Oklahoma Health Care Authority

Strategic Plan

SFY2014—2015

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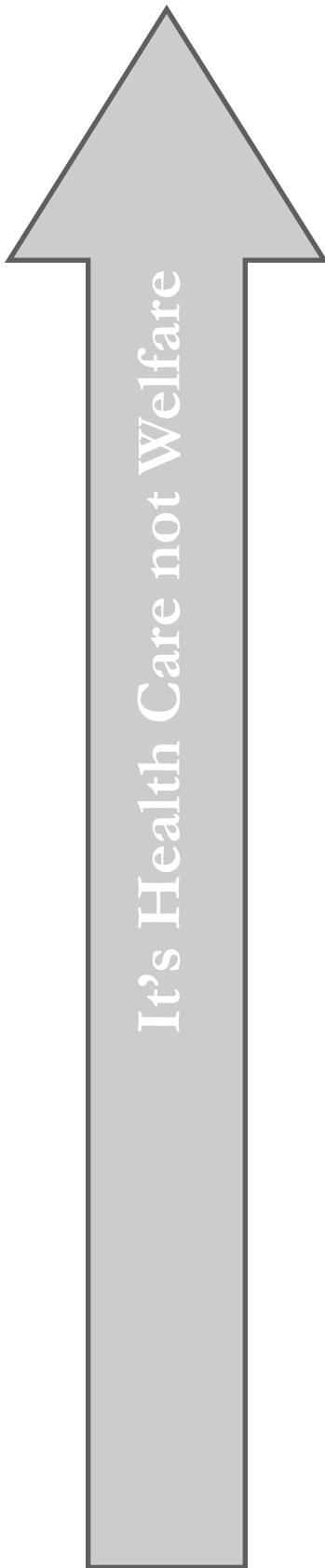 *Sylvia Lopez, MD*
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It's Health Care not Welfare

Introduction

Forty-seven years after President Lyndon B. Johnson signed the Medicaid program into law, Medicaid continues to be Oklahoma's number one defense against the crisis of the uninsured and underinsured. Oklahoma's Medicaid program, known as SoonerCare, is administered by the Oklahoma Health Care Authority (OHCA) and remains a vital source of health care for low-income children, seniors and the disabled. Low-income individuals being treated for breast or cervical cancer and those seeking family planning services are also included in the membership.

SoonerCare also provides supplemental coverage for low-income Medicare beneficiaries for benefits not covered by Medicare and for help in meeting Medicare's cost-sharing requirements. Insure Oklahoma is available to assist certain small businesses in providing and low-income workers in obtaining health care coverage for themselves and their families. In the absence of access to these combined health care products, over 1,000,000 Oklahomans would have joined the ranks of the uninsured during fiscal year 2012.

In addition to improving access to health care for its members, SoonerCare continues to be the source of many innovations in health care delivery and functions as Oklahoma's primary source of long-term care financing. The efforts of OHCA through SoonerCare have helped support health care providers and reduced the amount of uncompensated care in Oklahoma.
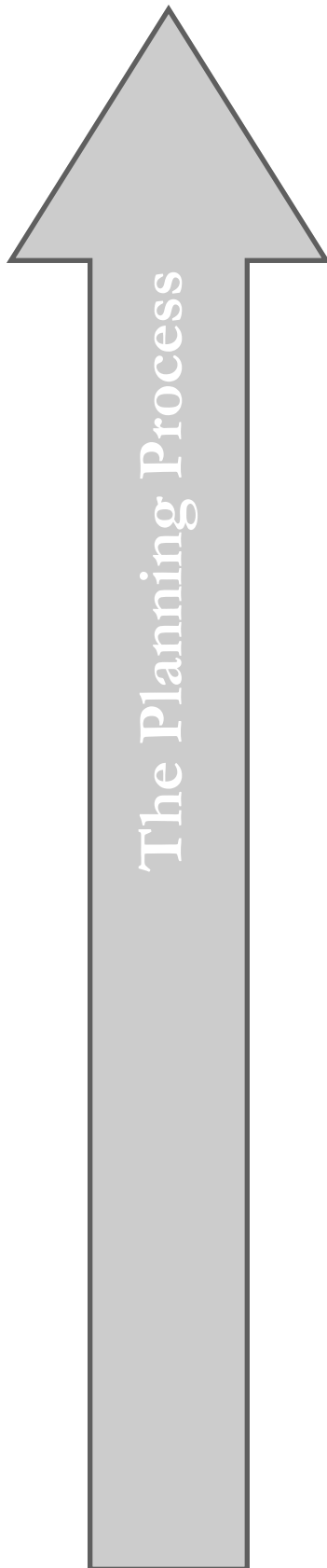
OHCA has demonstrated its efficiency in the most challenging of times: during economic downturns and times of rising health care costs. And, SoonerCare has laid the groundwork for values-oriented health care coverage.

When Medicare was created in 1965, Medicaid was added to the legislation to provide health coverage to recipients of federally supported cash assistance for the poor. Medicaid thus excluded adults who were not elderly, disabled or caring for dependent children. This history reflects attitudes about which groups of low-income people "deserved" federally subsidized cash assistance. When those programs were established, many policymakers and a large portion of the public viewed healthy, working age adults without child care responsibilities as unworthy of help, since they should be capable of supporting themselves. However, that judgment was made during the 1930s in the context of income assistance, not health care.

With annual expenditures of over $4 billion and over 1,000,000 Oklahomans' lives touched, the Oklahoma Health Care Authority (OHCA) plays a key role in the direction of the health care system in Oklahoma. OHCA has an unparalleled opportunity to improve care and to make it affordable for more of those who would not otherwise have access.

Many incremental efforts are underway in Oklahoma that can provide important lessons for other states and for national policy across a broad range of areas, from payment reform, to quality improvement, to disease management, to long-term care, to cost containment.

Oklahoma has shown commitment and innovation moving forward with improvements to health care access, costs and quality.

The Planning Process

OHCA's Strategic Planning Responsibilities

The Oklahoma Health Care Authority (OHCA) is responsible for administering the Medicaid program in Oklahoma. In carrying out its responsibilities, OHCA strives to be a leader in improving the delivery of cost-effective, appropriate, high-quality health care for all of its members, while meeting the highest standards of administrative performance.

In order to be a leader, OHCA must continually plan – plan for change. Changes are inevitable. A sound, deliberate strategy for the future is not just a good idea, it is a necessity for organizations in today's dynamic health care environment. Societal needs and expectations, federal and state legislation, technological advances, demographic and economic changes, stakeholder partnerships and interests - all must be considered in light of the agency's resources and capabilities as OHCA moves forward into an uncertain future.

> The one unchangeable certainty is that nothing is certain or unchangeable.
> *~John F. Kennedy~*

Throughout this strategic plan, OHCA sets forth the goals and objectives to be met to carry out this work. The strategic plan begins by presenting a brief overview of the mission, vision, and goals of the agency; followed by specific action plans the agency has developed to meet the strategic goals. This is followed by a summary delineating the key external factors and assumptions that might affect achievement of the agency's goals and objectives.

The ultimate success of the planning process is determined by how seriously OHCA takes its responsibilities, how willing people are to come together as a state to make difficult choices regarding direction and priorities and how committed stakeholders are to working together to support those choices in the future.

Strategic planning is a process by which OHCA can take charge of its future. Throughout the planning process, the agency poses the question:

> *Keeping sight of our mission and vision,*
> *how do we plan to make things happen?*

Mission: The purpose of the OHCA is to purchase State-funded health care in the most efficient and comprehensive manner possible and to study and recommend strategies for optimizing the delivery of health care in state programs.

Vision: For Oklahomans to enjoy optimal health status through having access to quality health care regardless of their ability to pay.

Answering this question keeping in mind opportunities and challenges, as well as the agency's strengths and weaknesses, is important when developing the strategic plan.

The first phase of the agency's review and planning process involved information-gathering and review of OHCA's culture and values, the external environment and those opportunities and threats the future may hold.

The logic of the plan remains the same. The heart of the strategic plan is the statement of primary strategic goals - - a short list of major emphases over the next several years. These goals represent not only an understanding of the agency's statutory responsibilities, but a broader sense of purpose and direction formed by a common set of agency values.
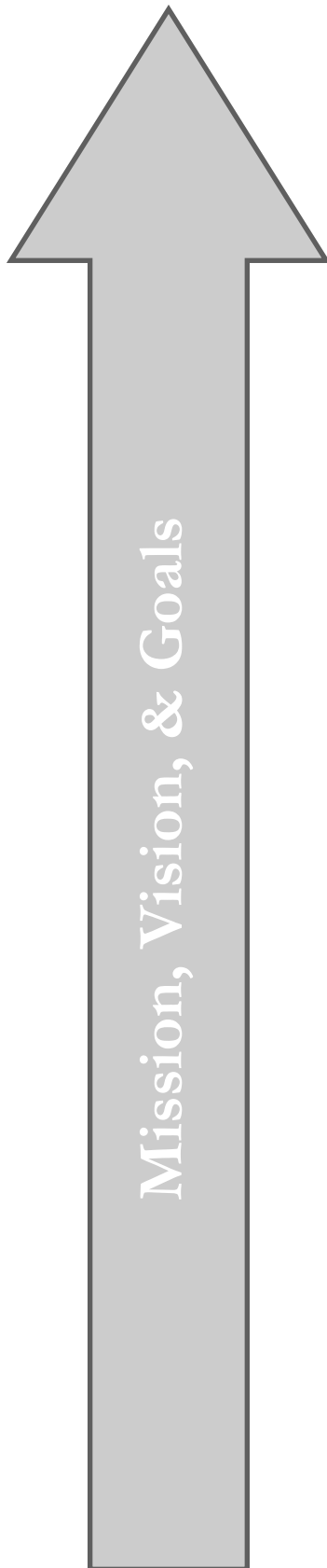
Subsequently, in the planning process agency goals were used as a frame of reference to create a plan of action with roles and responsibilities distributed throughout the agency. Some strategies overlap. Some strategies may not prove to be practical upon closer examination and may need to be refined or even eliminated. Some strategies are already well under way, while others may require legislative changes.

Next, in the planning process, priority-setting decisions resulted in preparation of the proposed strategic budget. Resource allocation decisions were based on shared goals and priorities and the strategies developed to achieve them.

A successful strategic planning process builds in accountability for results. Key performance measures (KPM) were designed to identify and monitor the activities set forth in this strategic plan. These performance measures allow the agency to be in a position to reach agency goals in a much more controlled and targeted manner.

However, OHCA must not close the book on planning. Strategic planning is not a closed loop but rather a path to success. Planning must be institutionalized through maintaining a continuous process of reviewing the effectiveness of the plans and strategies implemented in achieving agency goals and objectives and making changes when necessary.

Strategic Planning is a process by which we can envision the future and develop the necessary procedures and operations to influence and achieve that future." Clark Crouch

Mission, Vision, & Goals

Mission: The purpose of the OHCA is 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 delivery of health care in state programs.

Vision: OHCA's vision is for Oklahomans to enjoy optimal health status through having access to quality health care regardless of their ability to pay.

Values and Behaviors

The OHCA staff will operate as members of the same team, with a common mission and each with a unique contribution to make to our success;

OHCA will be open to new ways of working together; and

OHCA will use qualitative and quantitative data to guide and evaluate our actions and improve our performance in a purposeful way over time.

Long Term Goals

Goal #1 (Eligibility / Enrollment) - To provide and improve health care access to the underserved and vulnerable populations of Oklahoma.

Goal #2 (Quality) - To protect and improve member health and satisfaction, as well as ensure quality, with programs, services and care.

Goal #3 (Personal Responsibility) - To promote members' personal responsibilities for their health services utilization, behaviors, and outcomes.

Goal #4 (Benefits) – To ensure that programs and services respond to the needs of members by providing necessary medical benefits to our members.

Goal #5 (Financing / Reimbursement) – To purchase the best value health care for members by paying appropriate rates and exploring all available valid options for program financing to ensure access to medical services by our members.

Goal #6 (Administration) – To foster excellence in the design and administration of the Medicaid program.

Purpose of an Environmental Assessment

The Oklahoma Health Care Authority's (OHCA) environmental assessment is intended to identify issues critical to the future of the organization. Throughout this section is a look at the economic, social, political, technological, and other environmental changes taking place in public health and health care systems. These trends in the external environment will support and guide the development of agency goals, objectives, and strategies. The success of SoonerCare and Insure Oklahoma depends on the ability to predict, strategize around, and impact the trends in the larger environment.

Issues considered in the external environment include:

Economic Indicators
> *National Outlook*
> *Oklahoma Outlook*

Social / Demographic Issues
> *Uninsured*
> *Aging Population*

Government and Regulatory Issues
> *Affordable Care Act (ACA)*

Technology
> *Medicaid Information Technology Architecture (MITA)*
> *Online Enrollment*

Industry Trends
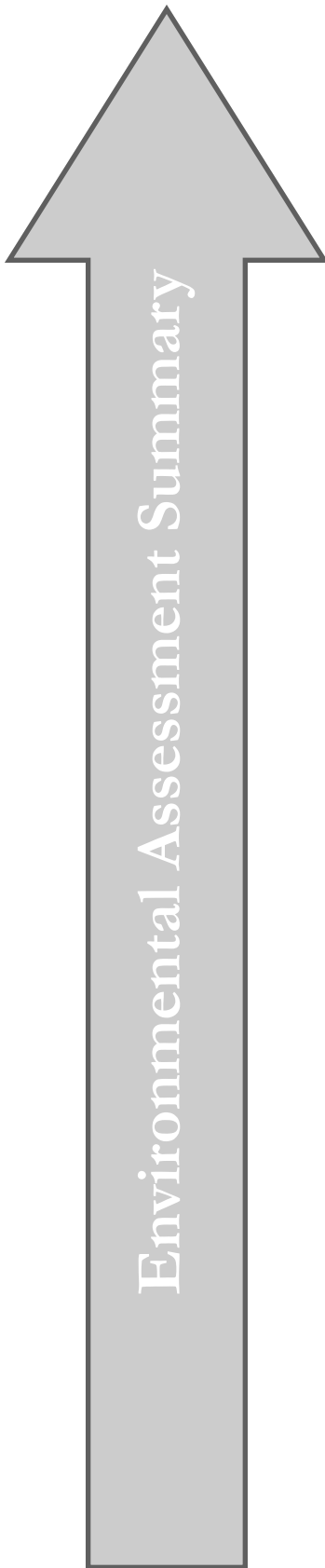> *Need for Flexibility*

Politics
> *State & Federal Government Perspective*

Competition / Marketplace
> *Medicaid Models of Care*

Internal Environment & Workforce Plan
> *Maintaining a Competitive Workforce*

Purpose of an Environmental Assessment

Environmental Assessment Summary

Environmental Assessment Summary

The results of the agency's environmental assessment help to support and to guide the development of agency goals, objectives and strategies. A summary of this assessment follows (additional detail can be found on pages 12 through 30).

Economic Indicators

National Outlook - Coming off the most severe recession since the Great Depression, the U.S. economy is still struggling to recover. The Congressional Budget Office (CBO) expects the slow recovery to continue the next two years under current laws governing taxation and spending. The CBO also expects unemployment to remain over 8% until 2015.

Oklahoma Outlook - While the recession swept across the country, Oklahoma fared better than many states. According to Professor Dan Rickman of Oklahoma State University, Oklahoma did not feel the full effects of the recession due to an absence of a housing market bubble and high energy prices that ran counter to the national economy. Oklahoma is performing quite well in many key economic indicators. From 2001 to 2011, Oklahoma ranked 9th highest in absolute job growth in the nation, and Oklahoma's Cost of Doing Business placed 6th lowest in the country according to the ACE Report issued by Oklahoma 21st Century, Inc.

Social / Demographic Issues

Uninsured - Nationally, in 2011, some 48.6 million people or an average of 15.7% of the U.S. population lacked health insurance. In Oklahoma, 17.4% of the population, or roughly 643,000 individuals, were uninsured. The number of uninsured continues to be of significant concern.

Aging Population - The first of the Baby Boom generation turned 65 in 2011 and the number of individuals over the age of 65 is expected to edge up to 71.5 million by 2030. This population is increasing quickly. As the baby boomers turn 65, the financing of their care will begin shifting from the private sector to publicly financed programs, including Medicaid and Medicare.

Government and Regulatory Issues

In June of 2012, the U.S. Supreme Court issued its decision in the case challenging the constitutionality of the Affordable Care Act (ACA). The two main provisions which were at issue were the unconstitutionality of the ACA's minimum essential coverage provision, known as the individual mandate and the ACA's Medicaid expansion.

The Supreme Court's decision about Medicaid expansion did not strike down any provision of the ACA. However, the practical effect of the Court's decision makes the ACA's Medicaid expansion optional for states because, if states do not implement the expansion, states can only lose ACA Medicaid funds.

As of November 2012, Oklahoma's state leadership has decided to forgo the expansion of Medicaid.

Technology

Beginning in 2005, the Medicaid Information Technology Architecture (MITA) initiative advanced a national framework to support improved systems development and health care management for the Medicaid enterprise. Building on the MITA initiative, CMS, in 2011, issued new enhanced federal funding opportunities for states to continue modernizing the Medicaid enterprise. The enhanced 90%/10% (federal/state share) funding is based on seven standards and conditions intended to provide states a common framework to plan, architect, engineer, and implement custom solutions to modernize Medicaid IT systems and processes. These technology investments will significantly change the current legacy systems to more modern and agile systems with improved efficiencies for the state administration of the Medicaid program. Modernized Medicaid systems will improve user experiences, and allow for greater effectiveness in managing care and producing improved health outcomes for SoonerCare members.

Online enrollment has enhanced the eligibility determination by accepting applications over the internet. Individuals now have the opportunity to apply for SoonerCare, SoonerPlan, Soon-to-be-Sooners, and Behavioral Health programs on the internet and receive immediate results from the information they have submitted. Future enhancements to online enrollment will go a long way to help the members have access to health care.

Industry Trends

SoonerCare, along with other public and private health care entities, must be flexible to adapt to the ever changing landscape of the health care market. The development of enhanced service delivery models, patient access to care, financing, and the need to improve the overall health of the nation are important areas to consider when analyzing industry trends.

Politics

A more conservative view of entitlement programs such as Medicaid continues to be the prevailing perspective from state executive, legislative and congressional leaders. This is reflected in a more detailed scrutiny of how federal and state dollars are spent, as well as who qualifies for Medicaid programs and why. State elected leaders continue to demonstrate a willingness to make informed decisions that impact thousands of people being served by the thousands of health care providers contracted within the system. Informed decision making helps shape these policies in an accountable and transparent manner. However, the political climate itself is very turbulent as federal health care reform laws have taken center stage in health care policy and it has resulted in potential standoffs about who controls state-level health care policies and expenses.
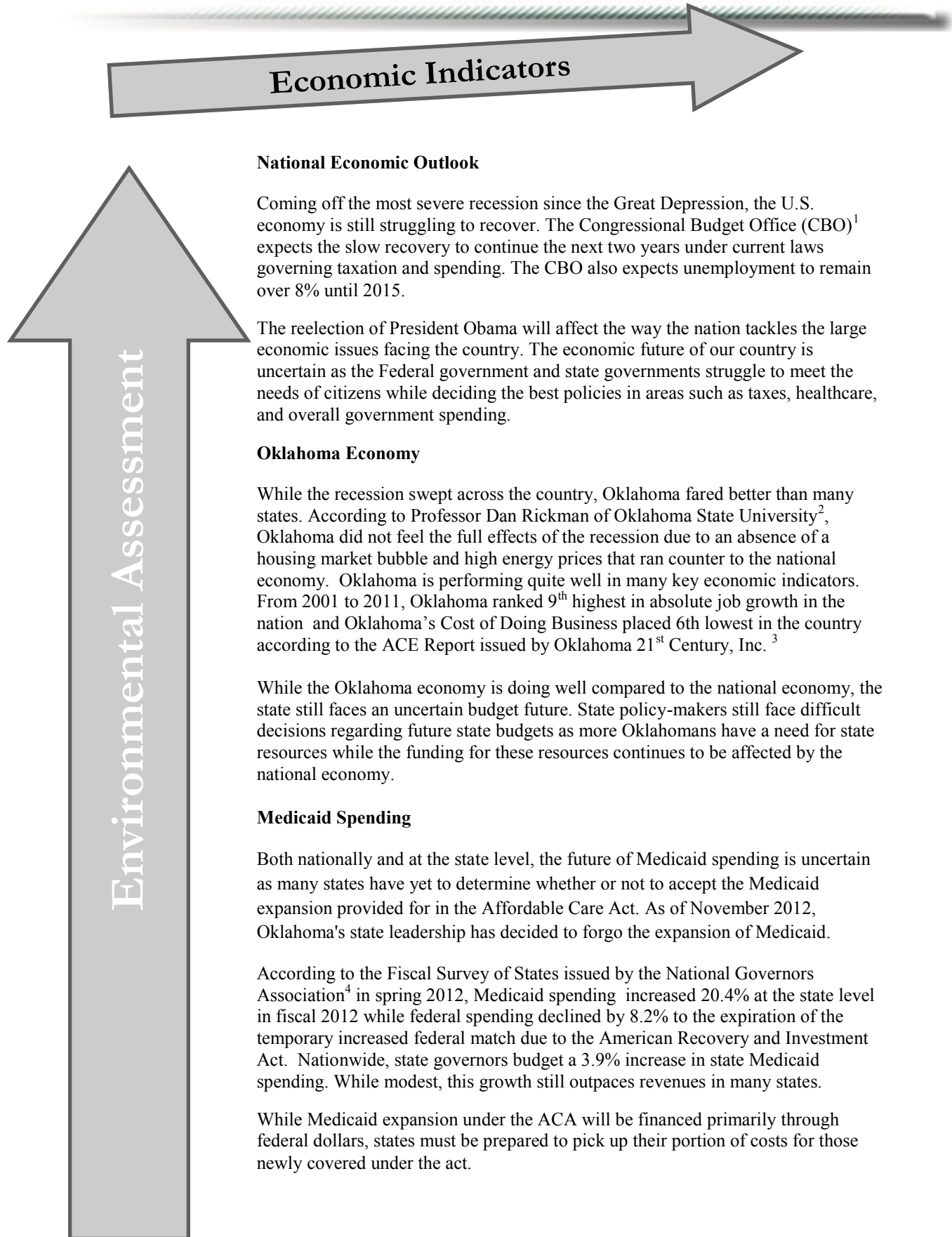
Competition/Marketplace

States can use an array of payment and care models in Medicaid. The two most effective and prevalent appear to be risk based plans and primary care case management (PCCM) programs. Between full-risk plans and primary care case management, programs stretch a continuum of managed care arrangements that borrow, adapt, and blend different aspects of the two approaches. Medicaid, in these two forms, continues to evolve as states try out new models of care organization, delivery, and financing. Oklahoma's PCCM program is a blend of conventional fee-for-service and conventional managed care. The agency contracts with the member's primary care physician to provide basic care and to coordinate and authorize any needed specialty care or other services. The primary care physician is paid a small case management fee per person per month, and other services are usually paid fee-for-service. States, such as Oklahoma, use different resources to conduct care coordination and management, including state staff, contractors and physician practices. A Center for Health Care Strategies evaluation of enhanced PCCM programs in five states (including Oklahoma) indicates that they may perform as well as or better than capitated MCOs on measures of access, cost and quality if sufficient resources are devoted to their design, implementation and management.

Internal Environment & Workforce Plan

As state leadership move to decrease the size of state government and gain efficiencies, consolidation of like efforts has begun. Of those, the one that has most affected the OHCA workforce is the combining of the state's Information Technology services.

The implementation of the Affordable Care Act will contribute to the shape of the OHCA workforce in the coming years. To accommodate the new membership, OHCA will require additional staff to work with providers and members, and to process the added tasks the increased membership brings.

With the possibility of Medicaid changes, the agency has strategies in place to recruit, develop and retain a competent and competitive workforce.

Economic Indicators

Environmental Assessment

National Economic Outlook

Coming off the most severe recession since the Great Depression, the U.S. economy is still struggling to recover. The Congressional Budget Office (CBO)[1] expects the slow recovery to continue the next two years under current laws governing taxation and spending. The CBO also expects unemployment to remain over 8% until 2015.

The reelection of President Obama will affect the way the nation tackles the large economic issues facing the country. The economic future of our country is uncertain as the Federal government and state governments struggle to meet the needs of citizens while deciding the best policies in areas such as taxes, healthcare, and overall government spending.

Oklahoma Economy

While the recession swept across the country, Oklahoma fared better than many states. According to Professor Dan Rickman of Oklahoma State University[2], Oklahoma did not feel the full effects of the recession due to an absence of a housing market bubble and high energy prices that ran counter to the national economy. Oklahoma is performing quite well in many key economic indicators. From 2001 to 2011, Oklahoma ranked 9th highest in absolute job growth in the nation and Oklahoma's Cost of Doing Business placed 6th lowest in the country according to the ACE Report issued by Oklahoma 21st Century, Inc. [3]

While the Oklahoma economy is doing well compared to the national economy, the state still faces an uncertain budget future. State policy-makers still face difficult decisions regarding future state budgets as more Oklahomans have a need for state resources while the funding for these resources continues to be affected by the national economy.

Medicaid Spending

Both nationally and at the state level, the future of Medicaid spending is uncertain as many states have yet to determine whether or not to accept the Medicaid expansion provided for in the Affordable Care Act. As of November 2012, Oklahoma's state leadership has decided to forgo the expansion of Medicaid.

According to the Fiscal Survey of States issued by the National Governors Association[4] in spring 2012, Medicaid spending increased 20.4% at the state level in fiscal 2012 while federal spending declined by 8.2% to the expiration of the temporary increased federal match due to the American Recovery and Investment Act. Nationwide, state governors budget a 3.9% increase in state Medicaid spending. While modest, this growth still outpaces revenues in many states.

While Medicaid expansion under the ACA will be financed primarily through federal dollars, states must be prepared to pick up their portion of costs for those newly covered under the act.

The bottom line:

Medicaid funding at the State Level will be a top focus for all stakeholders as the decision-makers deal with growing deficits at the Federal Level, tightening state budgets, and uncertainty over how to cover the uninsured.

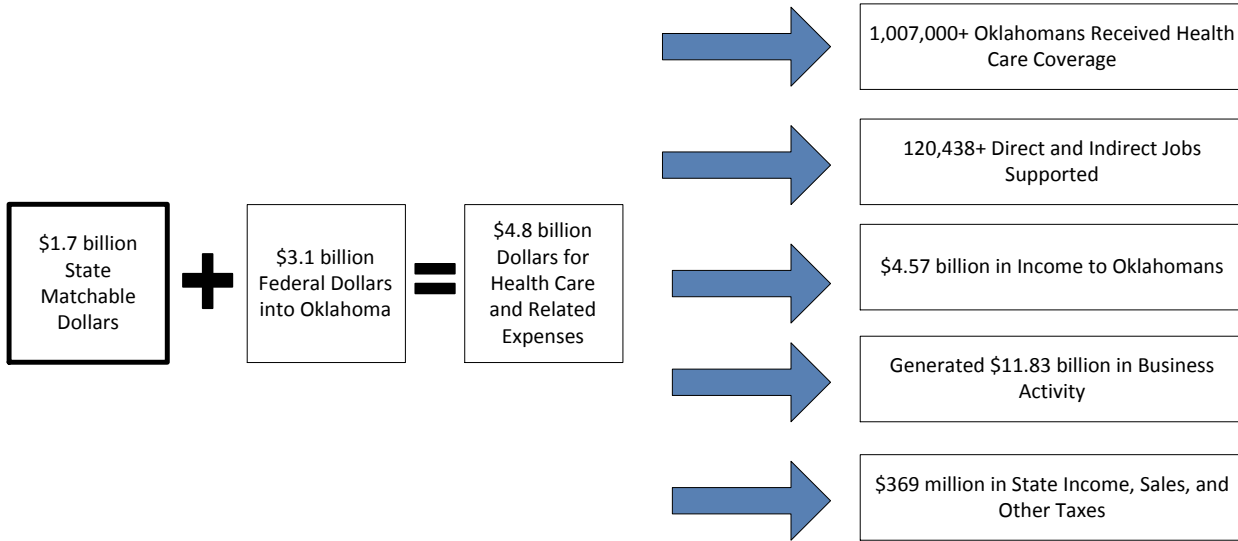**SoonerCare and its Effect on the Economy**

While SoonerCare and Insure Oklahoma's role in providing health care services is clear, the unique role Medicaid funding plays in stimulating state business activity and state economies is less clear. Every dollar Oklahoma spends on *SoonerCare* and Insure Oklahoma pulls new federal dollars into the state - - dollars that would not otherwise flow into the state. These new dollars can pass from one person to another in successive rounds of spending. Economists call this the "multiplier effect". Because of the multiplier effect, the aggregate impact of Medicaid spending on a state's economy is much greater than the value of services purchased directly by the program.

Additionally, SoonerCare and Insure Oklahoma spending provides a counter-cyclical stimulus to a state's economy during a recession or downturn because more citizens tend to utilize SoonerCare during an economic downturn. In SFY2012, unduplicated members served topped one million Oklahomans, a result of the economic recession and slow recovery. Increases in state government spending on most programs do not have the same multiplier effect as Medicaid spending increases because most state government expenditures simply reallocate spending from one sector of the economy to another. When a state increases its spending on Medicaid, by contrast, new federal matching dollars are brought into the state's economy.

The bottom line:

State dollar investments in SoonerCare and Insure Oklahoma are not only an investment in Oklahoma's health care system, but also as an investment in Oklahoma's economy.

Economic Impact of SoonerCare on the Oklahoma Economy

$1.7 billion State Matchable Dollars	**+**	$3.1 billion Federal Dollars into Oklahoma	**=**	$4.8 billion Dollars for Health Care and Related Expenses

→ 1,007,000+ Oklahomans Received Health Care Coverage

→ 120,438+ Direct and Indirect Jobs Supported

→ $4.57 billion in Income to Oklahomans

→ Generated $11.83 billion in Business Activity

→ $369 million in State Income, Sales, and Other Taxes

Source: OHCA SFY2012 Annual Report, based on IMPLAN values used in "The Economic Impact of the Medicaid Program on Oklahoma's Economy," National Center for Rural Health Works, Oklahoma State University, Oklahoma Cooperative Extension Service. State matchable dollars include funds appropriated to OHCA and other state agencies, drug rebates, quality of care fees, other fees and refunds.

Social / Demographic Issues

Uninsured

Nationally, in 2011, some 48.6 million people or an average of 15.7% of the U.S. population lacked health insurance. In Oklahoma, 17.4% of the population, or roughly 643,000 individuals, were uninsured. The number of uninsured continues to be of significant concern.[5]

The uninsured are primarily found in working families. About six in ten of the uninsured have at least one full-time worker in their family and 16% have only part-time workers. Generally, uninsured workers tend to have low-wage or blue-collar employment and work for small firms or in service industries when compared to insured workers.[6]

Low-income individuals make up a disproportionately large share of the uninsured. Close to 40% of the uninsured have family incomes below the federal poverty level ($22,350 a year for a family of four in 2011).[7]

Insurance premiums have continued to rise; the average annual single premium in 2012 was 3% higher than 2011 while the average annual family premium was 4 % higher than 2011. Average premiums for family coverage have increased 97 % since 2002.[8]

The uninsured suffer from negative health consequences due to their lack of access to medical care. About one-quarter of uninsured adults go without needed care each year. The uninsured are less likely than those with insurance to receive preventive care such as recommended screenings or services for major health conditions.[9] Adults that are uninsured are more likely to be diagnosed with a disease in an advanced stage. The uninsured are less likely to have a usual source of care outside of the emergency room. Lack of access to timely care caused more than 26,000 uninsured adults to die prematurely.[10]

The bottom line:
The crisis of the uninsured touches all Americans. Decisions must be made at the federal and state levels regarding programs and funding in light of the need to bring spending under control while trying to ease the burdens of those whose health care options are limited.

Aging Population
The first of the Baby Boom generation turned 65 in 2011 and the number of individuals over the age of 65 is expected to edge up to 71.5 million by 2030.[11] This population is increasing quickly.

As the baby boomers turn 65, the financing of their care will begin shifting from the private sector to publicly financed programs, including Medicaid and Medicare. As a result of improved medical care and prevention efforts, dramatic increases in life expectancy have occurred in the United States. The cost of providing health care for an older American is three to five times greater than the cost for someone younger than 65. As a result, by 2030, the nation's health care spending is projected to increase by 25 %.[12]

But the older Americans get, the more likely it is that they will eventually no longer be able to care for themselves or have access to support from family members. One spouse is likely to outlive the other and children will have long since received their own membership in AARP.

As many as 1.5 million Americans currently reside in nursing homes.[13] Medicaid continues to be the main source of long term care financing in the U.S. with estimates that Medicaid is responsible for reimbursing some 70 % of nursing home care costs. Medicaid financed long-term care includes nursing home services, as well as the use of home and community-based care services.

OHCA initiated the Focus on Excellence (FOE) program in 2007 with the aim of having top-rated care in nursing facilities thereby enhancing the lives of residents as well as their families. The program was designed to encourage nursing home improvements in quality, life, and care. Additional Medicaid payments are made to facilities that meet or exceed established FOE threshold requirements for quality performance measures.

The bottom line:
The aged population is growing. Most of these individuals will need long term care of some type in their lifetime, and an estimated two-thirds will need Medicaid to help finance all or part of that care. Long-term care costs, which currently account for an estimated 70 % of the Medicaid budget, will need to be managed.

Proposal for Dual Eligibles
In May 2012, OHCA submitted a proposal to the Centers for Medicare and Medicaid Services (CMS) under the Alignment Initiative to provide care coordination to members that are enrolled in both Medicare and Medicaid programs; these individuals are referred to as Dual Eligibles. OHCA, through a partnership with CMS, seeks to improve health outcomes through coordinating care and reducing duplicative medical services thereby generating a cost savings. Costs remain high for this disabled group of individuals yet Dual Eligibles represent a small percentage of enrollees in the Medicare and Medicaid programs, according to CMS. If CMS' approval is granted, implementation is slated to begin in January 2013 and could potentially affect as many as 79,000 Oklahomans.
OHCA's proposal highlighted three different conceptual approaches for Dual Eligibles to improve care while lowering costs and having Medicare and Medicaid work together more effectively. CMS may approve any or all of the three approaches submitted. The first two options will provide services to individuals of any age receiving both Medicare and Medicaid services, although data shows the majority of these individuals will be 65 years of age and older. The focus of the third option is somewhat different by design; efforts are expended to focus on care coordination and management of the members' chronic health conditions to positively affect health outcomes by delaying or averting entry into the dual status. Because it can be overwhelming and onerous to navigate the two programs, at the core of all models is care coordination and how it will be provided to help

individuals. Care Coordinators will engage members and act as the primary contact with the members while fostering a partnership with the members' providers as well. The Care Coordinators will help manage chronic health conditions and watch for duplication of services while seeking to improve the members' lives through the person-centered models.

The first model involves the creation of integration of care services which includes embedded medical education programs that specifically serve high cost Dual Eligible members. Multi-tiered approaches of care coordination will be provided in addition to the use of community level evidence based protocols in the management of chronic diseases.

The second model will focus on Dual Eligibles with behavioral health and long term care needs. This will be delivered through an enhanced care coordination service being offered as an overlay service.

The third model has the same focus of care coordination; it is an integrated care model. It differs, in that, it will be offered to individuals 45 years of age or older, experiencing two or more complex or chronic medical conditions, and eligible for either Medicare or Medicaid or both. Through early intervention, before members reach the status of a Dual Eligible, the goal is to keep members healthier by assessing their needs, planning their care, and better managing their chronic conditions.

These person-centered models have a care coordination component at the core of their development because this design is effective in providing a high quality of care, better health outcomes for members, and a reduction of health care costs through preventive services and elimination of duplication of services, achieving a cost savings for the programs.

Obesity in Oklahoma
Nationally, we are facing record numbers of individuals, both adults and children, battling obesity and current information suggests that the numbers are likely to increase dramatically over time. Oklahoma is no exception as its adult obesity rate has nearly quadrupled since 1998.[14] Oklahoma ranked 47th in the nation for obesity (or fifth most obese) and two-thirds of Oklahoma adults had a Body Mass Index (BMI) of 25+ (overweight and obese) while 14% of its youth were obese and 16 % were overweight. [15]

Unless we begin to reverse the current trend, health care costs will likely increase as obesity-related illnesses contribute to rising costs. If states' obesity rates continue on their current trajectories, the number of new cases of type 2 diabetes, coronary heart disease and stroke, hypertension and arthritis could increase 10 times between 2010 and 2020—and double again by 2030. [16] Education, physical activity, and consumption of more fruits and vegetables are important aspects to focus on in the challenge of obesity. It will be important to closely monitor obesity rates in the future since Oklahoma received a "D" on its report card in this area.[17]

5 Leading Causes of Death in Oklahoma
The five leading causes of death in Oklahoma are: Heart disease, cancer, stroke,

chronic lower respiratory diseases and accidents (unintentional injuries).[18]   For example, leading risk factors for heart disease include: physical inactivity, overweight and obesity, high blood pressure, cigarette smoking, high cholesterol and diabetes.[19] Some of the same factors appear under several of the health conditions. There are leading risk factors for each group, but it is safe to say that promotion of healthy behaviors such as a healthy diet, physical activity, and smoking cessation can have a significant impact on overall health.

The Oklahoma Hospital Residency Training Program Act
Meeting the healthcare needs of medically underserved areas is the focus of the Oklahoma Hospital Residency Training Program Act. This program is to be administered by OHCA and the purpose of the Act is to establish new residency training programs with OSU College of Osteopathic Medicine and OU College of Medicine in eligible hospitals. Residents of rural Oklahoma will benefit from its approval because it will place more doctors into rural counties, helping the medically underserved areas.

Government & Regulatory Issues

In June of 2012, the U.S. Supreme Court issued its decision in the case challenging the constitutionality of the Affordable Care Act (ACA). Two main provisions were at issue were the unconstitutionality of the ACA's minimum essential coverage provision, known as the individual mandate and the ACA's Medicaid expansion.

The Supreme Court's decision about Medicaid expansion did not strike down any provision of the ACA. However, the practical effect of the Court's decision makes the ACA's Medicaid expansion optional for states because, if states do not implement the expansion, states can only lose ACA Medicaid funds.

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The bottom line:
State leaders must make decisions concerning healthcare and the uninsured in Oklahoma as well as other provisions of the ACA.

Technology

Modernizing Medicaid Technology

Beginning in 2005, The Medicaid Information Technology Architecture (MITA) initiative advanced a national framework to support improved systems development and health care management for the Medicaid enterprise.[20] Building on the MITA initiative, CMS, in 2011, issued new enhanced federal funding opportunities for states to continue modernizing the Medicaid enterprise. The enhanced 90/10 (federal/state share) funding is based on "seven standards and conditions" intended to provide states a common framework to plan, architect, engineer, and implement custom solutions to modernize Medicaid IT systems and processes[21]. These technology investments will significantly change the current legacy systems to more modern and agile systems with improved efficiencies for the state administration of the Medicaid program. Modernized Medicaid systems will improve user experiences, and allow for greater effectiveness in managing care and producing improved health outcomes for Medicaid beneficiaries.

Online enrollment has enhanced the eligibility determination by accepting applications over the internet. Individuals now have the opportunity to apply for SoonerCare, SoonerPlan, Soon-to-be-Sooners, and Behavioral Health programs on the internet and receive immediate results from the information they have submitted. Future enhancements to online enrollment will go a long way to help the members have access to health care[22].

The nation continues to transform health care models using methodologies through federal incentive programs. The Health Information Technology for Economic and Clinical Health Act (HITECH) was enacted under Title XIII of the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. 111-5). Under the HITECH Act, the US Department of Health and Human Services is spending $25.9 billion to promote and expand the adoption of health information technology to create a nationwide network of electronic health records.

ARRA is an economic stimulus bill created to help the United States economy recover from an economic downturn that began in late 2007. Congress enacted ARRA February 17, 2009. ARRA allocated $787 billion to fund tax cuts and supplements to social welfare programs as well as increased spending for education, health care, infrastructure and the energy sector.

The HITECH Act sets meaningful use of interoperable Electronic Health Record (EHR) adoption in the health care system as a critical national goal and incentivized EHR adoption. The goal is not adoption alone but meaningful use of EHRs – that is, their use by providers to achieve significant improvements in care. Title IV of the act promises maximum incentive payments for Medicaid to those who adopt and use "certified EHRs" of $63,750 over 6 years beginning in 2011. In order to receive the EHR stimulus money, the Act requires doctors to show "meaningful use" of EHR system.

The Act specifically outlines how the federal stimulus money will be used to advance the design, development, and operation of a nationwide health

information infrastructure that promotes the electronic use and exchange of information. It established monetary incentives related to health care information technology in general (e.g. creation of a national health care infrastructure) and contains specific incentives designed to accelerate the adoption of electronic health record (EHR) systems among providers. Because this legislation anticipates a massive expansion in the exchange of electronic protected health information, the HITECH Act also widens the scope of privacy and security protections available under HIPAA; it increases the potential legal liability for non-compliance; and it provides for more enforcement[23].

Oklahoma has taken advantage of several initiatives offered by HITECH such as:

> The EHR incentive program which offers incentives to health care professionals and hospitals to adopt and meaningfully use EHR technology.
>
> The Beacon Community Program which incentivizes communities to build and strengthen their health information technology (health IT) infrastructure and exchange capabilities. The Greater Tulsa Health Access Network Beacon Community received HITECH funding for this program with the primary goal to leverage broad community partnerships with hospitals, providers, payers, and government agencies to expand a community-wide care coordination system, which will increase appropriate referrals for cancer screenings, decrease unnecessary specialist visits and (with telemedicine) increase access to care for patients with diabetes.[24]
>
> Oklahoma also received funding to participate in the State Health Information Exchange Cooperative Agreement Program. This program supports States in establishing health information exchange capability among healthcare providers and hospitals in their jurisdictions.[25]
>
> Oklahoma also received a sub-award of the SHIECAP effort called the Health Information Exchange Challenge Grant Program. This program encourages breakthrough innovations for health information exchange that can be leveraged widely to support nationwide health information exchange and interoperability.[26]
>
> Health Information Technology Extension Program: A grant program to establish Health Information Technology Regional Extension Centers to offer technical assistance, guidance and information on best practices to support and accelerate health care providers' efforts to become meaningful users of Electronic Health Records (EHRs).[27]

Community College Consortia to Educate Health Information Technology Professionals Program: A grant program that seeks to rapidly create health IT education and training programs at Community Colleges or expand existing programs. Community Colleges funded under this initiative will establish intensive, non-degree training programs that can be completed in six months or less. This is one component of the Health IT Workforce Program. Tulsa Community College was selected to be part of the 20

participating community colleges in Region D.[28]

While many of these initial HITECH efforts supported the adoption and use of technology by healthcare communities and professionals, future trends seem to focus on the collection and analysis of data to enhance performance. The leaders of pioneering U.S. patient care organizations began more than a decade ago to learn and adopt formal performance improvement methodologies leveraging point of care technologies ranging from health monitoring to telemedicine. Ultimately, all point of health care solutions depends on patients connecting with healthcare professionals via electronic means. Treating people this way can be beneficial both as a great cost savings and also from a quality standpoint. Nursing engineering is fast becoming a career of the future. So too are health monitoring, e-health, and health care information management for disaster situations.[29]

Lastly, many experts admit that a big part of building accountable care organizations will be extending the patient-physician interaction beyond the office visit using telemedicine tools, as well as using health information exchange (HIE) to aggregate and analyze data from multiple sources. Population health analytic solutions will be a key foundational element for these accountable care collaborations, but these care coordination tools can only be implemented after incentives are aligned between payers and providers.[30]

The bottom line:
Technology will continue to shape the landscape of the health care system. OHCA will continue to be an advocate and innovator in the development and implementation of technology in order to better serve its members.

Industry Trends

SoonerCare, along with other public and private health care entities, must be flexible to adapt to the ever changing landscape of the health care market. The development of enhanced service delivery models, patient access to care, financing, and the need to improve the overall health of the nation are important areas to consider when analyzing industry trends.

Focus on Improving Care in the Public and Private Healthcare Market
Several efforts are underway to integrate care, improve care coordination, and lower costs through enhanced service delivery models for members in both the public and private healthcare markets. The Department of Health and Human Services, Center for Medicare and Medicaid, and the Center for Medicare and Medicaid Innovation have launched initiatives such as integrating care for dual eligibles, health homes, and the Comprehensive Primary Care Initiative as opportunities for states to focus on integration and to foster collaboration through multi-payer funding streams as avenues to improve overall health care.

Patients Need Access to Care[31]
Patient access to primary care is a major concern in the healthcare market, especially in rural communities. The Affordable Care Act attempts to address this issue by creating new incentives to expand the number of primary care doctors, nurses and physician assistants. These include: funding for scholarships, loan repayments for primary care doctors and nurses working in underserved areas. There are also financial incentives for doctors to begin accepting more Medicare and Medicaid members through Medicare bonus payments for primary care and Medicaid reimbursements that will match Medicare rates for primary care services for two years; these increases are fully funded by the federal government to minimalize the fiscal impact on states.

Provider Capacity Impact Analysis and Outreach Efforts[32]
In March 2010, the President signed into law the Patient Protection and Affordable Care Act (PPACA) extending coverage to 32 million people through an optional expansion of Medicaid and new subsidies for moderate-income individuals; if all states choose to expand their Medicaid program, the newly eligible population could number between 15-20 million.

The new law bases eligibility for Medicaid on income without categorical restrictions for individuals under age 65 and establishes a national floor for Medicaid coverage at 133% of poverty ($14,404 for an individual or $29,326 for a family of four in 2009) in 2014. This will reduce state-by state variation in eligibility for Medicaid and also include adults under age 65 without dependent children who are currently not eligible for the program.

As of November 2012, Oklahoma's state leadership has decided to forgo the expansion of Medicaid.

Federal Medical Assistance Percentage (FMAP)
States and the federal government share the cost of serving SoonerCare members, as well as share in the cost of the premium assistance for Insure Oklahoma.The specific percentage that the federal government reimburses a state is referred to as

the federal medical assistance percentage (FMAP) and is calculated for each state according to a formula established in the Medicaid statute and based on the per capita income in each state. Based on new data calculations conducted by the Bureau of Economic Analysis, only 12 states will receive increased FMAPs in FY 2013 while 24 states will see decreases. The average FMAP is 57 %, but it ranges from 50 % (one federal dollar for each state dollar) to almost 80 % (four federal dollars for each state dollar), these averages are expected to remain static for FY 2013.[33] Reason being, increases totaling $1.091 billion for the 12 states almost offset decreases of $1.094 billion for 24 states. [34]

The FMAP formula is intended to adjust for differences in state fiscal capacity and to reduce program benefit disparities across states by providing more federal funds to states with weaker tax bases. The formula is recalculated each year, based on per capita personal income (PCI) data, and the resulting FMAPs are published in the Federal Register. States with relatively low per capita income receive higher matching rates than states with higher per capita income.
Because Medicaid expenditures are so large, the difference of even half a percentage point in an individual state's FMAP can make a significant difference in the state's budget. The lack of caps, at the federal level, on the amounts of FMAP fluctuation per year, can cause states unanticipated – yet significant – budget problems.

OK Health Indicators/ Preventions and Wellness Initiatives
The overall health status of Oklahoma continues to rank near the bottom compared to other states and the nation as a whole. For 2011, The United Health Foundation ranked Oklahoma 48th out of 50 states in overall health outcomes[35] , and the Oklahoma 2011 State of the State's Health Report ranked Oklahoma 46th in the nation[36].   While Oklahoma's health status indicators are among the worst in the United States, there are many efforts underway in the state to curb this trend. Over recent years, initiatives such as "Shape Your Future", the Oklahoma Certified Healthy Business program, the Strong and Healthy Oklahoma Initiative, the Oklahoma Turning Point Council and others aimed at prevention and wellness across the lifespan have been gaining momentum. For 2011, the Oklahoma Hospital Association adopted goals to encourage all member hospitals to become Oklahoma Certified Healthy Businesses and to become tobacco-free campuses[37]. Within the health community, there has been a strong focus to communicate the message to "eat better, move more and be tobacco free."[38]   Through CHIPRA funding, the OHCA started SoonerEnroll and has staff dedicated to statewide community outreach activities assisting community partners to enroll qualified uninsured children in SoonerCare. SoonerEnroll helps ensure these children have access to important health care services, including preventive care. As determinates of poor health status are better understood and community interventions become more effective, those in the health care industry hope to see positive trends showing improvement in Oklahoma's health status. Improvement in Oklahoma's health will not only benefit members of the SoonerCare Program, but also the entire state population.
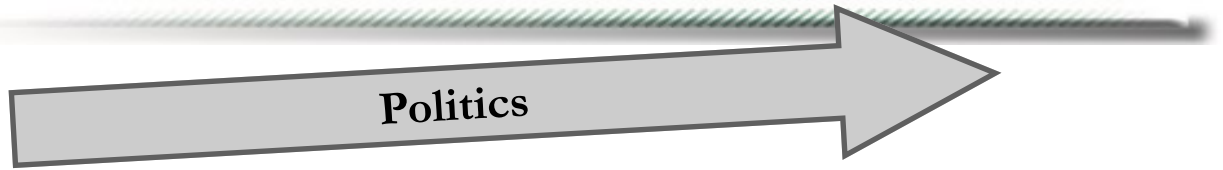
ICD-10 Compliance
HHS will postpone the date by which certain health care entities have to comply with International Classification of Diseases, 10th Edition diagnosis and procedure codes (ICD-10). The provider community expressed concern about the

that has long been using ICD-10. Entities covered under the Health Insurance
Portability and Accountability Act of 1996 (HIPAA) will be required to use the
ICD-10 diagnostic and procedure codes[39].

The Bottom Line:
Quality of care, access to care, financing, prevention and wellness and the use
of data to improve outcomes will continue to be points of emphasis in the
health care environment.

Politics

A more conservative view of entitlement programs such as Medicaid continues to be the prevailing perspective from state executive, legislative and congressional leaders. This is reflected in a more detailed scrutiny of how federal and state dollars are spent as well as who qualifies for Medicaid programs and why. State elected leaders continue to demonstrate a willingness to make informed decisions that impact thousands of people being served by the thousands of health care providers contracted within the system. Informed decision making helps shape these policies in an accountable and transparent manner. However, the political climate, itself, is very turbulent as federal health care reform laws have taken center stage in health care policy and it has resulted in potential standoffs about who controls state-level health care policies and expenses.

The bottom line:
The political climate regarding federal health care reform laws is turbulent and issues exist at every level. State leaders need and are seeking information regarding health care and taking a hard look at Medicaid funding, programs, and populations in order to weigh options concerning health care policies.

Competition / Marketplace

States can use an array of payment and care models in Medicaid. The two most effective and prevalent appear to be risk based plans and primary care case management (PCCM) programs. Between full-risk plans and primary care case management, programs stretch a continuum of managed care arrangements that borrow, adapt, and blend different aspects of the two approaches. Medicaid, in these two forms, continues to evolve as states try out new models of care organization, delivery, and financing.

Oklahoma's PCCM program is a blend of conventional fee-for-service and conventional managed care. The agency contracts with the member's primary care physician to provide basic care and to coordinate and authorize any needed specialty care or other services. The primary care physician is paid a small case management fee per person per month, and other services are usually paid fee-for-service. States, such as Oklahoma, use different resources to conduct care coordination and management, including state staff, contractors and physician practices. A Center for Health Care Strategies evaluation of enhanced PCCM programs in five states (including Oklahoma) indicates that they may perform as well as or better than capitated MCO's on measures of access, cost and quality if sufficient resources are devoted to their design, implementation and management.

The bottom line:
Medicaid allows states flexibility in the design and implementation of payment and care models. Oklahoma's enhanced PCCM program, which blends fee-for -service and conventional managed care has been proven to perform well when compared to capitated managed care models.

Internal Environment & Workforce Plan

As state leadership moves to decrease the size of state government and gain efficiencies, consolidation of like efforts has begun. Of those, the one that has most affected the OHCA workforce is the combining of the state's Information Technology services.

The implementation of the Affordable Care Act will contribute to the shape of the OHCA workforce in the coming years. To accommodate the new membership, OHCA will require additional staff to work with providers and members, and to process the added tasks the increased membership brings.

With the possibility of Medicaid changes, the agency has strategies in place to recruit, develop and retain a competent and competitive workforce.

How many and what types of jobs are needed in order to meet the performance objectives of the organization?

As Medicaid expands, programs evolve, and changes in government happen, the Oklahoma Health Care Authority continues to fully utilize every FTE available to the agency. Additional FTE are requested in the upcoming budget years to meet the growing work demands of the program areas. The unclassified workforce allows more flexibility to develop specific jobs to meet the performance objectives of the organization.

How will the agency develop worker skills?

OHCA has maintained previous years' efforts to enhance worker skills and has made strides to establish a formal process of workforce development. The agency has established a position of Training Coordinator to manage the enterprise learning management system; monitor and promote the training of agency supervisors; and build a foundation for more formalized workforce development agency-wide.

The agency continues to contract with Oklahoma State University to provide management training classes upon request and utilizes the OMES HRDS classes. OHCA continues to administer and promote the tuition reimbursement program to encourage workers to further the education and development of skills that will enhance their ability to perform their duties.

What strategies should the agency use to retain these skills?

OHCA continues to partner with the Hay Group to maintain a market-competitive salary administration plan and evaluate job descriptions. Job descriptions are evaluated to establish a credible and consistent hierarchy of job values across the organization to reflect the evolving job needs within the programs. The salary administration plan supports competitive hiring rates, allowing OHCA to attract a greater number of qualified applicants for agency vacancies.

The agency has successfully implemented a Telework program for select program areas. Alternate work schedules continue to effectively contribute to work performance and employee satisfaction while remaining a popular recruitment tool.

How have retirements, reduction in work force and/or hiring freezes affected your agency's ability to get the work done?

Retirements, reduction in workforce and hiring freezes have had little impact on the agency's ability to get work done.

Action Plan Summary

Action Plan Summary

OHCA's action plans involve individuals at all levels of the organization. The thinking and decision-making that occurred during the planning process were further expanded in the development of the action plans. The plans address four major themes: 1) Benefits; 2) Eligibility; 3) Financing; and 4) Program Administration.

The benefits available to members are under continual review for appropriateness and quality of service. Recent action plans have focused attention on the re-use of durable medical equipment whereby efficiencies may be gained in the delivery of necessary and appropriate equipment to members. Recent federal regulation has required the out of pocket costs incurred by American Indian and Alaska Native members to be decreased substantially, if not altogether eliminated, in many service areas.
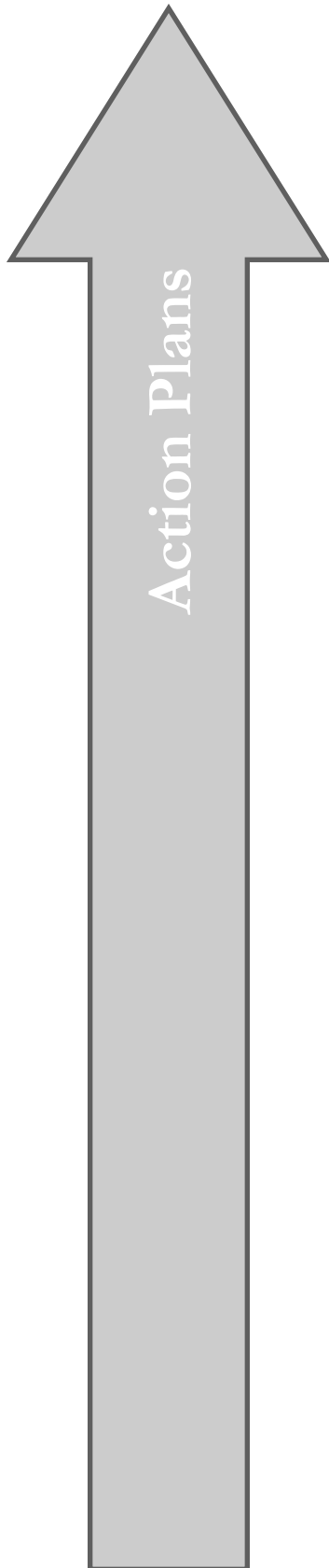
Increased responsibility has been placed on the OHCA to develop a more coordinated delivery system of care, especially for high cost / high need populations such as those dually eligible for Medicare and Medicaid services as well as those with multiple chronic and mental health conditions. As a result, the agency has established action plans that identify and develop coordinated care plans for several population groups, not previously targeted for intervention.

The OHCA operates essentially a state-administered managed care organization. To do so requires the agency to abide by regulations that pertain not only to the public Medicaid program, but also to private payers in the realm of coding, processing claims, and making payments to providers. Several action plans are being pursued such as the National Correct Coding Initiative and migration to the ICD-10 coding system which will yield higher levels of claim detail received from providers. Along with this higher level of detail comes opportunity to enhance program integrity efforts, not only to identify possible areas of error, but also to ensure providers are rendering the right service, to the right person, at the right time, with the desired outcome.

Historically the OHCA has relied upon the development and maintenance of relationships with a variety of stakeholders to gain input for the purpose of bettering Medicaid programs and services. This spirit of collaboration has been the foundation upon which health information technology, delivery system models, payment structures, and enrollment processes have been built. Many agency action plans include the ongoing commitment to collaboration with partners at all levels – local, state, federal, national. Bringing together the OHCA, other state agencies, providers, members and private partners to discuss the future of Oklahoma's health care system and develop specific action plans to determine feasibility of aspects of access, coverage, cost and quality is key to strengthening the integrity of both SoonerCare and Insure Oklahoma.

Specific financing action plans include the continued pursuit of grant funding to support the development and testing of innovative and cutting-edge practices within Oklahoma's Medicaid programs. Oklahoma has made great strides in the

advancement and modernization of SoonerCare and Insure Oklahoma program infrastructure, much stemming from significant grant funds instead of additional state appropriation. One such initiative can be seen in the Comprehensive Primary Care effort whereby the OHCA's Patient-Centered Medical Home model is being explored by other private payers as a mechanism for health care providers to receive additional financial support for adoption of best practices (See pages 33 through 49 for more details on specific action plans).

Action Plans

Not in Priority Order *(alphabetical by short description)*		
MANDATES		
Short Description	Report Reference	Category
National Correct Coding Initiative	1	Program Administration
Elimination of Native American Cost Sharing	2	Benefits
Durable Medical Equipment Retrieval and Recycle Program	3	Benefits
Medicaid Program Integrity Requirements	4	Program Administration
Medicaid Changes Required by Affordable Care Act	5	Eligibility / Benefits
Online Enrollment Changes	6	Program Administration
Physician Fee Schedule to 100% of Medicare	7	Financing
Insure Oklahoma Changes	8	Eligibility
ICD-10 Conversion	9	Program Administration
Collaboration with the Department of Mental Health and Substance Abuse Services	10	Program Administration / Financing
Conversion of Social Security Eligibility Processes (209b to 1634)	11	Eligibility
OTHER		
Short Description	Report Reference	Category
Dual Eligible Care Coordination Grant Project	12	Financing / Program Administration
Electronic Health Information Exchange Collaborative	13	Program Administration
Medicaid Electronic Health Record Incentive Payments	14	Financing
Health Information Technology – ePrescribing Initiatives	15	Program Administration
Health Homes for Enrollees with Chronic and Mental Health Conditions	16	Benefits / Financing
Comprehensive Primary Care Initiative	17	Financing
Oklahoma Health Insurance Survey 2012 (SHADAC)	18	Program Administration
Medicaid Grant Opportunities	19	Financing
Miller Trust	20	Eligibility

Action Plans

1. National Correct Coding Initiative

The National Correct Coding Initiative (NCCI) is a federal mandate created from the ACA which required CMS to create and implement correct coding methodologies to control improper coding leading to inappropriate payment of claims under Medicaid. The initiative contained the NCCI edits, which are sets of codes that should not be billed together for the same member on the same day, and the Medically Unlikely Event (MUEs) edits which limit the number of units that can be billed on the same day, for the same member. New edits will be implemented on a quarterly basis as CMS determines guidelines.

OHCA staff reviewed the NCCI and MUE codes sets and compared the codes to OHCA policy and payment methodology. A request was submitted to CMS for exceptions to allow non-activation of NCCI and MUE edits where conflict with OHCA policy and payment methodology existed.

Action plans include, continued negotiation with CMS regarding activation of edits that would adversely affect OHCA providers by improperly denying payment. As new edits are received, they will be reviewed by OHCA staff for conflict and appropriate requests for exceptions will be submitted.

2. Native American Cost Sharing – New Federal Requirements

Since tribal governments are considered "domestic dependent nations" by the federal government they have a unique and distinct relationship with the federal and state governments. The federal government has entered into enduring agreements (treaties) with tribes that create certain responsibilities for the federal government including providing health care for tribal members.

In recognition of the federal trust responsibility for American Indian (AI) health care, Congress stipulated that a 100% federal medical assistance percentage to states would apply for SoonerCare services delivered to American Indians through Indian Health Service facilities and tribally operated facilities.

On February 17, 2009 the president signed the American Recovery and Reinvestment Act of 2009 (ARRA). Among numerous other provisions this act grants protections for AI. ARRA prohibits premiums and cost-sharing for AI who are provided services by Indian Health providers or referred by contract health services. Similarly, payments to Indian Health providers cannot be reduced by the amount of any enrollment fee, premium, or cost-sharing in Medicaid or CHIP.

After consultation with tribal partners, policy changes were enacted to eliminate AI cost sharing for services provided by Indian Health providers or referred by contract health services. In January of 2012 all system and rules changes were complete to enable AI SoonerCare members to be exempted from cost sharing according to federal law.

Action plans include monitoring claims data to ensure that exemptions are applied and providers are properly reimbursed.

3. Durable Medical Equipment (DME) Retrieval and Recycle Program

In May of 2007, the Oklahoma Legislature enacted a law that mandates the Oklahoma Health Care Authority (OHCA) to implement a program to retrieve DME equipment that is no longer being used by SoonerCare members and donate said equipment to community based programs. The community based programs will then distribute the equipment to elderly and disabled individuals. These "refurbished" items will also be distributed to SoonerCare members generating the potential for savings to the OHCA.

OHCA workgroups met and consulted with a variety of external stakeholders and other state programs in an effort to learn what has worked elsewhere and what could be replicated in Oklahoma. Implementation required a change in policy to clarify OHCA's ownership of the equipment

An RFP was issued and the contract to operate the program was awarded to AbleTech. AbleTech established a facility and hired staff needed to retrieve, refurbish and reassign the equipment. The program went live on April1, 2012 with a limited pickup and delivery area. The program has gotten positive attention and a steady flow of donations both from SoonerCare members and the general public.

Action items include continued monitoring of the program to ensure all equipment is properly refurbished and reassigned according to medical need. Future plans include the expansion of the program to be able to offer pickup and delivery service to a larger geographic area.

4. Medicaid Program Integrity Requirements

Program integrity is essential to any successful business venture; it plays a critical role in ensuring that the directed mission is met, operations run efficiently and effectively, operations are in compliance with applicable laws, and in securing the trust of the business stakeholders. When public funds, as with the SoonerCare program, are added to these business elements, program integrity becomes even more important. The Oklahoma Health Care Authority (OHCA) has an obligation to the public to ensure these funds are spent appropriately. OHCA understands and fulfills its program integrity role. The OHCA has a long established Program Integrity and Accountability Unit which oversees the agency's program integrity efforts.

OHCA must also adhere to Federal regulations regarding Medicaid services; CFR Title 42, Parts 455 & 456 mandate specific provisions Medicaid agencies must follow to receive federal funds. Part 455 requires agencies to have a fraud detection and investigation program; Part 456 requires agencies to have a utilization control program. Compliance with these regulations requires that provider audits/reviews be performed. These audits/reviews are necessary to ensure OHCA is paying appropriate amounts to legitimate providers for medically necessary services provided to eligible members. OHCA must also comply with other Federal regulations such as those imposed by the Deficit Reduction Act, Improper Payments & Information Act, and the Affordable Care Act.

In addition to OHCA's oversight duties, the Federal Government now significantly

participates in Medicaid Program Integrity efforts. Federal programs / efforts recently established include the Medicaid Integrity Contractors, Medi-Medi program, Payment Error Rate Measurement Program, and the Recovery Audit Contractors. OHCA participates daily in the coordination and operations of these activities.

OHCA performs annual Payment Accuracy Reviews of SoonerCare payments. These reviews result in a measurement of how well OHCA is administering the program and allow us to identify areas for improvement and initiate corrective action. This program is recognized as a National best practice by CMS.

Action plans include continuing our efforts addressed above. We plan to implement the Federal RAC program in early 2013. Also, we will be implementing a new Case Management System in the fall of 2012. New FTE authorized for SFY 2013 will be directed towards prepayment reviews, cost avoidance and ROI efforts, focused EOMB audits, and clinical review audits.

5. Medicaid Changes Required by Affordable Care Act

The federal Patient Protection and Affordable Care Act (ACA) was enacted in March 2010 and most of its provisions become effective in 2013 and 2014. As of November 2012, Oklahoma's state leadership has decided to forgo the expansion of Medicaid.

OHCA has begun taking steps to implement key parts of the law that are mandatory, and to preserve viability of options for other provisions.

The 2,000-page ACA contains sweeping changes to nearly every aspect of the health care system – the insurance marketplace, preventive health care, quality and efficiency, health care workforce, etc. Only one of its 10 chapters relate to OHCA's mission – Medicaid and CHIP. However, that chapter contains the biggest changes to the program since its inception in 1965:

- A totally new eligibility-determination process for most members.
- To insure real-time verification of eligibility factors such as citizenship and income, the law requires the capability for instant data exchanges between states and a Federal Hub that catalogs such information.
- Synchronization with a second Insurance Affordability Program (Health Insurance Exchange) which provides federal subsidies to all persons between 133-400% of the federal poverty level (FPL) who do not have access to adequate employer-sponsored coverage. OHCA and the Exchange must be equally capable of receiving coverage applications from all Oklahomans. While OHCA has for years adopted a No Wrong Door (NWD) approach to Medicaid applications, the ACA expands NWD to groups whose incomes are above Medicaid thresholds.
- Potential expansion of coverage to 200,000 low-income adults (at or below 133% of the federal poverty level or FPL, or $25,400 for a family of 4) who did not meet previous categories of eligibility (pregnant, parents, disabled, etc.). This would represent the largest one-year expansion of Oklahoma's Medicaid program ever.

The mandatory administrative changes to Medicaid required by ACA center around an overhaul of Medicaid's scope. Whereas the program was designed to cover only certain categories of people whose health needs were considered paramount – children, pregnant women, the disabled and elderly – ACA proposes Medicaid become the universal coverage mechanism for all citizens who are at or under 133% FPL.

Under ACA, Medicaid is expected to partner with the other Insurance Affordability Program (Health Insurance Exchange) to provide seamless coverage to all persons under 400% of FPL. To facilitate exchanges with its partner IAP, Medicaid's eligibility criteria will be converted to match criteria rooted in income tax laws, known as Modified Adjusted Gross Income or MAGI standards.

OHCA has initiated a large Information Technology project, in collaboration with other social-service agencies and Office of Management and Enterprise Services, to facilitate expansion of its automated Medicaid systems, already considered a model for other states. Architecture, software and operations changes will allow OHCA to meet aggressive deadlines for refining its two-year-old On-line Eligibility system, which is the nation's first real-time system. The upgrades also are essential to ensuring program integrity (accurate payment and eligibility determinations) and allowing interaction with other IAPs.

The project's Executive Steering Committee consists of OHCA's Executive Staff. Monthly meetings have been conducted since May 2012 to review workgroup progress and make decisions about implementation. Advising the steering committee are 12 workgroups with the following objectives:

Policy: Make changes to Medicaid State Plan, waivers and rules necessary because of the ACA. This includes impact evaluation, notice to the public and stakeholders, and reviews by advisory, governing and legislative panels.

Administrative/Professional Contracts: Plans for revisions in contracts with providers of health care, call center and transportation services due to mandatory process changes and optional expansion.

Information Services: Changing architecture and programming in OHCA computer systems to accommodate ACA-mandated changes in eligibility-determination processes.

OHCA Organizational Structure for ACA'14 Medicaid Changes Project

Audit: Ensure audit functions are adapted to accommodate ACA'14 changes.

Finance & Reporting: Make changes to OHCA financial and reporting processes that are necessary to implement ACA changes, especially preserving functionality during technology transitions.

Human Resources: Ensure smooth transition of staffing assignments that may result from ACA changes

Information Services: Design, develop and implement IS changes to accommodate MAGI conversion and other ACA changes. Ensure new MMIS reports reconcile new programs and populations with legacy reports so that historical consistency is preserved. Ensure SoonerCare's eligibility system is integrated with the Federal Hub and other IAPs.

Insure Oklahoma: Implement transition plan to ensure IO members are seamlessly converted to either SoonerCare or other IAPs, if necessary, based on state leadership decisions on ACA opportunities.

Marketing, Outreach & Education: Synchronize public-education efforts with other IAPs to ensure that Oklahomans are aware of insurance coverage options under ACA. Determine role of community partners in messaging and communications related to ACA-related SoonerCare changes.

Call Center / Member Services: Ensuring that Medicaid enrollees are smoothly transitioned to other IAPs, if necessary, because of the ACA.

Provider Network: Make changes to the provider network and provider training made necessary by ACA'14 changes. Assess capacity of providers to serve increased membership and adopt recruitment plan, if necessary.

SoonerCare Operations: Evaluate the best delivery model for potential new adult group and consider care coordination needs with regard to both the PCPs and the OHCA care-management unit. Devise business plan for transitioning SoonerCare members to Exchange plans and vice versa.

6. Online Enrollment

In October 2007 the Oklahoma Health Care Authority (OHCA) received a $6.3 million dollar Transformation Grant through the Centers for Medicare and Medicaid Services (CMS) for a project to develop a web based online application and eligibility determination system to improve the ease and efficiency of Medicaid enrollment. Originally known as No Wrong Door, the process allows potential members to apply for SoonerCare electronically.

The online enrollment (OE) system is a comprehensive web-based eligibility system that utilizes a relational data base and business rules engine to determine Medicaid eligibility. The system provides the capability to do online enrollment and real-time eligibility determinations with the efficiency and flexibility to combat the rapid rates of change that exist in the current healthcare environment. This process is highly-adaptable and removes many of the enrollment obstacles for thousands of Oklahomans which previous processes could not effectively address.

There are five sub-workgroups that have been tasked with application and system modifications; one such workgroup is Eligibility and Enrollment.

Eligibility and Enrollment OE Workgroup
The Eligibility and Enrollment workgroup task is to: redesign the database and web application from household centered to person-specific, system changes required for new business processes and rules associated with statutory guidelines, and to establish an eligibility framework to support new populations and programs across multiple agencies.

Action plans include: identifying necessary systems modifications for each categorical population and making those changes, reviewing guidance and regulations from CMS.

Business Rules Engine/Business Process Management OE Workgroup
As part of the Eligibility and Enrollment project the BRE/BPM workgroup is charged with the following tasks needed to complete the enhancement to the OE rules engine: Utilizing an automated rules engine to enforce and enhance policy implementation and enhance automated workflow; Implementation and management of the Workflow and Business Process Modeling software; Establish and maintain the technical requirements for the integration of workflow processes and business process models; Document, redesign, and further automate eligibility business processes; Publish business process models to CMS repository; Leverage BPM tools and process models for reuse; Analyze Inter Agency business process interactions and reengineering opportunities (Medicaid and Eligibility); Model, modularize, and decouple business rules in the BRE;

Action plans include, acquiring and training staff for Rules Engine development, modeling the "to be" processes under the new MAGI rules and identification of additional changes needed for project completion.

Service Oriented Architecture (SOA) / Enterprise Service Bus (ESB) OE Workgroup
As part of the Eligibility and Enrollment System Project, the ESB/SOA workgroup is charged with tasks associated with implementing an Enterprise Service Bus (ESB) to expand the use of web services and to link the multiple applications in a Service Orientated Architecture (SOA); including links with other agencies, the Health Information Exchange (HIE), and the Health Insurance Exchange (HIX).
The system will function as an interoperable, MITA-compliant, ACA-compliant, modular system for determining eligibility and enrolling people in real-time, providing Oklahomans with the gold standard of access to Medicaid.

Action plans include workgroup review of the APD and identifying central high-level ESB requirements that will be integrated into an Oracle ESB product. In October 2012, the workgroup is anticipated to begin requirement verification sessions with interagency stakeholders and the Hewlett Packard project development team.

7. Physician Fee Schedule to 100% of Medicare
On May 9, 2012, the Center for Medicare and Medicaid Services released proposed regulations to implement section 1202 of the Health Care and Education Reform Act of 2010. Section 1202 increases Medicaid payments made to primary care

physicians for primary care services during the years 2013 and 2014 to Medicare payment rates, with the additional cost covered by the federal government. Providers eligible for this increase are those providers who practice family medicine, general internal medicine, and pediatric medicine specialists and subspecialists recognized by the American Board of Medical Specialties.

While Oklahoma traditionally pays at or close to 100% of Medicare rates, state Medicaid programs universally pay physicians at lower rates than Medicare and in 2008, paid on average 2/3 lower than Medicare[1]. With the Affordable Care Act increasing Medicaid coverage to adults with incomes below 138% of the Federal poverty level, there will be an increased demand for primary care physicians. Congress increased Medicaid primary care rates for two years to temporarily help states address that need. Pending any changes to federal guidelines, states must implement the program on January 1, 2013 and will sunset December 31, 2014.

Action plans include continued communication with CMS, systems modification, changes to the electronic provider enrollment system, exploration of strategies for confirming primary care provider eligibility. The state will also identify primary care provider outreach strategies and engage relevant stakeholders, including state and local medical societies and non-physician provider groups.
No SFY budget request was submitted for the program changes that are required by the Health Care Reform Act.

8. Insure Oklahoma
Today, Insure Oklahoma offers two program types- Employer Sponsored Insurance and the Individual Plan; both plans allow a member to cover their eligible spouse, child, and college dependent. Employer Sponsored Insurance (ESI) was implemented in November 2005 and initially benefited qualified Oklahoma small businesses with 25 or fewer employees. The Medicaid Reform Act of 2006 authorized the program to be offered to small businesses with 50 or fewer employees. This was implemented in October 2006. The program pays for part of the private health plan premiums for qualified employees working for small businesses. To date the program has nearly doubled the existing membership.

The Individual Plan (IP) is designed as a heath care coverage program for people who cannot access private health coverage through their employer. The Insure Oklahoma, IP program kicked off in January of 2007. This plan extends coverage to uninsured self-employed individuals, workers whose employers do not provide health coverage, workers who are not eligible to participate in their employer's health plan, sole proprietors not eligible for small group health coverage, and the unemployed who are currently seeking work. The Individual Plan allows qualified persons to purchase state-sponsored health coverage for a monthly premium based on household income. Individuals are responsible for co pays on certain benefits, and may access services from a network of IP contracted providers. The plan offers a limited benefit package and a lifetime benefit maximum. Total out-of-pocket costs (including premiums) for the family cannot exceed 5 % of household income.

Insure Oklahoma - Developing Considerations for 2014
The agency is currently working on three waivers to present to CMS, the first is our regular renewal for the program, second is a transition plan that realigns the program to meet ACA requirements, and the third is a phase out plan that details how the population will be transitioned to other health coverage options available if the state of Oklahoma chooses to expand Medicaid. All three waiver plans are due

to CMS by November. The Health Care Authority is also conducting analysis on cost savings if IO was modified to only cover adults to 100% of Medicaid, while sending all other IO members to obtain coverage on a health exchange. Preliminary research suggests operating cost would reduce to approximately 30 million dollars. If the program continues to exist as it does today, covering working adults up to 200 % FPL with a 35 thousand member cap, yearly program cost would total approximately 132 million dollars. These totals represent both state and federal share and are used to as tool for agency preparedness when a decision is made by the Governor.

Action plans include: continued cost analysis, identification of systems modifications necessary to continue, modify or terminate the IO program, contingent upon legislative approval, and reviewing guidance and regulations from CMS.

9. ICD 10 Conversion

The structure of ICD-9-CM has not allowed new procedures associated with rapidly changing technology to be effectively incorporated as new codes. As a result, in 1992 the U.S. Centers for Medicare and Medicaid Services (CMS) funded a project to design a replacement for ICD-9-CM. The new system is the ICD-10 Procedure Coding System (ICD-10PCS).

ICD-10-PCS has a seven character alphanumeric code structure. Each character contains up to 34 possible values. Each value represents a specific option for the general character definition. This allows for more exact and accurate coding and allows for future codes to be developed as technology changes.

Critical issues have been identified to ensure the timely implementation of this project. These issues include the accurate crosswalk of the ICD 9 codes to the more specific ICD 10 code set. Another critical area of concern is the cooperation with providers and partner agencies to enable compatible code defining for the new process. Conversion to the ICD-10 coding system was included in the agency fiscal agent procurement and is under development.

Even though the implementation deadline was delayed by CMS from October 1, 2013 to October 1, 2014, the agency intends to follow the original timeline to have the conversion completed and ready to implement by the new deadline.

Action plans include, continuing to work with specialized cross walking tools to assist in the accuracy of the conversion; making the needed systems changes to accommodate the new codes and working with providers and partners to coordinate changes and prepare for the implementation date.

10. Collaboration with the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS)

The 2011 Oklahoma Legislative Session yielded a new piece of state law directing the ODMHSAS to further collaborate with the OHCA and assume a lead role managing the behavioral health programs available to Medicaid members. The law directed the transition to become effective on July 1, 2012. The transition plan included responsibilities for ODMHSAS such as the development, recommendation and enactment of behavioral health policies, provider outreach and education, and budget management. The ODMHSAS and OHCA now share policy change processes whereby the OHCA, as the single state Medicaid agency, reviews

recommended changes made by ODMHSAS and completes the Medicaid rule promulgation process as well as state plan/waiver amendment processes including submissions to the federal partner, the Centers for Medicare and Medicaid Services (CMS). Another requirement of the transition plan included the transfer of the state share costs for the behavioral health programs from OHCA to ODMHSAS. Although the ODMHSAS is responsible for the management and oversight of the Medicaid behavioral health programs, the OHCA continues to administer the shared claims payment system utilized by both agencies. The consolidated claims payment system has been in operation for 4 years and processes payments for all behavioral health claims for Medicaid Title 19 and 21, as well as for ODMHSAS state-only funded services.

Action plans include continued collaboration and monitoring of the Medicaid behavioral health programs, refinement of policy change processes, and coordinated provider education efforts.

11. Conversion from a 209B State

OHCA is researching the possibility of transitioning from a 209(b) state to an SSI Criteria state. Unlike a 1634 state which would mean the Social Security Administration would make Medicaid eligibility determinations for SSI recipients, Oklahoma would use the SSI criteria, but the State would still make the eligibility determinations. OKDHS was consulted in early conversations on the topic, and it was determined that moving to SSI Criteria will not require many operational changes for them, since current OHCA policy essentially use the SSI rules with a couple of exceptions. OHCA has submitted a Corrective Action Plan to CMS regarding making this transition, along with some questions regarding our $10,000 limit on irrevocable burial trusts in state statute.

Action plans include awaiting the response from CMS to the CAP. Then the change will require State Plan and rule amendments.

12. Care Coordination for Dual Eligibles

In April 2011, the Department of Health and Human Services announced several initiatives that offer states more flexibility to adopt innovative practices in order to provide better and more coordinated care for Medicare and Medicaid enrollees who are "dually eligible" under both of these programs. Oklahoma is one of fifteen states that have been awarded a contract to support the design of projects that aim to improve the coordination of care for people with Medicare and Medicaid coverage.

The OHCA proposal involves taking a three pronged approach to determining the most efficient methods of care integration. Each of the three concepts identifies a different aspect of care for the dual eligibles and will be developed to identify the feasibility and effectiveness of each concept.

The first concept describes the efforts of the University of Oklahoma at Tulsa, School of Community Medicine to create a multi-tiered approach to care coordination by focusing on behavioral health and the restructure to integrate more effective care coordination, the inclusion of population level clinical analytics to facilitate the management of the beneficiaries, the use of community level integrated care plans, the development of community level evidence based protocols in the management of chronic disease, and the integration of these methodologies into graduate medical education.

The second concept involves exploring the feasibility of establishing an enhanced care coordination program, administered and operated by the state. Under this proposal, existing medical services will be integrated with the support of an interdisciplinary care team.

The final concept creates a PACE like demonstration design that would utilize the current infrastructure of a PACE demonstration model with modifications. This model will be called an Integrated Care Site (ICS) allowing for an increased number of individuals to benefit from the proven model. In the ICS model the age qualification have been increased to 45 and older and the individual does not need to be required to meet nursing home level of care. ICS will provide a comprehensive continuum of care designed to maintain and improve the quality of life for the elderly. The proposal was submitted in May 2012 due to requested changes of services originally considered.

Action Plans include the release of a Request for Proposal (RFP), negotiations with CMS for a MOU and submission of a waiver application for the ICS model.

13. Health Information Technology (HIT) and Health Information Collaboratives

Numerous public, private, and public private collaborative efforts continue toward improving population health outcomes and quality of healthcare for Oklahomans. This is being accomplished through clinical information sharing, meaningful use of certified EHR technology to measure the health outcomes and to reduce cost of healthcare by eliminating duplicate services. The Oklahoma Health Care Authority (OHCA) foresees achieving these goals through implementation of the OHCA Health Information Exchange for SoonerCare stakeholders.

Health Information Infrastructure Advisory Board (HIIAB)

Early in 2009, the Oklahoma legislature demonstrated Oklahoma's commitment to HIE amongst government agencies by enacting legislation that created the Health Information Infrastructure Advisory Board (HIIAB). The board is comprised of a number of state agencies involved in various aspects of public health. The legislation directed the board to assist Oklahoma's Medicaid Agency, OHCA, in developing strategic approaches for adoption of electronic medical records technologies and HIE. The legislation also directed OHCA to serve as the hub for exchange amongst state agencies. OHCA continues to work in collaboration with the HIIAB to achieve the goals of Title 63, O.S., Sec 1-131.

Later that same year (2009), in conjunction with OHCA's reprocurement effort request for proposal OHCA leveraged this opportunity to create a health information infrastructure which, when implemented, will enhance our ability to provide a more robust synergistic view of a SoonerCare member to SoonerCare providers. OHCA is in the final steps of defining requirements for the creation of a health information infrastructure whose initial capabilities may be available by the end of 2013. Minimal capabilities will include the display of member claims data, in a clinical format, to authorized providers while maintaining access controls, to ensure personal health information security and privacy requirements in accordance with federal, state and local laws and regulations. This infrastructure will continually be enhanced to provide greater utility to SoonerCare providers and members. Future enhancements include: a more robust provider portal, additional sources of member clinical and administrative data to support the EHR incentive program goals, clinical messaging, and a member portal with access to a personal

health record.

Open Health Information Organization (Open HIO)
The HIIAB will leverage OHCA's health information infrastructure as the cornerstone to create a state health agency information hub named "Open Health Information Organization" (Open HIO). The vision for Open HIO is to improve health outcomes and quality of care for Oklahomans and decrease healthcare costs through the secure and appropriate sharing of public health information between patients, providers, health related state agencies and other health information organizations, while meticulously maintaining patient privacy and security of health information as required by state and federal law. This vision will be modified periodically as new and innovative methods and technologies become available allowing for greater health benefits to Oklahomans. All members of the HIIAB are actively engaged in the planning stages of the Open HIO.

The goals and visions of OHCA HIE and Open HIO dovetails nicely with Oklahoma Health Information Exchange Trust's "Network of Networks" Model approach to technical architecture. Upon implementation of the Open HIO, the HIIAB will reach out to other HIOs within the State of Oklahoma thereby reinforcing the State of Oklahoma Health Information Exchange. Collaboration with OHIET participants and HIIAB members will continue to improve HIE and standardization of data formats and metadata descriptions will occur. National standards will be adopted and used by all participants in these exchanges as soon as these standards are available.

Oklahoma Health Information Exchange Trust (OHIET)
The Oklahoma Health Information Exchange Trust (OHIET) serves as the organizational structure and eventual state designated entity (SDE) through which Oklahoma will achieve its objectives of expanding existing resources and leveraging new resources to promote HIE under the State Health Information Exchange Collaborative Agreement Program (SHIECAP) grant. The OHIET is a state beneficiary public trust created by legislation expressly aimed at establishing an entity capable of serving not only as Oklahoma's permanent SDE during the SHIECAP grant period, but that could also continue into the future to advance HIE in the state.

The Oklahoma HIE Strategic and Operational Plans will result in the development of a statewide HIE that will allow health care providers to exchange clinical information, such as medication histories and test results, access that information at the point of care, and make better informed decisions with their patients. These plans will promote and support the effort of eligible professionals who wish to achieve Meaningful Use.

Action plans include OHCA's continued support and commitment to advancing the HIE goals in Oklahoma by finalizing requirements and implementing OHCA's health information infrastructure, plan and resource enhancements to the health information infrastructure providing greater utility to SoonerCare providers and members, developing a business model for expanding OHCA's health information infrastructure to members of the HIIAB, and conduct collaboration with other state of Oklahoma HIOs allowing for the sharing of health information across the state.

14. Medicaid EHR Incentive Payments to Medicaid Providers for HIT Adoption and Implementation

The Oklahoma Health Care Authority planned and implemented provisions of the American Recovery and Reinvestment Act of 2009 that provides incentives to eligible professionals (EPs) and eligible hospitals (EHs) for meaningfully using certified electronic health records (EHR) technology. The Recovery Act provides for a 100% Federal match for State expenditures for provider incentive payments to encourage SoonerCare providers to purchase, implement and operate certified electronic health record technology. The legislation also establishes a 90% match for the administration of the incentive payment program.

Under the Medicaid EHR Incentive program, payments are made to eligible professionals (EP) and eligible hospitals (EH) that adopt, implement, or upgrade and/or meaningfully use certified EHR technology. The incentive payments are not a direct reimbursement for purchasing certified EHR technology, but are incentives made to EPs and EHs that meet the specific criteria outlined in the EHR Incentive program. EPs may receive incentive payments across six years, and EHs may receive payments across three years. The Oklahoma EHR Incentive program was launched in January of 2011 and continues to provide incentive payments to SoonerCare providers. The Oklahoma EHR incentive program will sunset in the spring of 2022.

Action plans include annual updates to Oklahoma's State Medicaid HIT Plan (SMHP), periodic updates to the Implementation Advanced Planning Document (IAPD-U), monitoring the program timeline, continued stakeholder collaboration, continued improvement of OHCA business processes and infrastructure, SFY 2014 budget approval and development of future budget needs, information system upgrades for future stages of meaningful use, coding and testing of upgrades, as well as periodic reviews of agency rules needing Medical Advisory Committee (MAC) consideration, board approval and governor approval.

15. SoonerCare ePrescribing

SoonerCare ePrescribing: The OHCA is modifying its current approach to e-prescribing in Oklahoma to expand the use of Surescripts services for SoonerCare members beyond the current Surescripts prescription routing network functionality. When implemented, the new approach will allow SoonerCare providers to utilize the Surescripts network to access SoonerCare member eligibility, medication history, and SoonerCare formulary and benefits. This approach will promote the adoption of certified EHR technology by clinicians. E-prescribing is rapidly becoming the industry standard and about one third of office-based prescribers now e-prescribe. OHCA has recently received federal funding to implement this robust ePrescribing program using Surescripts network.

Action plans include finalizing contractual obligations, designing and building the interface, and SoonerCare provider training and outreach.

16. Health Homes for SoonerCare Members with Chronic Conditions

In March 2010, the President signed into law the Patient Protection and Affordable Care Act affording states the opportunity to create innovative ways to integrate care, improve care coordination, and lower costs through enhanced service delivery models for members. One such initiative is outlined in section 2703 which allows states to elect to provide health homes for enrollees with chronic conditions. This provision gives states an opportunity to receive additional Federal support, for eight

quarters from effective date, for the enhanced integration and coordination of primary, acute, behavioral health (mental and substance abuse) and long-term service and supports for persons across the lifespan of the condition.

To be eligible, individuals must have a minimum of two chronic conditions, one chronic condition and at risk of another, or one serious and persistent mental health disorder. The Health Home provision provides states an opportunity to create, or incorporate into existing models, a person-centered system of care. These systems must achieve improved outcomes for beneficiaries and better services and value for state Medicaid programs.

The OHCA has partnered with the Department of Mental Health and Substance Abuse Services (ODMHSAS) to develop health homes for SoonerCare members who suffer from a serious mental illness or severe emotional disturbance. With DMH taking the lead, community mental health centers (CMHCs) will be transformed into health homes that will consist of multidisciplinary teams coordinating the full range of physical, behavioral health and long-term services and supports. For children with severe emotional disturbance (SED), Oklahoma intends to utilize specialty health homes for children to ensure a holistic, wraparound approach addressing the child's needs in all life domains.

Action plans include: system modifications for identification purposes, continued communications with CMS during the development of the state plan amendment, contract changes between OHCA and ODMHSAS and facilitating ODMHSAS in the procurement of memorandums of understanding from external partners. The OHCA will also establish new procedures and business processes to incorporate the new requirements into the current business processes.

17. Comprehensive Primary Care Initiative

The Comprehensive Primary Care Initiative (CPCi) will seek to strengthen freestanding primary care capacity by testing a model of comprehensive, accountable primary care supported by multiple payers. Broadly, the initiative aims to achieve better health, better health care and lower costs for all patients in the Greater Tulsa market including Adair, Atoka, Cherokee, Craig, Creek, Delaware, Hughes, Lincoln, Mayes, McIntosh, Muskogee, Noble, Nowata, Okfuskee, Okmulgee, Osage, Pawnee, Payne, Pittsburg, Pushmataha, Rogers, Sequoyah, Tulsa, Wagoner, and Washington counties. Practices selected for this initiative will be held accountable for accomplishing the core set of comprehensive primary care functions.

Recognizing that the impact of any one payer alone is limited, the payers in this initiative have committed to establishing an approach that is coordinated with that of the Innovation Center to transform the way in which primary care is practiced and financially supported in the practices selected for this initiative. Over the next four years, the Comprehensive Primary Care initiative will evaluate whether a core set of comprehensive primary care functions, coupled with payment reform, enhanced data to guide practice improvement, and the meaningful use of health information technology can achieve better health, better health care, and lower costs through continuous improvement.

The findings of this initiative may be used to inform future Medicare and Medicaid payment and program decisions. The payers in this initiative believe that reimbursement designed to deliver the five comprehensive primary care functions

outlined in the Solicitation is a potential sustainable business model for all payers. These payers aspire to become a learning community that will lead the nation's efforts to transform health care and leverage the potential of public-private partnerships.

Action Plans include, working with the Innovation and other participating payers and practices to align payment methodology and primary care functions.

18. Oklahoma Health Care Insurance and Access Survey – 2012 Update

The University of Minnesota, State Health Access and Data Assistance Center (SHADAC) has provided a series of independent, state-specific reports on Oklahoma's insurance rates and access to care factors. The OHCA has engaged SHADAC to conduct comprehensive surveys of Oklahoma residents. Previous reports on survey results were issued in 2004 and 2008. The 2008 survey was conducted between July and September. For Oklahoma residents of all ages, the survey estimated that 16.7 % were uninsured (579,036 Oklahoma residents). The survey identified various groupings that are important to the discussion of potential coverage options because of their disproportionately high rates of uninsurance, and associated uncompensated care costs borne by Oklahoma health care providers. Higher uninsurance rates were seen among young adults (19-34 year olds), Hispanics, American Indians, Oklahomans not in labor force, and low income adults.

Looking ahead and considering the evolving health care coverage landscape, another opportunity for an independent study has been presented. The OHCA leadership made the decision to invest in another Health Care Insurance and Access Survey. The 2012 survey (with final report issued in 2013) will provide information on the characteristics of the uninsured as well as factors of Oklahoman's access to care, thus shaping programs, policies and outreach activities. It is anticipated the results of the 2012 survey will be used to help guide policy-makers in making informed decisions with regards to Oklahoma's coverage issues during the next legislative session.

Action plans include continued partnership with SHADAC, monitoring survey progress, and sharing results with stakeholders.

19. New Medicaid Grant Opportunities

The ACA includes many grant opportunities for Medicaid programs to assist with the development of new programs. These grant opportunities are aimed at reaching underserved areas and populations in order to reduce the numbers of the uninsured. Targeted areas covered by these new grant opportunities include: behavioral health, wellness programs, health benefit exchange, HIT, quality measures, long term care, medical home and provider training.

Action plans include: the close monitoring of new grant opportunities as they are released; ensuring that the appropriate agency departments are notified when these grants are published and the oversight and monitoring of applications to ensure that OHCA is able to take advantage of opportunities for expansion.

20. Miller Trust

A Miller Trust, also known as a Medicaid Income Pension Trust (MIPT), is a

method to allow an individual to qualify for Medicaid long term care benefits when his or her income is in excess of the established maximum income of 300% of the Federal Benefit Plan. Under current rules, applicants whose countable income exceeds the maximum, but is under $3,000, and who meet all other points of eligibility, may establish a Miller Trust in order to qualify for Medicaid.

The average monthly cost of nursing home care, however, has increased to $4,235 per month as of September 2012. People who need nursing home care whose income is less than the cost of the nursing facility but more than the $3,000 cap on the Miller Trust may not have their needs met as a result. Increasing the Miller Trust cap to the average cost of nursing home care will allow the cap to shift as required when costs increase without requiring rule changes each time.

Further action plans include making the appropriate policy changes and proceeding with current funding in order to increase to the maximum monthly income for a Miller Trust.

Assumptions

Assumptions

All health care spending in the United States is projected to grow at an annual average rate of 5.8 % for the period 2010 through 2020.[40]

Oklahoma's uninsured rate is an estimated 16.9 %; the national average is 15.7 %.[41]

Annual premiums for employer-sponsored family health coverage rose 4 % in 2012. This year's premium increase is moderate by historical standards, but outpaced the growth in workers' wages (1.7 %) and general inflation (2.3 %). Since 2002, premiums have increased 97 %, three times as fast as wages (33 %) and inflation (28 %).[42]

The uninsured are less likely than those with insurance to receive preventive care and services for major health conditions and chronic diseases – and many suffer serious consequences.[43]

The majority of the uninsured are in working families;[44] 76.7% of the uninsured in Oklahoma make below 300 % of the federal poverty level (FPL).[45]

Nearly 80 million baby boomers will file for retirement benefits over the next 20 years – an average of 10,000 per day. The likelihood of baby boomers needing some kind of long-term care is great, whether it be assisted living or skilled nursing care.[46]

In SFY 2011, SoonerCare funded 65.9 % of Oklahoma's long-term care occupied beds.[47]

One thing people don't recognize very well, however, is who pays for long-term care. In a poll, the majority of those both retired and not-yet-retired thought Medicare, private savings and private insurance would be the primary payers if they needed nursing home stays longer than 100 days. In fact, the primary payer for nursing home care across the nation is the joint federal-state Medicaid program. Yet that was identified as the most likely payer for their own long-term nursing care by only 7 % of retirees and 10 % of not-yet-retired boomers.[48]

Oklahoma's federal medical assistance percentage (FMAP) has continued to decrease for over five years.[49]

Mobile will be big in the health care industry. The use of tablets, smartphones, and tablet applications in healthcare continues to grow. In fact, nearly one-third of providers use mobile devices to access EMRs or EHRs. And with the onslaught of this mobile technology, providers will need to balance usability, preferences security, and more all while adopting written terms of use with employees and contractors.[50]

A perfect storm is brewing in the healthcare industry. Experienced workers are leaving the industry at a far higher rate than qualified workers are entering — and the medical industry is rapidly expanding.[51]

In the U.S., as of August 16, 2012, there are 5,721 Primary Care Health Professional Shortage Areas (HPSA) with 54.4 million people living in them. It would take 15,162 practitioners to meet their need for primary care providers (a population to practitioner ratio of 2,000:1).[52]

Medical cost trends in 2013 will surprise the industry with another year of historically low growth. The continued slowdown is the result of a sluggish economy, medical plans with greater cost sharing, and new care models that reward value over volume.[53]

But across the healthcare landscape behaviors are beginning to change. Employers are pushing wellness programs with real enforcement muscle. Healthcare providers and drug makers are embracing the quest for value. And patients are becoming more cost-conscious medical consumers.[54]

OHCA SFY 2011 Annual Report Highlights[55]

59 % of the estimated Oklahoma population younger than age 18 has been enrolled in SoonerCare at one point during SFY2011. Approximately 13 % of Oklahomans aged 65 and older are enrolled in SoonerCare.

SoonerCare covers approximately 64 % of the births in Oklahoma. In calendar year 2010, SoonerCare deliveries were 33,125 of the 51,799 total state births (OSDH preliminary figures accessed 7/18/2011).

OHCA administrative costs comprised 2.55 % of the total SoonerCare expenditures. OHCA operating costs represented 40 % of OHCA administrative cost, and the other 60 % were contracting costs.

Endnotes

End Notes

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