

Demand for new women's cancer treatment program is high

The number of women responding to Oklahoma Cares – the Oklahoma Breast and Cervical Cancer Treatment Program (BCCTP) – has exceeded expectations since the program went into effect Jan. 1, 2005. By May 13, the total number of applications received was already at 1,554.

Of those, 932 applications have already been approved as eligible for Medicaid benefits through the new BCCTP, while 52 other applications were determined to be eligible under traditional Medicaid.

Of those approved applications, 88 percent have already been assessed by Care Management, with 507 women still in the diagnostic phase and 259 women currently undergoing treatment.

Through the new program, Oklahoma provides Medicaid benefits to women between the ages of 19 and 65 with low income and no creditable health insurance coverage for breast or cervical cancer who are screened through the Breast and Cervical Cancer Early Detection Program (BCCEDP) and found to be in need of treatment for either breast or cervical cancer or a pre-cancerous condition. Implementing

and coordinating the BCCTP has been a collaborative effort of the Oklahoma Department of Human Services (OKDHS), Oklahoma State Department of Health (OSDH), Kaw Nation of Oklahoma, Cherokee Nation and Oklahoma Health Care Authority.

“We really didn't know how many applicants to expect but had set a goal of 2,400 applicants for this first year.

If the applications continue to come in like they have, we will have far more than that,” said Myloee Yeager, OKDHS supervisor of the centralized eligibility unit on site at OHCA.

“We actually started processing early applications in December 2004 for

women who had already been screened and diagnosed with either breast or cervical cancer through the BCCEDP, so they would be ready to go when the program went into effect,” Yeager said. “The number of applications we have already received just verifies the serious need in Oklahoma for such a program.” Before the program was implemented, it was projected that as many as 62,000 women in Oklahoma could qualify for the screenings.

Yeager works closely at OHCA

with **SoonerCare** Member Service Coordinators Lana Brown and Davina Murrell, Director of **SoonerCare** and Care Management Becky Pasternik-Ikard, Care Management Supervisor Carolyn Reconnu, RN, and Senior Exceptional Needs Coordinator Gail Livengood, RN, to ensure that the entire process flows smoothly for applicants. They have heard from many women who had received the diagnosis of breast or cervical cancer but had no alternatives to receive treatment before hearing about the BCCTP.

“They're very appreciative of the opportunity to receive treatment for this life-threatening disease,” Pasternik-Ikard said. “Many were in dire straits; the bills were piling up and they were running out of options. We're very pleased that we are able to help women who otherwise might not receive the care they need.”

Before a woman can complete an application for the treatment program, she must be diagnosed by a certified

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OKLAHOMA HEALTH CARE AUTHORITY



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DRUG UTILIZATION REVIEW FOR OKLAHOMA MEDICAID

To decrease the amount of material in your inbox, OHCA will be incorporating the DUR Newsletter into Provider Update.

Help line available for tobacco users

The Oklahoma Tobacco Help Line, funded by the Oklahoma Tobacco Settlement Endowment Trust, offers free telephone-based cessation counseling to assist tobacco product users in quitting.

The help line can be reached at 1.866.PITCH-EM (1.866.748.2436). (For Spanish-speaking callers, the number is 1.800.793.1552.)

Counselors use a cognitive-behavioral approach and motivational interviewing to increase motivation, overcome triggers to relapse and improve the participant's chance of success in quitting tobacco use. Assistance is available for any tobacco user in any stage of readiness to quit, as well as pregnant smokers, former smokers who would like relapse prevention support, friends and relatives of smokers, and health care providers who require resources for their patients.

Three levels of intervention are available. Level 1 consists of information and referral; it is for callers who are not interested in quitting or callers who are seeking referral information only. Level 2 is a single call in-depth intake and counseling in which callers interested in quitting can talk to a tobacco cessation specialist to explore their options. Level 3 is intensive intervention in which callers who are interested in receiving follow-up can enroll in the help line's intensive telephone-based program.

Tobacco cessation help lines have been shown to increase quit rates in comparison with the success of smokers who try to quit on their own with no counseling. Use of help lines can remove client barriers such as transportation and child care issues, and the line can provide confidential services that are individualized to the participant.

The help line is available 24 hours a day; live counselors are available every day from 7 a.m. to 11 p.m., and voice mail is available from 11 p.m. to 7 a.m., with all messages returned within 24 hours. The help line is operated by Free & Clear Inc. of Tukwila, Wash.

Smoking cessation is a priority for Oklahoma Medicaid. All smoking cessation products are covered, including OTC products with a valid prescription. Smoking cessation products are covered without prior

authorization for the first 90 days in any 365-day period.

After the first 90 days of therapy in a 365-day period, the next 90 days of therapy require prior authorization, which is dependent on the patient being enrolled in a smoking cessation behavior modification program. Such programs can include telephone-based programs like the help line.

After the patient has had 180 days of treatment, the client must wait another 180 days before smoking cessation treatment will be covered again, since nicotine replacement products are not intended to be used long term as permanent replacements for tobacco products.

Smoking cessation products do not count against the monthly Medicaid prescription limit. In fiscal year 2004, 732 Medicaid clients took advantage of this coverage by filing at least one claim for a smoking cessation product.

Pharmacy provider contracts up for renewal

Current pharmacy provider contracts with the *SoonerCare* program will expire July 1, 2005.

Pharmacies that wish to renew their contracts can download the necessary forms from the Oklahoma Health Care Authority's Web site, www.ohca.state.ok.us, and send them to OHCA.

Guidelines recommend ACE inhibitor use in clients with diabetes and hypertension

Current evidence-based guidelines recommend treatment with an antihypertensive regimen that includes either an angiotensin-converting enzyme inhibitor (ACEI) or an angiotensin receptor blocker (ARB) for patients with both diabetes and hypertension.

The Oklahoma Medicaid population was examined for ACEI and ARB use in diabetic clients. Diagnosis information was extracted from ICD-9 coding submitted on Medicaid medical insurance claims. Diagnosis information was reviewed for 502,907 clients for the period of January through December 2004. Of those clients, 43,907 had a hypertension diagnosis coded, 25,606 had a diabetes diagnosis coded, and 15,022 had both diabetes and hypertension diagnoses coded.

Of the 15,022 clients with both diabetes and hypertension, 8,324 (55.4 percent) had a pharmacy claim for an ACEI at some time during the year, and 2,540 (16.9 percent) had a pharmacy claim for an ARB. From the available information, it was not possible to determine how many of the remaining clients were eligible to use an ACEI or ARB but had never tried it, versus how many had tried and failed both.

There may be a sizeable population of diabetic Medicaid clients who could benefit from ACEI or ARB use but who are not currently receiving either. The majority of ACEIs and ARBs are available to Medicaid clients without prior authorization. For a list of the tier-1 antihypertensives, see the OHCA Web site at: http://www.ohca.state.ok.us/provider/pharmacy/billing/prior_authorization.htm#ANTIHYPERTENSIVE.

The American Diabetes Association's guidelines for the treatment of hypertension in diabetics are available at care.diabetesjournals.org and are available in print at Diabetes Care. 2005 Jan;28(suppl 1):S4-S36.

The following recommendations are found in the ADA guidelines:

- Diabetics should maintain a blood pressure of <130 mmHg systolic and <80 mmHg diastolic.
- If patients have systolic blood pressure 140 mmHg or diastolic blood pressure 90 mmHg, they should receive drug therapy in addition to lifestyle and behavioral therapy.
- All diabetic patients' antihypertensive drug regimens should include an ACEI or an ARB, and if needed, a thiazide diuretic should be added.
- With any of these drugs, renal function and serum potassium should be monitored.

Drug classes that have been demonstrated to reduce cardiovascular events in diabetic patients are ACEIs, ARBs, beta blockers, diuretics and calcium channel blockers.

ACEIs have been shown to improve cardiovascular outcomes in patients with high cardiovascular risk, including those without hypertension. In patients with congestive heart failure, ACEIs have been associated with better outcomes than ARBs. ACEIs have also been suggested in clinical trials to be superior to dihydropyridine calcium channel blockers (DCCBs) in reducing cardiovascular events for diabetic patients.

DCCBs are not more effective than placebo in slowing the progression of diabetic nephropathy, so their use in nephropathic diabetic patients should be restricted to additional antihypertensive therapy in patients already being treated with ACEIs or ARBs.

For pregnant patients, target blood pressure goals are 110–129/65–79 mmHg, and ACEIs and ARBs are contraindicated. Methyldopa, labetalol, diltiazem, clonidine and prazosin are known to be safe and effective antihypertensive drugs for pregnant women.

Drug reference software available

The Oklahoma Health Care Authority continues to offer prescription drug reference software free to all providers who have handheld personal data assistants (PDAs), said Alex Easton, pharmacy operations manager.

The Epocrates software, which covers more than 3,000 brand-name and generic drugs, is intended to help providers improve quality of care and cut lag time for many Medicaid patients who now must wait to receive their prescriptions.

Providers can see at the point of care what drugs are available and whether the prescription requires prior authorization or has quantity limits. If so, a list of therapeutically equivalent alternative drugs covered without restrictions is given.

The software also can show clinical guidelines and warn of adverse reactions or contraindications.

The software can be downloaded at www.epocrates.com.

Medicare Act brings changes for pharmacies

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) represents the most significant changes to the program since its inception. Passed by Congress late in 2003, the bill includes provisions for temporary assistance with prescription costs as well as a permanent pharmacy benefit for Medicare beneficiaries.

The temporary assistance includes the Pharmacy Discount Card for 2004 and 2005 and cash assistance for some low-income, non-Medicaid-eligible individuals. The pharmacy benefit is called Medicare Part D, and it will begin Jan. 1.

The Centers for Medicare & Medicaid Services (CMS), the federal agency that administers Medicare, has divided the country into regions for implementation of the Part D program. The state of Oklahoma has been designated as one Prescription Drug Plan (PDP) region. For Medicare Advantage plans, Oklahoma and Kansas are grouped together as one region. Medicare Advantage plans may offer prescription coverage, and those plans are referred to as MA-PD plans.

The Part D benefit is a publicly funded, privately operated program. Insurance companies and other private sector businesses are submitting bids to become Prescription Drug Plan sponsors. The PDP sponsors have flexibility in designing their benefit packages, but they must meet the minimum standards of the MMA.

The Medicare Part D benefit includes a standard pharmacy benefit and three subsidized benefits. The standard benefit will be available to individuals who are not eligible for Medicaid and have incomes greater than 150 percent of the Federal Poverty Level (FPL). Three levels of the Low Income Subsidy will be available to individuals with incomes less than 150 percent of the FPL and those eligible for Medicaid.

Individuals who are either eligible for Part A or enrolled in Part B of Medicare are eligible to enroll in Part D. Like Part B, enrollment in Part D

is optional and requires a premium payment. It is important to remember that there is no Medicare drug benefit for an individual who chooses not to participate in Part D. This is true even for those individuals who have previously been covered by Medicaid. The Medicaid pharmacy benefit will no longer cover individuals who are also eligible for Medicare.

The process for enrolling in Part D is similar to those for employees during an open enrollment period. Our region will have at least two PDPs from which to choose. One of those may be a Medicare Advantage Prescription Drug program.

Standard coverage can be thought of as a high-deductible catastrophic coverage policy with some earlier payments to encourage compliance with maintenance medications. There are no lifetime or annual caps on prescriptions or expenditures and no monthly limits on the number of prescriptions covered. The premiums are community rated, with no underwriting based on age or health. This benefit provides predictable budgeting for moderate-income individuals. The catastrophic coverage begins after an individual has spent \$3,600 out of pocket.

Beneficiaries have the annual option of selecting a Part D PDP or an MA-PD. They may select a plan with standard coverage or pay an additional premium for enhanced coverage. Beneficiaries can change plans only at open enrollment, unless they are dual eligibles, who have continuous open enrollment.

CMS determines the basic premium for standard coverage in each region based on the bids of the plans awarded. Different plans may have different premiums, but every enrollee that has maintained continuous coverage will pay the same premium as every other enrollee in a plan. A beneficiary pays a 1 percent penalty for each month there is a lapse in standard coverage.

Medicaid impact

As of Jan. 1, federal Medicaid funds will be cut off for Medicaid beneficiaries who are older than age 65 or disabled and are entitled to Medicare Part A or enrolled in Part B. These are the "dual eligibles," and they must obtain their prescriptions through the Medicare Part D benefit.

If a dual eligible individual does not select a PDP or MA-PD plan, CMS will "auto-enroll" that person before Jan. 1. Premiums for dual eligibles are paid by the federal government by the federal low income subsidy. Individuals have the right to disenroll from a plan to which they have been assigned and choose another.

Dual eligibles in long-term care (LTC) facilities never pay anything for their Part D benefit.

Dual eligibles not in LTC facilities with incomes less than 100 percent of the FPL – income less than \$9,310 for an individual, \$12,490 for a couple – pay no monthly premium and never pay more than \$1 for a generic and \$3 for a brand-name prescription.

Dual eligibles not in LTC facilities with incomes more than 100 percent of the FPL pay no premium and never pay more than \$2 for a generic and \$5 for a brand-name prescription.

Low-income, non-Medicaid-eligible individuals with incomes under 135 percent of the FPL – income must be less than \$12,569 for an individual, \$16,862 for a couple with liquid assets less than \$6,000 for an individual, \$9,000 for a couple – pay no monthly premium and never pay more than \$2 for a generic and \$5 for a brand-name prescription.

Low-income, non-Medicaid-eligible individuals with incomes between 135 percent and 150 percent of the FPL – less than \$13,965 for an individual, \$18,735 for a couple with liquid assets less than \$10,000 for an individual, \$20,000 for a couple – have no coverage gap, but pay sliding scale premiums, a \$50 deductible and then 15 percent of the cost of their prescriptions.

OHCA CEO named 2005 Administrator of the Year

Mike Fogarty, MSW, JD, chief executive officer of the Oklahoma Health Care Authority (OHCA), was named the 2005 Administrator of the Year by the Oklahoma Chapter of the American Society for Public Administration.

The award is given annually to a public servant in Oklahoma whose career exhibits the highest standards of



excellence, dedication and accomplishment. This year's award presentation was made May 2 at the Public Service Recognition Banquet.

Fogarty's public service career began 34 years ago when he joined the Oklahoma Department of Human Services as a social worker. In 1995, he was appointed state Medicaid director, and in 1997, he added the duties of chief operating officer. He has been chief executive officer of the agency since September 1999.

Under his leadership, OHCA has expanded medical coverage for children, pregnant women, people with disabilities and elderly adults. He has been instrumental in OHCA's revenue maximization initiatives. Since its inception, OHCA has increased federal revenue by more than \$790 million, a 97 percent increase. He has also been responsible for many other initiatives that have benefited Oklahoma residents.

Fogarty is also active in volunteer

public service activities. He currently serves on the Community Hospitals Authority – Tulsa, the University Hospitals Trust, the University Hospital Authority, the Oklahoma Commission on Children and Youth, the Oklahoma Pharmacy Connection Council, the Oklahoma Partnership for Children's Behavioral Health and the Oklahoma Partnership for School Readiness. He is a member of the Oklahoma Bar Association and a graduate of Class IV of Leadership Oklahoma.

Fogarty has earned the respect and appreciation of many people during his career, the public administration society said, and "it is fitting that he was chosen for recognition through this most recent award for his leadership, professional and ethical standards, his record of achievement and his unending commitment to public service."

Business is booming for family planning waiver program

SoonerPlan, the family planning waiver program that went into effect April 1, has been met with enthusiasm by uninsured women and men who desire family planning assistance. More than 1,000 applications came in during the first full week after the program was implemented, with that total tripling before the end of April.

SoonerPlan is designed to provide family planning services and contraceptive products to a traditionally ineligible population, with the aim of reducing unintended pregnancies.

Oklahoma's new family planning program was implemented and is coordinated jointly by the Oklahoma Health Care Authority (OHCA), the Oklahoma State Department of Health (OSDH) and the Oklahoma Department of Human Services (OKDHS). Because it has been

projected that as many as 90,000 men and women in Oklahoma may potentially qualify for this program, the centralized OKDHS unit housed at OHCA is receiving the family planning waiver applications to process.

The program is limited strictly to the reproductive health services currently covered under the state Medicaid plan and includes over-the-counter contraceptives, a component many states do not have. Oklahoma is the only state to include tubal ligations and vasectomy procedures in its family planning waiver program.

Eligible individuals include uninsured Oklahoma women and men age 19 or older who meet income requirements and who are not eligible for regular Medicaid or do not have other health insurance coverage for family planning. Individuals can pick

up applications at the county offices of the OSDH, OKDHS and statewide family planning clinics and providers. Applications also are available on the Web sites of OKDHS (www.okdhs.org), OSDH (www.health.state.ok.us), Oklahoma Areawide Services Information System (oasis.ouhsc.edu) and OHCA (www.ohca.state.ok.us) or by calling the **SoonerCare** Helpline.

Because the family planning waiver is restricted to family planning services, providers are encouraged to verify eligibility before providing health care services. Verification can be done by swiping the patient's white plastic Medicaid I.D. card, calling the **SoonerCare** Helpline or checking electronically online at the providers' secure Web site at www.ohca.state.ok.us.

Providers need to submit encounter data in timely manner

All *SoonerCare* contractors must submit encounter data for all services provided in the benefit package listed in Attachment A of the *SoonerCare* contract.

The primary care provider/case manager (PCP/CM) must use the *SoonerCare* provider number and submit an encounter for any single health care related service for any individual properly enrolled in *SoonerCare*. Claims for all services provided to *SoonerCare* members must be submitted in the same manner and on the same forms used to submit regular Medicaid fee for service claims for all other Medicaid recipients.

Encounter claims must be submitted within 60 days of the date of service. **Providers must correct and resubmit denied encounter claims within 60 days of adjudication.**

A provider who is not submitting encounter data for services rendered to *SoonerCare* members is not in compliance with the contract and will be subject to corrective action and penalties until requirements are met.

Referred services

Claims submitted for referred services must include the PCP/CM's *SoonerCare* provider number in block 17A on the HCFA 1500 or block 83B on the UB92. If the PCP/CM is a group provider, the group *SoonerCare* number should be used.

Coverage

Encounter data is also required when the PCP/CM makes arrangements with another provider to cover patients during a temporary absence. Arrangements for payment for coverage for capitated services are the responsibility of the PCP/CM. The covering provider may bill, however, for services that are noncapitated (in other words, services not listed in Attachment A of the contract).

In filing claims for coverage when capitated services have been rendered, the PCP/CM should submit the encounter data with a Q5 modifier.

The PCP/CM should give the provider who covered a referral for submitting claims for noncapitated services. With the appropriate referral from the PCP/CM, the covering provider will be paid based on the Medicaid fee schedule and policy.

Resources

OHCA assists providers in working to ensure that encounter claims requirements are met. In addition to consultation and training services furnished by the agency, providers may monitor their claims data by using such tools as the OHCA Remittance Advice and Medicaid on the Web.

Encounter claim pitfalls

Two encounter claim issues merit critical attention by the contractor.

The first is having a system in the office practice to monitor that all claims are submitted accurately and in a timely manner. The second is avoiding billing errors that may be construed as Medicaid fraud.

A PCP/CM must have procedures in place to prevent improper payments, such as referring to self for capitated services. If a contractor identifies such errors through self-audit, the PCP/CM should take steps to void the claims and repay OHCA.

For information about filing encounters and using OHCA resources to meet contractual requirements in this area, contractors are urged to speak with their provider representatives in *SoonerCare*. The toll-free number is 877.823.4529.

Reminder

All dental care providers working in a dental clinic or group must have an individual dental provider contract with the Oklahoma Health Care Authority in order for Medicaid patient care to be covered.

A clinic cannot contract to cover any and all providers working there.

Job opportunity: physician medical reviewer (no nights or weekends)

The Oklahoma Health Care Authority (OHCA), located near the state Capitol building in Oklahoma City, is seeking a physician medical reviewer. OHCA is the state agency that administers the Medicaid program, which provides access to health care for approximately 500,000 members.

Primary duties of this position include:

- Reviewing clinical records for appropriateness of care and medical necessity.
- Taking input from and providing feedback to

providers regarding issues of medical care and other issues of mutual concern.

- Developing, recommending and updating protocols for medical necessity and utilization review.
- Researching new technologies and treatment protocols.

The salary and benefits of this position are commensurate with state employment regulations.

Preferred education and experience include:

- Medical degree (DO or MD)

- Current active Oklahoma license
- Seven years of primary care experience
- Evidence-based medicine
- Medicaid experience

For more information, contact Dr. Paul Keenan at 405.522.7176. To submit a CV, it can be faxed to 405.522.7420, e-mailed to personnel@ohca.state.ok.us or mailed to 4545 N. Lincoln, Suite 124, Oklahoma City, OK 73105, attn: HR.

Closing date for the position is July 15.

OHCA and OSU-OKC launch certified nurse's aide training

Classes began in May for a pilot program to certify nurse's aides to work at long-term care facilities. The classes are being offered at no cost for qualifying Oklahoma and Logan county residents who earn certification and gain employment at a Medicaid long-term care facility for at least 12 months. The program, developed by

the Oklahoma Health Care Authority (OHCA) and Oklahoma State University-Oklahoma City in collaboration with various state agencies, also gives participants a free lab coat and three sets of scrubs.

OSU-OKC is providing the curriculum that is designed to prepare students to complete the state's nurse aide competency examination. The curriculum consists of 80 hours of training, including 16 hours of supervised clinical training. Students are required to pass an Oklahoma State Bureau of Investigation background check and nurse aide registry screening prior to beginning training.

"Oklahoma's long-term care facilities have long struggled with a manpower shortage," said OHCA Chief Executive Officer Mike Fogarty. "We believe this program is an important step in helping

Medicaid facilities in their quest to provide enduring quality care to their residents."

"We are very excited to be participating in this new program," said Dr. Mike DeLong, OSU-OKC academic affairs associate vice president. "We hope to meet the challenges of direct care work force shortages and develop a certified nurse training program that serves to deliver quality staff and enhance continuity of care," he said.

OHCA staff, along with other agencies, will track various outcomes related to the effectiveness of the program, areas for improvement and challenges for future program expansion. Program expansion will be considered around March 2006.

"Agency staff will conduct surveys, coordinate focus groups and perform on-site observations in addition to using other data-gathering methods throughout the many phases of the program cycle, ranging from identifying training barriers to employment issues such as transportation, recruitment and retention," said Teri Dalton, OHCA projects manager. "We are firmly committed to building enduring quality care for residents," she said.



Mike Fogarty, OHCA's chief executive officer, signs a contract with Oklahoma State University-Oklahoma City to create a pilot training program for certified nurse's aides. Looking on are, from left, Teri Dalton, special projects manager; Howard Pallotta, director of legal services; and Tana Parrott, projects coordinator.

New women's cancer treatment program

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screening provider under any of three BCCEDP programs: OSDH's "Take Charge!" program, the Kaw Nation of Oklahoma and the Cherokee Nation. The OSDH is still seeking providers (physicians, physician assistants, nurse practitioners and nurse midwives) who are interested in joining the network of nonfunded screening providers.

Once it has been determined that an applicant is eligible for Medicaid assistance under the BCCTP, she is eligible for all Medicaid benefits

during the time that she is in the program. In addition to health care coverage, women in the program also can receive care management services, transportation to receive treatment through SoonerRide and access to the **SoonerCare** Helpline and 24-hour Nurse Advice Line. Eligible women will continue to receive services through **SoonerCare** until they are determined by their provider to no longer be in need of treatment for their cancer.

Providers who are interested in signing a Medicaid contract to provide diagnostic or treatment services may contact OHCA Provider Enrollment at 405.522.6205 or 800.522.0114 (select option 5). To learn more about becoming a certified screener through the Take Charge! Program, providers may contact the Oklahoma Cares hotline at 1-866-550-5585 or e-mail OKCares@health.ok.gov.

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Please submit any questions or comments to Meri McManus in the Oklahoma Health Care Authority's Public Information Office at 405.522.7026.



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