.69	60	\$326.33	25
WOODWARD	\$6,220,587.37	55	\$303.44	66	\$247.26	63

²¹ County Population Projections were downloaded from the Oklahoma Department of Commerce website. (www.odoc.state.ok.us)

²² Eligibles listed above represent an unduplicated count of individuals that were enrolled in Medicaid for the month of June 2000. The data does not represent the number of individuals eligible within the quarter or the year.

Oklahoma Health Care Authority Annual Report SFY2000

Figure 18 OHCA's Organizational Chart



Organization as of June 30, 2000.
 FY2000 authorized FTE 257.5

Core Function Summary

Executive Office Support

Administrative Services answers and directs all calls, which come into the main agency telephone number through the receptionist desk and coordinates space requests and general maintenance issues. The Administrative Services Unit also performs the administration, maintenance and monitoring of a variety of activities including the agency's security and telephone systems, a continuing program for the economical and efficient management of agency records in compliance with state statute, as well as sorting and delivering all incoming and outgoing mail to appropriate designations. *Administrative Chief of Staff, James Smith (405) 522-7150*

Government Relations acts as a liaison between the agency and the legislative and executive branches of state government providing clarification and information regarding agency programs and operations. This unit also provides assistance to legislators regarding constituent concerns within the scope of the OHCA and coordinates fiscal, policy and program impacts with agency staff regarding pending legislation. *Director, Dana Brown (405) 522-7404*

Executive Communication/Information and Referral documents, controls and distributes for informational purposes and for timely responses to requests, all federal, state and other customer correspondence which comes addressed only to OHCA or which agency personnel have authorized the unit to process. *Director, Donna Huckleberry (405) 522-7452*

Civil Rights Compliance reports directly to the CEO and is responsible for planning, directing, and managing all phases of the affirmative action program involving targeted recruitment and assessment of programmatic outcomes, required by state and federal statistical analysis and management/employee counseling. *Civil Rights Compliance Officer, Donna Huckleberry (405) 522-7452*

Health Systems Unit acts as internal consultant to CEO on ongoing implementation of 1115(a) waiver-based Medicaid managed care system in Oklahoma. Responsible for tracking and monitoring of Federal legislation with implications for Medicaid system, in general, and for keeping CEO and agency administrators advised as to implications, available options and recommendations regarding impact of this legislation. *Deputy Administrator for Health Systems, Leigh Brown (405) 522-7419.*

Medicaid Operations

Lynn Mitchell, M.D., M.P.H., State Medicaid Director

Fiscal Agent Reprourement is responsible for preparing the Invitation to Bid (ITB) for a new fiscal agent, as well as plans and implements details relating to the contracting of a fiscal agent, such as coordination of the contracting entity, consultants for OHCA and OHCA staff for timely contract award and implementation. *Coordinator, Richard Evans (405) 522-7393*

Health Policy develops and presents upcoming policy issues to the Medical Advisory Committee (MAC) for the purpose of receiving direction from the members regarding additional research and/or consideration in addition to receiving requests from the members to research and subsequently report on other policy issues. This unit also monitors existing Medicaid programs to ensure compliance with new state and federal regulations and to coordinate with the HCFA Regional Office on questions related to Medicaid policy, issues of noncompliance, expenditures and the State Plan. The Health Policy Area also directs the OHCA's scheduled review of administrative rules, statutes and internal policies, reporting to the Governor, the President Pro Tempore of the Senate, and the Speaker of the House of Representatives those rules to be modified or repealed and statutes or policies which should be promulgated pursuant to the Administrative Procedures Act. *Director, Jim Hancock (405) 522-7268*

Behavioral Health Services interfaces with other state agencies, consumer groups, providers and internal OHCA units regarding Medicaid policies related to behavioral health services, provides operational monitoring and support for Oklahoma Foundation for Medical Quality (OFMQ) prior authorizations and review services, as well as evaluates and coordinates requests for placement in out of state residential treatment. *Director, Terrie Fritz, L.C.S.W. (405) 522-7377*

Core Function Summary (continued)

MEDICAID OPERATIONS (continued)

Pharmacy Services performs concurrent and retrospective reviews for drug claims for quantity abnormalities, drug rebates and reversals of claims which result in recoupment of Medicaid dollars and provides a service to providers regarding Federal Upper Limits (FUL) and service to providers and recipients regarding compensability and eligibility. The Drug Rebate Unit within Pharmacy Services, plans, coordinates and processes activities of the Medicaid Drug Rebate Program which includes invoicing and collecting rebates and interest, adjusting erroneous pharmacy claims, resolving rebate disputes and Federal reporting of receipts and receivables. *Pharmacy Director, John Crumly, R.Ph. (405) 522-7325*

Dental Services coordinates preventive and restorative dental services for eligible children which will enable them to retain their teeth for a lifetime with the goal being to educate clients as to the importance of oral health as an integral part of their overall physical health. Dental Services also provides ongoing consultations and guidance regarding policy changes as they pertain to Medicaid dental benefits as well as day to day reviews of dental program authorizations and utilization. *Director, Ella Matthews, R.N. (405) 522-7314*

Quality Assurance designs, implements and monitors a State Quality Assurance plan for **SoonerCare** which is in compliance with Federal guidelines and waiver protocols, as well as develops and maintains a reporting format for the monitoring processes which indicate improvement toward implementation or level of compliance as appropriate for each health plan and for health plans in aggregate. Quality Assurance unit staff organizes and facilitates every other month, agency-wide, Quality Assurance Committee meetings which addresses quality issues across all Medicaid programs. This unit also coordinates and monitors the recoupment process for areas of noncompliance identified through the OFMQ review process. EPSDT Services, within the Quality Assurance Unit, coordinates and monitors the EPSDT program, subsequently preparing and submitting required Federal reporting, as well as working with school districts in maximizing EPSDT/EI services to Medicaid eligible children through school based services. *Director, Darendia McCauley, Ph.D. (405) 522-7355*

Surveillance Utilization Review Subsystem (SURS) develops comprehensive statistical profiles and utilization patterns of health care delivery and reveals suspected instances of fraud and abuse by individual providers and recipients. This unit also provides education and training to providers, through SURS/review processes, regarding acceptable utilization and appropriate maintenance of file documentation and claim filings. *Supervisor, Jana Webb, R.N. (405) 522-7112*

Medical Authorization Unit reviews, responds and manually prices, when necessary, medical and dental requests for services for all recipients participating in the DHS Crippled Children Program, and any services that require prior authorization for adults and children eligible for Medicaid. This unit also performs prior authorization reviews and manually prices durable medical equipment, when a standard allowable cost is not in the claims payment system and answers telephone inquiries from all sources regarding Medicaid policy, scope and procedures. *Manager, Peggy Davis (405) 522-7371*

Level of Care Evaluation Unit (LOCEU) coordinates the Federal PASRR (Pre-Admission Screening and Resident Review) Program statewide, screening all clients entering Medicaid certified nursing facilities (NFs) for possible Mental Retardation (MR) and/or Mental Illness (MI) Level I screening and conducting Level II assessments to insure that this population requires NF Level of Care and receives proper treatment for mental illness and/or mental retardation. LOCEU approves all Medicaid clients for intermediate care facilities for the mentally retarded (ICF/MR) & DDSD Home and Community-Based Waiver Level of Care and provides medical determination for disability and incapacity of DHS clients. The Unit also audits the ADvantage and DDSD ICF/MR Home and Community-Based Waiver programs. *Manager, John Russell, M.Ed. (405) 522-7309*

Medical Case Management – Nurse Managers establish medical appropriateness for services referred for prior authorization from the Medical Authorization Unit and review medical data referred from other divisions within the agency as well as outside entities. Medical Services personnel determine applicability of payment for ventilator level of care for long term care patients and other procedures which have been determined to require medical review. Program integrity is monitored to verify compensation of medically appropriate services within the scope of the program through claims review and oversight of claims editing. Case management is provided for Fee for Service and transition plan members on an ad hoc basis. *Kathe Eastham, R.N. (405) 522-7155*

Core Function Summary (continued)

MEDICAID OPERATIONS (continued)

SoonerCare Plus participates in the development and evaluation process of the Request for Proposals from Health Plans, monitors compliance of health plans with **SoonerCare** contracts, particularly in the areas of operational data reporting requirements through administrative readiness reviews, operational compliance activities, and other contracting and reconciliation activities. **SoonerCare Plus** also implements and operationalizes all activities related to program tasks and activities of the **SoonerCare** fully capitated program, as well as identifying and resolving provider contractual issues, provider and member incidents and complaints, and review of network composition or access/quality issues related to program standards. *Acting Administrator, Kevin Rupe (405) 522-7498*

SoonerCare Choice acquires services either through direct contracting or through the Fee for Service system, monitors **SoonerCare** Choice services by reviewing and researching the **SoonerCare** Nurse Advice Line reports, and enrollment agent incident reports, limited on-site reviews and monitoring activities through the contracted peer review organization – Oklahoma Foundation for Medical Quality (OFMQ), and the OHCA Quality Assurance Committee. Another function of this unit is administering Choice services through the identification and determination of enrollment issues, the gathering, developing and mailing of informational supplies to providers, provider recruiting, and collaborative development, updating and maintaining the provider directory, as well as scheduled and Ad Hoc telephone communication with providers addressing concerns, issues and training needs. **SoonerCare** Choice also monitors compliance of Primary Care Providers (PCP's) with **SoonerCare** contracts, particularly in the areas of operational and financial data reporting requirements through compliance activities, financial audits and other contracting activities. *Acting Administrator, Charlene Benson, R.N./CPUR (405) 522-4788*

SoonerCare Professional Services monitors and reports on **SoonerCare** enrollment and expenditure data, preparing related costings of financial impact for budget requests and budget reports, as well as monitoring compliance of health plans with **SoonerCare** Plus contracts in the area of financial data reporting. This unit also prepares the computations and maintains the supporting documentation for delivery supplement payments and resident bonus payments and also develops the capitation methodologies related to the **SoonerCare** Program. *Director, Kevin Rupe (405) 522-7498*

Customer Relations consists of Customer Service and Provider Training and is responsible for technical assistance to all of the various participants in the Medicaid Program. The Unit answers a large volume of incoming telephone inquiries and correspondence from providers, vendors, recipients, DHS county offices, legislators, other state Medicaid agencies and others relating to agency and Federal Medicaid policy and OHCA procedures for all Medicaid programs. Customer Relations also reviews and authorizes processing for those specialized claims requiring additional medical documentation. The Unit offers individual and group training for Medicaid providers regarding both the Fee for Service Program and billing for the **SoonerCare** program. *Director, Susan Nicholson (405) 522-7360*

Information Services Division

John Calabro, Associate Director for Information Services

Contractor Systems monitors problems identified in the MMIS and recommends appropriate specifications to correct the deficiency, analyzes test results and monitors production environment for problems, as well as coordinates all maintenance and modification system changes with ongoing enhancements. This unit is responsible for system enhancements and is accountable for the fulfillment of data processing performed by the contracted fiscal agent, systems analysis and programming to implement requested system enhancements. Contractor Systems also establishes priorities for systems development and data processing projects according to departmental requirements, as well as develops plans for future utilization of data processing services in the overall agency program. *Director, Donna Witty (405) 522-7242*

Network and Telecommunication Management plans, designs, and supervises the installation, maintenance and modifications of the Agency's LAN, WAN and teleprocessing systems and provides for liaison with users of network services, develops improved techniques and methods for agency activities making more efficient use of processes. *Network Manager, John Calabro (405) 522-7424*

Mainframe Development and Maintenance performs all programming analysis, design, coding, implementation and operations for all computer systems not covered by the fiscal agent contract which runs on the DHS mainframe computer. This unit also maintains mainframe systems and reports including actuarial studies, data reporting, PS-2 to RMF interface and file transfer protocol. *Project Leader, Wayne Heiderich (405) 522-7219*

Core Function Summary (continued)

Information Services Division (continued)

Applications Development is responsible for maintenance and modification change requests and is accountable for the fulfillment of data processing performed on the OHCA network, systems analysis and programming to implement requested changes, in addition to overseeing and maintaining the OHCA LAN DBMS for the collection of agency data and the usage thereof. This unit also designs applications to be flexible, cost effective and relevant to address the needs of OHCA, as well as coordinates agency data processing activities with other state agencies, private sector entities and all OHCA units or divisions for network and telecommunication services. *Director, Jeff Slotnik (405) 522-7152*

Data Processing Administration is accountable for all data processing performed both within the division and development performed by the contracted fiscal agent, including equipment selection and purchase, systems analysis, programming, operations and data entry, in addition to recommending new uses for data processes or abandonment of inefficient present uses. *Data Processing Administrator, Judi Worsham (405) 522-7222*

Finance Division

Anne Garcia, Associate Director for Financial Services

Financial Management prepares the annual agency budget request, prepares and processes federal expenditure reports, agency budget work programs and any necessary revisions, as well as prepares and maintains the Cost Allocation Plan. This unit also researches and analyzes claims history and cost report data in order to develop, implement and support reimbursement rates for institutional providers and submit state plan documentation. *Director, Debbie Ogles (405) 522-7270*

General Accounting draws administrative and Medicaid program federal matching funds in accordance with the US Treasury CMA Agreement and maintains the general ledger for accounting of all funds, including balancing cash to Office of State Finance (OSF) and the State Treasurer's Office (STO), and posting of all receipts and expenditures of agency funds. This unit prepares the monthly financial statement reports, quarterly cost allocation schedules and annual Generally Accepted Accounting Principles (GAAP) conversion packages for the statewide Comprehensive Annual Financial Report (CAFR). General Accounting also tracks and reconciles adjudication reports produced by the fiscal agent before authorizing weekly payment tapes to be transmitted to the STO for production of medical warrants, in addition to preparing and processing all agency payrolls, as well as processing all Medicaid provider garnishments and tax levies and reconciling and approving annual 1099 and W2 information. *Director, Carrie Evans (405) 522-7359*

Adjustments researches and reconciles claims of erroneous provider payments as reported through various sources, researches and initiates corrective action on claims for which refunds have been received from medical providers. The Adjustments Unit also identifies problem areas with the claims and recoupment process, recommending that training be provided to individual providers or provider groups. *Supervisor, Michelle Thomas (405) 522-7305*

Third Party Liability ascertains the legal liability of third parties to pay for care and services furnished to Medicaid recipients and seeks reimbursement from third parties. This unit uses the cost avoidance method of payment when there is a probable existence of TPL at the time the claim is filed, unless a waiver has been approved by HCFA, in addition to demonstrating effective and timely submission of third party resource data into the TPL data base, as well as effective and timely recovery of paid claims upon identification of a third party source. *Supervisor, Diane Flowers (405) 522-7254*

Claims Resolution and Monitoring monitors the timely and accurate input and output of the Claims Processing System for Medicaid Providers and controls the edits in the claims processing system. This unit handles claim problems and inquiries by working with other divisions/units of the OHCA, other state agencies, the MMIS contractor and medical providers. *Manager, Mary Lou Schniedermeyer (405) 522-7243*

Purchasing anticipates, initiates and processes purchase requests and encumbrance documents submitted by units within the agency, as well as follows up on purchase orders, monitors funding amounts and prepares change orders to increase, decrease or cancel encumbered funds. Purchasing also initiates and stocks supply orders for the entire agency. *Purchasing Director, Vickie Kersey (405) 522-7482*

Core Function Summary (continued)

Management and Audit Services

Cindy Roberts, Associate Director for Management and Audit Services

Audit, Design and Evaluation plans and coordinates both audit and strategic projects of organizational, functional and program activities for the purpose of evaluating the effectiveness of controls, compliance and/or strategic feasibility. Additionally, this unit is responsible for the data collection, analysis and preparation of the agency's quarterly and annual reports, as well as the required Service Efforts and Accomplishments (SEA) reporting which accompanies the annual budget request. Another aspect of this unit's work includes both waiver and Title XXI reporting. *Associate Director, Cindy Roberts (405) 522-7077*

Public Information develops and implements public information and communication strategies targeted to public and private entities, oversees the development, design and production of all internal and external educational and informational communications and coordinates, develops and produces various reporting mechanisms that detail the agency's activities and accomplishments. Public Information also writes and disseminates press releases related to the operational aspects of the OHCA and its managed care programs. *Public Information Officer, Nico Gomez (405) 522-7484*

Human Resources monitors and assures agency compliance with all relevant state and federal personnel regulations in addition to the basic personnel principals and practices. This unit also maintains a human resources information system for tracking recruitment, processes personnel transactions, employee evaluation activities, compensation management and supervisory training and subsequently generates monthly, quarterly and annual personnel related reports, as well as conducts the human resources personnel transactions in a way that maximizes the agencies use of full time employees (FTE) and allocated budget. Human Resources also serves as the liaison on employee benefits, retirement, and ethics, as well as monitors safety and workers' compensation issues. *Director, Ron Wilson (405) 522-7418*

Legal Services

Howard Pallotta, J.D., Associate Director for Legal Services

Legal Services coordinates all litigation for the agency, renders legal opinions and advises CEO, Board members and agency management on administrative legal issues. This unit also coordinates and hears all Administrative Law Judge (ALJ) appeals filed by providers and recipients and represents the agency before administrative, state and federal courts or tribunals. *Associate Director, Howard Pallotta, J.D. (405) 522-7431*

Contract Services oversees the establishment, including negotiating costs, terms and conditions, of the agency's professional service and interagency contracts and writes contracts, amendments, validates invoices, monitors performance and provides reporting functions relative to the fiscal agent contract. The Service Contracts Operations area within the Contract Services Unit verifies and coordinates information from the various licensure boards and regulatory agencies regarding current licensure, probation, suspension, changes of ownership and closures, etc., in addition to advising providers on issues such as whether they need a Fee for Service or Managed Care contract, contract status, provider numbers and/or effective contract dates. *Director, Rolando Davila, J.D. (405) 522-7234*

Glossary of Terms

ABD	The A ged, B lind and D isabled Medicaid population.
Capitated Payment	A monthly payment of a predetermined amount, per person, for an individual's required health care services within managed care.
SCHIP	S tate C hildren's H ealth I nsurance P rogram for children under age 18 that have no creditable insurance and meet income requirements.
Eligible	For this report, an individual who is qualified and enrolled in Medicaid, who may or may not have received services during the reporting quarter.
Fee-For-Service	The method of payment for the Medicaid population that is not covered under managed care. Claims are generally paid on a per service occurrence basis.
FFY	F ederal F iscal Y ear. The federal fiscal year starts on October 1 and ends September 30 each year.
FMAP	F ederal M edical A ssistance P ercentage - The federal dollar match percentage.
ICF/MR	I ntermediate C are F acility for the M entally R etarded.
EPSDT	E arly P eriodic S creening, D iagnosis and T reatment
SFY	S tate F iscal Y ear. The state fiscal year starts on July 1 and ends June 30 each year.
TANF/AFDC	T emporary A ssistance for N eedy F amilies, formerly known as A id to F amilies and D ependant C hildren.
Title XIX	A grant in aid of the Medical Assistance Program, enacted in 1965 under the Social Security Act financed by both Federal and State dollars.
Title XXI	A Medicaid expansion Program, see SCHIP.

Figure 19 Technical Notes

Throughout this report a combination of data sources were used to provide the most accurate information possible. The total number of eligibles and recipients are calculated on a statewide basis and various subsections. When any type of subsection is measured (i.e., aid category, county, etc.) recipient numbers may exceed eligible numbers. Provider billing habits can cause this. All quarterly report claim data is extracted with the date paid by OHCA being within the quarter. Provided that a recipient is eligible at the time of service, a provider has one year from the date of service to submit a claim. Some providers hold claims and submit them all at once. For example, if a recipient receives a Medicaid service in May and the provider submits and is paid for the claim in July, that recipient will be counted as a recipient and the dollar totals will be included in the July reporting quarter, even if the recipient may not be eligible within that same reporting quarter. If that recipient is not eligible at some point within the reporting quarter, they will not be counted in the "Eligibles".

Additionally, county Department of Human Services offices may determine that a person's eligibility began at an earlier point in time. When a person is deemed to be eligible prior to the current month, these are called retro-certifications. Retro-certifications could cause any subsequent reports for the same reporting period to have varied outcomes.

