



Oklahoma Health Care Authority

Strategic Plan

SFY2009—2010

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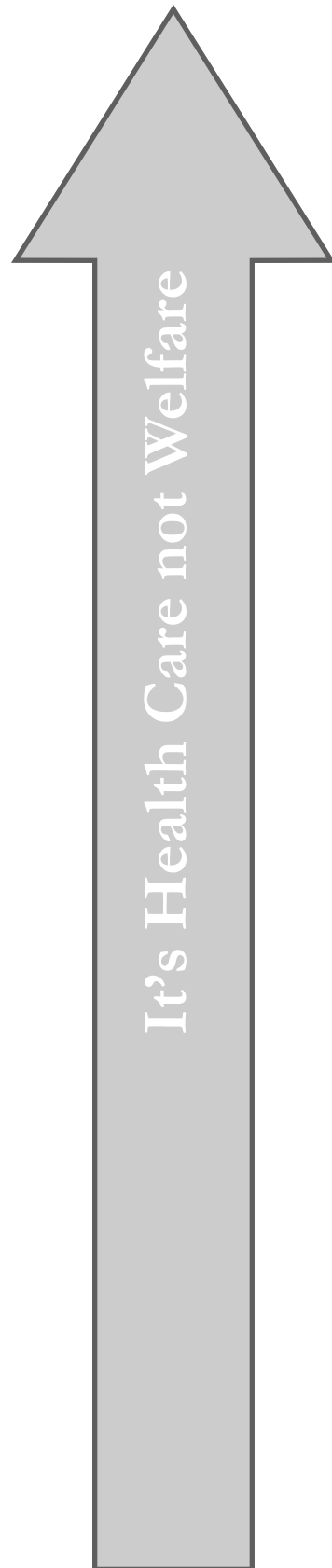
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Introduction

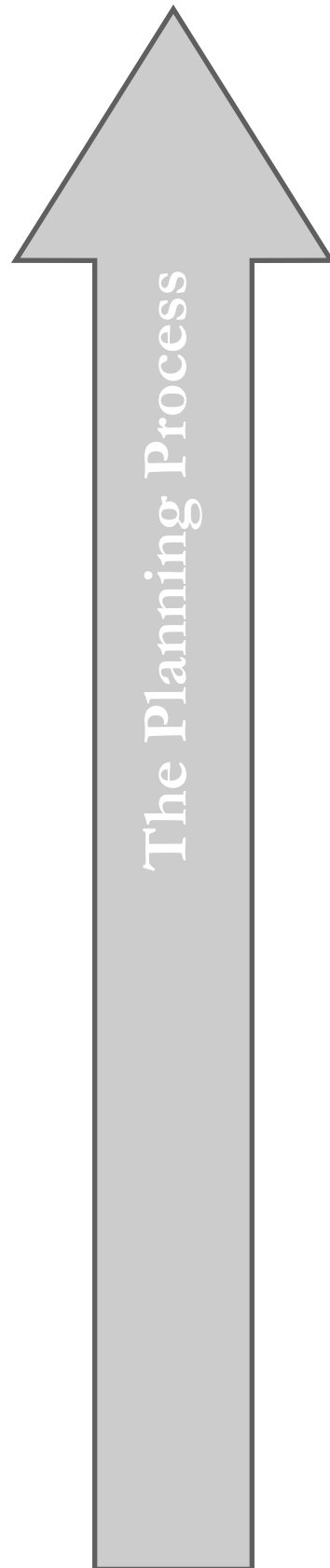
Forty plus years after President Lyndon B. Johnson signed the Medicaid program into law, Medicaid continues to be Oklahoma's number one defense against the crisis of the uninsured and underinsured. SoonerCare remains a vital source of health care for low-income children, seniors and the disabled. Included in its membership are also low-income individuals being treated for breast or cervical cancer or those seeking family planning services.

The program also provides supplemental coverage for low-income Medicare beneficiaries for benefits not covered by Medicare and Medicare's cost-sharing requirements. Financing initiatives and bi-partisan legislative support have also made it possible to assist low-income workers with obtaining health care coverage for themselves and their spouses through Insure Oklahoma / O-EPIC. In the absence of access to these combined health care products, 797,000+ Oklahomans would have joined the ranks of the uninsured during fiscal year 2008.

In addition to improving access to health care for its members, SoonerCare has financed many innovations in health care delivery and functioned as Oklahoma's primary source of long-term care financing. Funding has also helped support health care providers and reduced the amount of uncompensated care.

SoonerCare 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.¹ However, that judgment was made during the 1930s in the context of income assistance, not health care.



OHCA's Strategic Planning Responsibilities

The Oklahoma Health Care Authority (OHCA) is responsible for overseeing 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 our members, and in meeting the highest standards of administrative performance.

In order to be a leader, OHCA must continually plan – plan for change. Changes are inevitable. Successful change is hinged on a picture of a desirable future. A sound, deliberate strategy for the future is not just a good idea, it is a requirement for organizations in today's fast paced environment. Societal needs and expectations, technological advances, demographic and economic change, stakeholder partnerships and interests - all of these need to be considered in light of the agency's resources and capabilities as we move forward towards the future.

***Change is powerful:
OHCA can lead it or
can re-act to it.***

Through this Strategic Plan, OHCA sets forth its goals and objectives for carrying out this work. OHCA's Strategic Plan begins by providing 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 our strategic goals and objectives.

How seriously we take our responsibilities, how willing we are to come together as a state to make difficult choices regarding direction and priorities and how committed we are to work together to support those choices in our future actions will determine whether this planning process is ultimately successful.

Strategic planning, as used in this proposal, is a process by which OHCA can take charge of its future. Throughout the planning process, the agency asks 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 in light of the opportunities and challenges, as well as the agency's strengths and weaknesses, will help us develop our 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 holds for Oklahoma's SoonerCare and Insure Oklahoma / O-EPIC programs.

The logic of the plan remains the same. The heart of the Strategic Plan is the statement of our primary strategic goals - - that short list of major emphases over the next several years. These goals represent, not only our understanding of the agency's statutory responsibilities, but our broader sense of purpose and direction formed by a common set of agency values.

Subsequently, the planning process turned the goals into a plan of action with roles and responsibilities distributed throughout the agency. Some strategies overlap. Some strategies may not prove practical upon closer examination and may need to be refined or even eliminated. Some strategies are already well under way, others may require legislative changes.

Next the planning process (priority-setting decisions) came together with the proposed strategic budgeting process (resource allocation decisions). As a result of this effort, programmatic and resource decisions were based on shared goals and priorities and on 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 will allow the OHCA to be in a position to reach agency goals in a much more controlled and targeted way.

At this point OHCA must not close the book on planning. We must institutionalize planning by maintaining a continuous process of reviewing the effectiveness of the plans and strategies implemented in achieving our goals and priorities.

*“There are basically three kinds of organizations.
Those that make things happen. Those that watch
things happen.
Those that wonder what just happened...”*
Anonymous

Executive Summary

With annual expenditures of almost \$4 billion and over 797,000 Oklahomans' lives touched, the Oklahoma Health Care Authority (OHCA) plays a key role in the overall 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 could 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 issue areas, from payment reform, to quality improvement, to disease management, to long term care, to cost containment, to coverage expansions.

Oklahoma has shown commitment and innovation as we have moved forward with improvements to health care access, costs and quality.

Environmental Assessment Summary

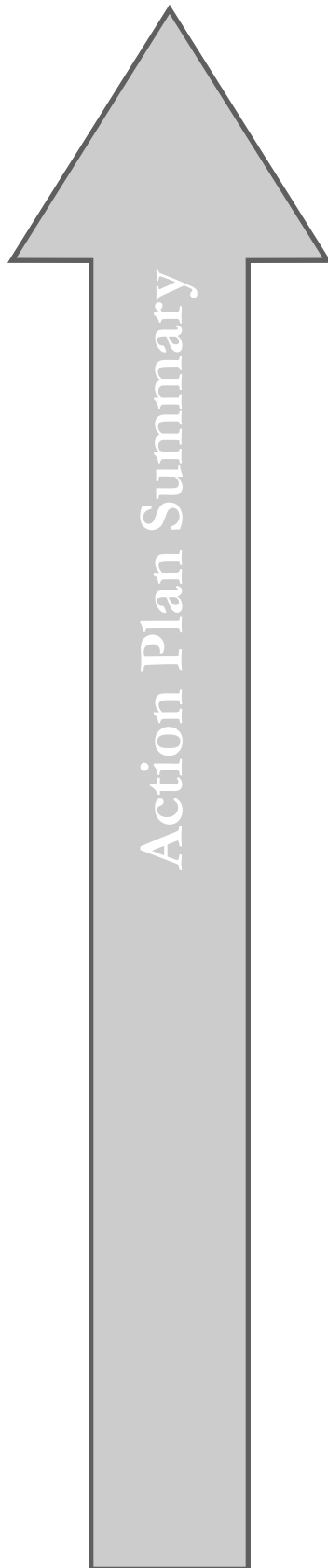
The results of the agency's environmental assessment will help support and guide the development of agency goals, objectives and strategies. A summary of this assessment follows (additional detail can be found on pages 10 through 26).

⊕ Medicaid's current economic outlook for growth does not appear particularly favorable considering only current federal and state funding streams. The federal deficit, coupled with a declining federal contribution to the state and an anticipated low or stand-still budget at the state level will make for hard decisions for policy-makers as they consider pressures from health, education and other programs.

● Demographic information indicates that action plans are headed in the right direction with designs to provide access to health care coverage to more of the uninsured and other coverage models to care for Oklahoma's growing aged population.

⊕ Oklahoma's biggest obstacle to action on health care reform at the present time seems to be at the federal level. Ideological and policy differences between the right and left have resulted in conflicting interpretations and guidance, as well as delays in necessary waivers.

⊕ Keeping an eye on health care industry trends has never been more important. The health care industry is accustomed to constant change, but nothing compares to the changes predicted for the next few years. Technology, consumer engagement in quality information, and workforce shortages in the medical field, are just a few issues that will have major impacts for policy-makers.



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 five major themes: 1) Eligibility; 2) Benefits; 3) Financing; 4) Program Administration; and 5) Opportunities for Living Life.

Ideas include, but are hardly limited to, bringing OHCA, other state agencies, providers and private partners together to help more individuals obtain access to health care coverage, reviewing and researching medical quality and consumer choice, as well as exploring how technology can be used to overcome barriers to enrollment and retention while at the same time strengthening the integrity of both SoonerCare and Insure Oklahoma / O-EPIC.

Specific eligibility action plans include continuing down the path of providing health care access through Insure Oklahoma / O-EPIC for low-income adults who are not eligible for traditional Medicaid. Other action plan considerations in this group include State Plan coverage for 19—20 year olds.

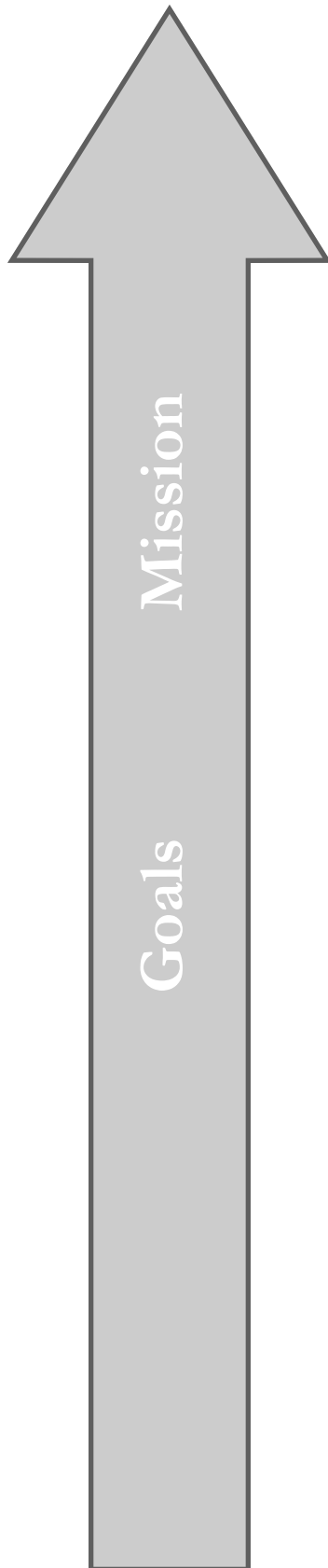
The agency will also continue to work with its many partners in the continued outreach of both SoonerCare and Insure Oklahoma / O-EPIC. It is important that those who are eligible to access health care through these avenues are aware of the opportunities.

Technology plays a large role with future action plans. Electronic Health Information (EHI) partnerships, electronic provider enrollment, online member enrollment, preparing for new populations, single-payer systems and telemedicine, as well as the MMIS (Medicaid Management Information Systems) re-procurement, are the major pieces of the technology pie OHCA has on the table at this time.

OHCA will also continue to review reimbursement rates and methodologies to ensure that provider payments are consistent with efficiency, economy and quality of care. New strategies may be recommended that would optimize the delivery of health care, as well as provide for the most appropriate rate structures.

The Opportunity for Living Life (OLL) action plans continue to describe our many partnerships with other agencies, providers and advocates to develop collaborates to improve access to long-term support services, and provide for better choice and control for our aging population.

See pages 27 through 56 for more details on specific action plans.



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: 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.

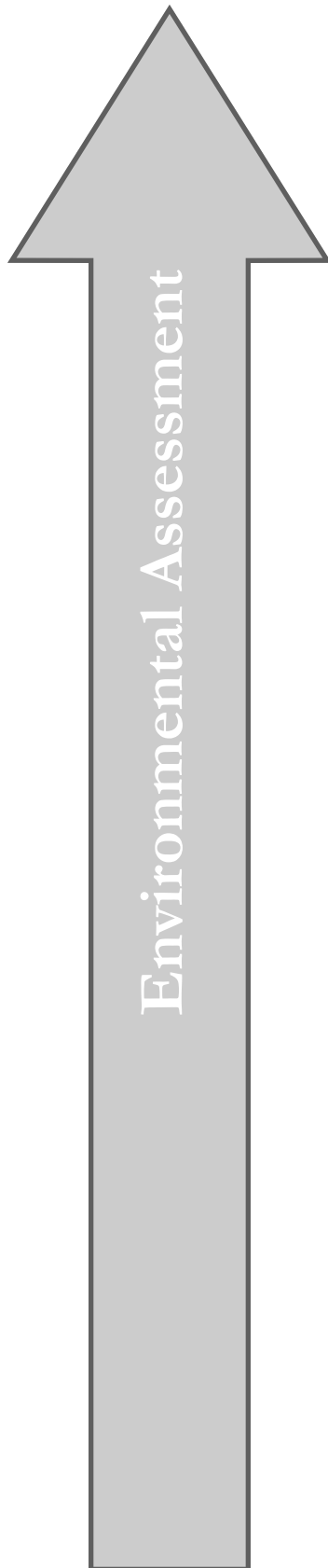
Goal #2 (Quality) - To protect and improve member health and satisfaction, as well as ensure quality, with programs, services and care.

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 External Assessment

The Oklahoma Health Care Authority’s (OHCA) external assessment is a process used to identify issues critical to the future of the organization. Throughout this section we will 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 / O-EPIC in Oklahoma depends on our ability to predict, strategize around, and impact the trends in the larger environment.

Issues considered in the external environment include:

- **Economic Indicators**

- National Economy*
- Oklahoma Economy*
- SoonerCare’s Effect on the Economy*

- ✚ **Social / Demographic Issues**

- Uninsured*
- Aging Population*

- **Government and Regulatory Issues**

- Current Medicaid Law*
- Federal Waiver Approval Delays*
- Federal Medical Assistance Percentage (FMAP)*
- New Proposed Federal Regulations*

- **Technology**

- **Industry Trends**

- ✚ **Politics**

- Presidential Outlook for Health Reform*
- Oklahoma Political Landscape*

- **Competition / Marketplace**

- **Internal Environment & Workforce Plan**



Economic Indicators

National Outlook

In early September 2008, the Congressional Budget Office (CBO) reported that the budget deficit will jump by \$246 billion to \$407 billion during FFY2009. “Over the long run, growing budget deficits and the resulting increases in federal debt would lead to slower economic growth,” the agency said. The CBO attributes the jump to a substantial increase in spending and a halt in the growth of tax revenues. The CBO’s estimate for the cumulative deficit over the next 10 years is now \$2.3 trillion. Earlier this year, the CBO estimated the country would have a \$300 billion surplus by 2018. But that was wiped out in part because of new spending approved by lawmakers for the war in Iraq and Afghanistan and revised economic projections.²

Oklahoma Economy

The story in Oklahoma and much of the central region of the country is much different, as broad economic conditions remain quite strong relative to the nation. Twelve month job growth in Oklahoma is currently running at a 1.4 percent rate; ranking the state among the top ten nationally along with other energy states. The state’s strong performance is principally due to the influence of the energy sector. While energy states will continue to receive a boost from high energy prices, this does not necessarily translate into recession-proof economies or states that are flush with dollars for general appropriations.³ In Oklahoma, it is expected that policy-makers will have difficult decisions to make with regards to the SFY2010 budgets.

Medicaid Spending

Nationally, Medicaid spending increased by an estimated 5.8 percent in fiscal year 2008 compared with 6.6 percent in 2007, according to an annual survey conducted by the National Governors Association and the National Association of State Budget Officers. The survey found that Medicaid accounts for 22 percent of state spending and continues to constrict state budgets. Projections from the Congressional Budget Office indicate an estimated annual average growth of 8 percent in health care spending through 2017.⁴

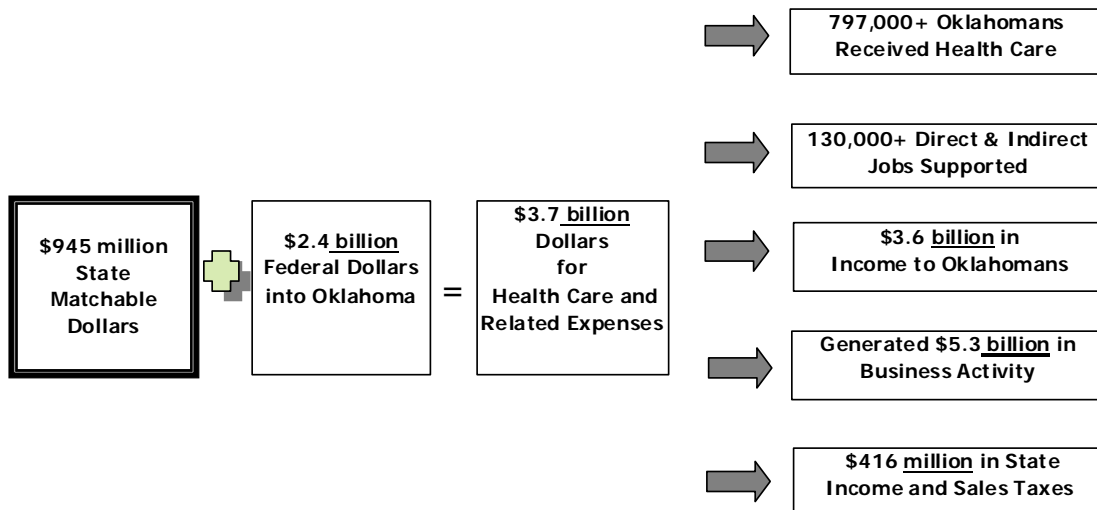
The bottom line: (economic indicators)

With impending deficits at the Federal level and a tight budget year at the State level, both levels of government are sure to be more guarded about any new spending proposals that are not backed by sound outcomes for future cost avoidance or savings.

SoonerCare and its Effect on the Economy

While SoonerCare and Insure Oklahoma / O-EPIC’s role in providing critical health care services is clear, what is less clear is the unique role that Medicaid funding plays in stimulating state business activity and state economies. Every dollar Oklahoma spends on SoonerCare and Insure Oklahoma / O-EPIC pulls new federal dollars into the state - - dollars that would not otherwise flow into the state. These new dollars 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 / O-EPIC spending provides a uniquely positive, counter-cyclical stimulus to a state’s economy during a recession or downturn. State Medicaid spending has a greater economic impact than other state spending. 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.



Source: OHCA SFY2008 Financial Reports; Economic Impact of the Medicaid Program on Oklahoma’s Economy, June 2007, prepared by the National Center for Rural Health Works

The bottom line: (SoonerCare & the economy)

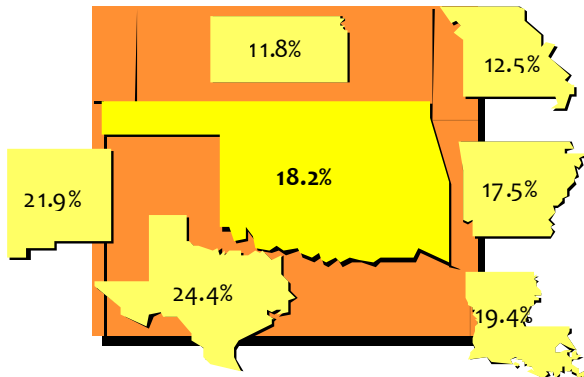
State dollar investments in SoonerCare and Insure Oklahoma / O-EPIC are not only an investment in Oklahoma’s health care system, but also an investment in Oklahoma’s economy.



Uninsured

In 2007, more than 45.7 million people, an average of 15.4 percent of the population in the U.S. lacked health insurance. In Oklahoma, 18.2 percent of the population, or roughly 640,000 individuals, were uninsured. Reversing the trend of the high number of uninsured has become the focus of many task forces and policy efforts.

Uninsured Rate Comparison with Surrounding States, 2007



Source: U.S. Census Bureau Income, Poverty and Health Insurance Coverage in the United States, 2007, August 2008.

Most of the uninsured are in working families and do not have access to employer-sponsored insurance. Eight in ten of the uninsured live in families with at least one worker. Uninsured workers typically do not have employer sponsored insurance offered through their jobs and cannot access it through a family member.⁵

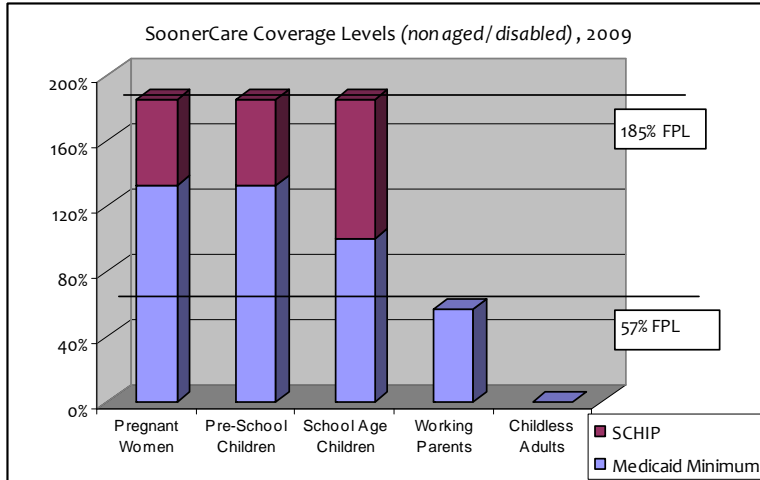
More than eight in ten of the uninsured are low or moderate income families. About two-thirds of the uninsured have incomes below 200 percent of the federal poverty level (FPL) (about \$42,000 for a family of

four). Only about one in ten are above 400 percent of the FPL. The average annual cost of employer-sponsored family coverage for 2008 rose to \$12,680 – with employees paying \$3,354 on average out of their paychecks.⁶ This year many workers are also facing higher deductibles in their plans, including a growing number with general plan deductibles of at least \$1,000.

Premiums have more than doubled since 1999 when total family premiums stood at \$5,791 (of which workers paid \$1,543). During that same time period, workers’ wages increased 34 percent and general inflation rose 29 percent.

The uninsured suffer from negative health consequences due to their lack of access to necessary medical care. About one-quarter of uninsured adults go without needed care due to cost each year. The uninsured are less likely than those with insurance to receive preventive care and services for major health conditions. Lack of access to timely care causes more than 20,000 uninsured adults to die prematurely each year.⁷

Low-Income and Uninsured...But Not Eligible for Medicaid....



One preconceived notion is that by virtue of being low income, all of these individuals are eligible to enroll in Medicaid. Not true. Most adults with low and moderate income are not eligible for Medicaid. Medicaid coverage is primarily available to low-income children, very low-income parents, pregnant women, people with disabilities, and the elderly. Most non-disabled adults under age 65 who do not have dependent children are not eligible for Medicaid regardless of their income.

It's Health Care not Welfare...Insure Oklahoma / O-EPIC—A Public / Private Partnership Evolves

An approved HIFA (Health Insurance Flexibility and Accountability) waiver from the Centers for Medicare and Medicaid Services (CMS) authorized the implementation of the Insure Oklahoma/ Oklahoma Employer and Employee Partnership for Insurance Coverage (O-EPIC) program. The program provides a means to affordable health coverage for low income working Oklahomans (up to 200 percent of FPL). Employer Sponsored Insurance (ESI), benefits qualified Oklahoma small businesses with 50 or fewer employees. The program pays for part of the private health plan premiums for qualified employees, and their spouses, who work for small businesses.

This waiver is funded by tobacco tax collections and therefore is limited in funding. Due to the fact that the Insure Oklahoma/ O-EPIC program is not an entitlement program like SoonerCare, enrollment will be limited based on available funding (estimated 40,000 lives).

The Individual Plan (IP), is designed as a health care coverage program for people who cannot access private health coverage through their employer. 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.

The bottom line: (uninsured)

Oklahoma has a high percentage of uninsured – most of who belong to working families, who make below 300 percent of the federal poverty level (FPL), can't access affordable health care insurance, and don't qualify for SoonerCare because of federal policy barriers. Partnerships need to continue in order to move Oklahoma forward in providing affordable options for the uninsured.

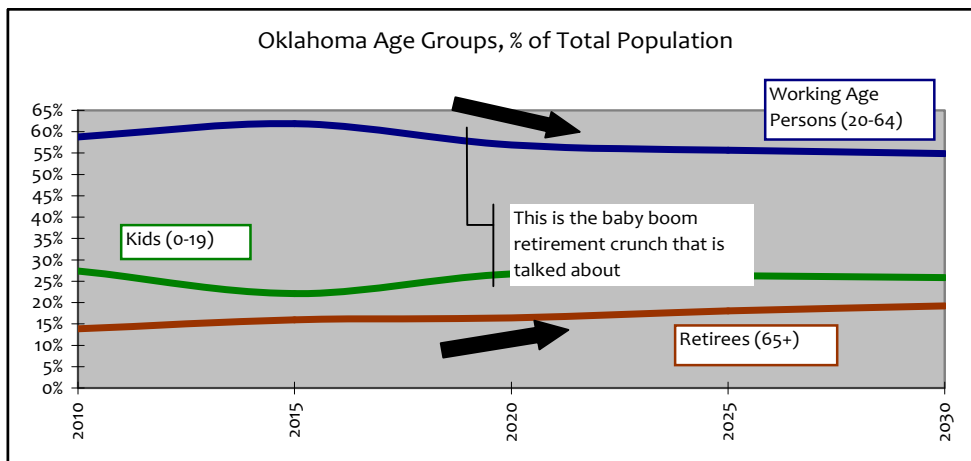
Aging Population

Baby Boomers – they grew up on the Beatles and Elvis, drove the first Ford Mustangs and made political and social protests the norm. Born between 1946 and 1964, the 78 million U.S. “Baby Boomers” drive the labor and housing markets, influence cultural trends and introduce lifestyle changes that have lasting impacts. Every day, almost 11,000 Boomers turn 50 – that’s one every eight seconds. The first of them will turn 64 in 2010. Thanks to many medical advances over their lifetime – from polio and measles vaccines to radical heart surgeries – more Boomers are living longer.

People are living longer because of both lifestyle changes and advances in health care. For example, fewer people smoke today than in the past. In the 1950’s more than half of men and a third of women smoked cigarettes. By 2005, those numbers were down to 23 percent of men and 19 percent of women. Thanks to major advances in medicine, fewer people die at an early age from heart disease and cancer. The five-year cancer survival rate improved

from 50 percent in the mid 70’s to 66 percent at the turn of the 21st century.

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.



Source: Oklahoma Department of Commerce, Population Projections of the State by Age and Sex, Selected Migration Assumptions: 2000-2030.

As we enter the 21st century, the provision of financing long-term care is significantly different than in previous eras due to convergence of many key factors driving how Boomers will impact health care. Medicaid has become a primary way of financing long-term care for elderly people in nursing homes. Of the 40 percent or more of those who need long-term care during their lives, about two-thirds of all of these individuals must depend on Medicaid for financing at some point. Medicaid financed long-term care includes nursing home services, as well as the use of home and community-based care services.

The bottom line: (aging)

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 percent of the Medicaid budget, will need to be managed.



Government & Regulatory Issues

Current Federal Medicaid Law

Federal Financial Participation— In exchange for federal financial participation, states agree to cover certain groups of individuals (referred to as “mandatory groups”) and offer a minimum set of services (referred to as “mandatory benefits”). States can also receive federal matching payments to cover additional (“optional”) groups of individuals and provide additional (“optional”) services.

Eligibility. A defining characteristic of Medicaid law has been the creation of Medicaid as a part of the welfare system. To be eligible for Medicaid, a person has had to fit into a welfare category. Notably, single individuals and childless couples (who are not aged or disabled) are not a coverable category; these persons cannot ever qualify for Medicaid regardless of how low their assets and incomes.

Benefits. In order to meet the diverse needs of Medicaid members, states may receive federal matching funds for a broad array of services. As is the case with eligibility, benefits under the current Medicaid system are either categorized as “mandatory” or “optional”. Within certain specific parameters, the state may define the amount, duration and scope of a benefit - - such as the number of prescription drugs allowable in one month - - but then the must deliver all of the covered benefits to all of the Medicaid members without regard for any pre-established budget.

Cost Sharing. Because the traditional population served by Medicaid had little or no ability to access medical services, federal law limited the amount of cost sharing permitted under the program. Premiums are not allowed except in limited situations, and certain groups of individuals and some services are fully or partially exempt from cost sharing.

Waiver Requests

The Social Security Act was designed to give the Secretary of Health and Human Services an opportunity to permit states to grant waivers to allow states to use federal Medicaid funds in ways that do not conform to federal program standards or options.⁸ There are different types of waivers: narrow, more targeted “Section 1915” waivers, such as those that allow states to provide home and community based services in lieu of nursing home care; and more comprehensive “Section 1115” waivers. Section 1115 demonstration waivers were originally designed as “research and demonstration” waivers, the purpose was to provide a testing ground for policies that might eventually be codified through legislation.

The Office of Management and Budget (OMB) has a long-standing administrative requirement that such waivers must be budget neutral, meaning that projected federal expenditures may not exceed those forecast under current law or booked as savings by the state from other demonstrations

State Plan Amendments (SPA)

Although this process is thought to be considerably less complicated than applying for and negotiating a section 1115 waiver, it does not give states carte blanche to change their Medicaid programs. When proposing to make “traditional” changes to Medicaid policies, states submit requests to amend the approved state Medicaid plan. State plan amendments (SPAs) are subject to review and approval (or disapproval) by CMS. The process consists of a 90 day review period at CMS, with the possibility of requests for additional information, which stop the “clock” until the state responds. If the state’s response is not sufficient, CMS may make additional requests, stopping and resetting the review clock until federal officials are satisfied that the SPA is consistent with the intent of their interpretation of the statute.

Federal Waiver Approval Delays

The State continues to await approval of a waiver amendment request from the Centers of Medicare and Medicaid Services (CMS) that was submitted in August of 2007. The amendment request marks the longest waiver review process in OHCA's history and one that has been fraught with unlegislated policy changes at CMS. OHCA has responded to more than 70 questions and participated in more than 20 conference calls about the amendment thus far.

In State legislative sessions of 2006 and 2007, Gov. Brad Henry and the Oklahoma Legislature directed the Oklahoma Health Care Authority (OHCA) to extend premium assistance to children and working adults. The Medicaid Reform Act of 2006 extended coverage to adults with incomes up to 250 percent of federal poverty and employed by businesses with up to 250 employees and also for college students ages 19-22 years in households of up to 300 percent of

federal poverty. The All Kids Act of 2007 directed premium assistance for coverage of children in households up to 300 percent of federal poverty.

In the State's favor, Oklahoma was the only state that sought and received an 1115 managed care demonstration waiver (1995) with no expansion provisions. OHCA believed strongly that the expected cost savings should be actually realized before committing to expansion coverage.

Throughout the years, managed care (both in the fully-capitated and partially capitated form) have performed very well resulting in a booked savings for the federal / state Medicaid program of more than \$1.8 billion, much more than the anticipated cost of covering more working Oklahomans who are outside traditional Medicaid categorical eligibility.

In its present form, the amendment will allow OHCA in its Insure Oklahoma, Oklahoma's Employer/Employee Partnership for Insurance Coverage (O-EPIC) program to cover more working adults and, for the first time in the program's history, their children family members. Specifically, Insure Oklahoma will add coverage for dependent children younger than 19 in families with

household incomes up to 250 percent of the federal poverty level (FPL.) Full-time college students ages 19-22 in households with incomes up to 200 percent FPL will also be made eligible for coverage, regardless of the business size. Other adult applicants with no children will qualify for Insure Oklahoma participation if they are employed by businesses with up to 250 employees. Insure Oklahoma is currently approved for businesses with up to 50 employees.

A State Health Officials (SHO) letter of August 17, 2007, addressing SCHIP limitations and new onerous requirements preventing crowd-out has had a major impact on the State's proposal.

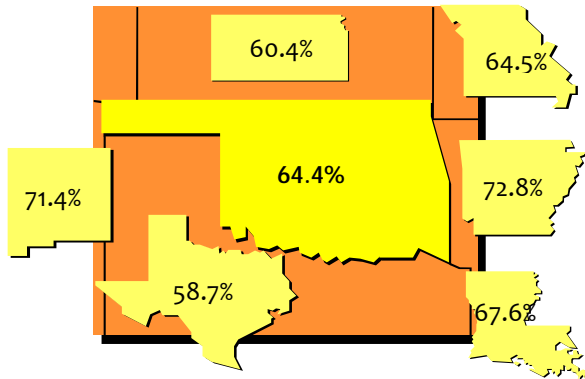
Getting two arms of CMS to agree and remain consistent has been the biggest challenge in this arduous waiver amendment request journey. In this case, CMS officials who oversee the Title XIX Medicaid demonstrations and those assigned to the Title XXI State Children's Health Insurance Program must collaborate on amendment review and recommendations. The Title XIX Project Officer and review team have Medicaid demonstration expertise regarding SoonerCare Choice and Insure Oklahoma/O-EPIC. The Title XXI Project Officer and review team lend SCHIP expertise and are critical to the portions of the amendment request requesting coverage of dependent children at 186-250 percent FPL.

Final clearance of the approval package from CMS involves review by multiple layers of CMS officials. In addition, the amendment recommendation faces review by the Office of Management and Budget and the CMS Office of General Counsel.

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 / O-EPIC members. The specific percent 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. The average FMAP is 57 percent, but it ranges from 50 percent (one federal dollar for each state dollar) to almost 80 percent (four federal dollars for each state dollar).

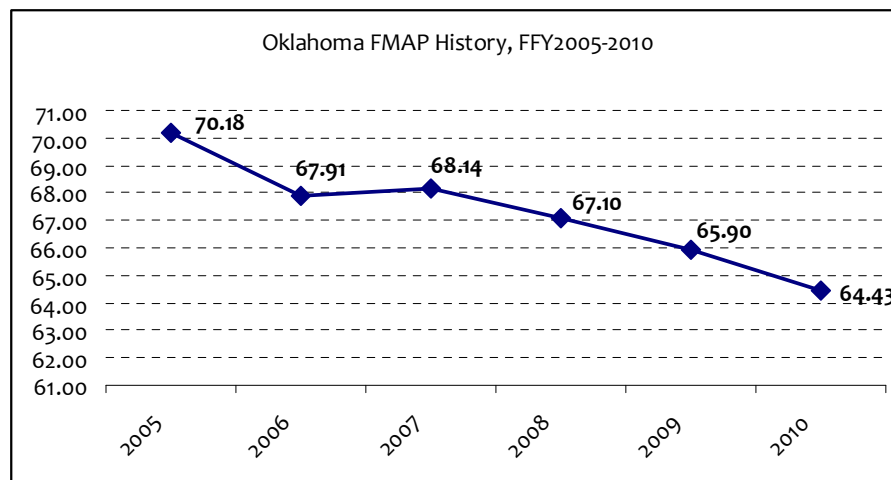
FMAP Comparison with Surrounding States, 2010



Source: Federal Funds Information for States (FFIS), Issue Brief 08-50, September 23, 2008

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.



Source: Federal Funds Information for States.

New Proposed Federal Regulations

During the past year and a half, the Federal administration has moved forward with changes to the Medicaid program via rule making that would have significant implications for states, providers, members - - and federal spending. Taken together, the six new regulations could result in an estimated \$12 billion reduction in federal Medicaid spending over the next five years according to regulatory impact statements prepared by CMS. While the Administration views the estimated five year reduction in federal Medicaid spending as a very small share of expected Medicaid spending over the next five years, members of Congress, states, members and providers have raised concerns that these changes could have serious negative consequences and may be inconsistent with Medicaid policies enacted by the Congress. Five of these six proposed rules would actually apply to Oklahoma.

Congress has imposed moratoriums on four of the rules until April 2009⁹; however, decisions regarding how, when and to what extent the rules will be put into place are still looming. Rules applying to Oklahoma are as follows:

Regulations	Description
Cost Limit for Providers Operated by Units of Government	<i>Rule would limit reimbursement for government providers to cost; narrow the definition of a unit of government.</i>
Graduate Medical Education (GME)	<i>Rule would eliminate Medicaid reimbursement for GME (cost for medical residents).</i>
Rehabilitation (Rehab) Service Option	<i>Rule would restrict the scope of rehab services that are eligible for federal Medicaid matching payments and eliminate coverage for day habilitation services for people with developmental disabilities.</i>
Outpatient Services	<i>Rule would restrict the scope of Medicaid outpatient hospital services and clarify the outpatient upper payment calculation.</i>
Targeted Case Management (TCM)	<i>The rule restricts the scope of case management services and targeted case management (TCM) and specifies that federal Medicaid is not available for TCM if there are other third parties liable to pay for those services.</i>

The bottom line: (government & regulatory issues)

Challenges continue with the federal side of the Medicaid partnership, which can make planning difficult. Reform comes slow. States have frustrations with the application of older federal rules governing the scope and eligibility of the program— rules that were written decades ago when Medicaid was a very different program. Waivers and the ability to use state plan amendments (SPA) for some options have provided some relief—but the application and CMS negotiation process— can make this a long and arduous journey.

This in and of itself would be enough to test State policy-makers. Add to this the declining federal medical assistance percentage (FMAP) available for Oklahoma programs and the situation starts to get stickier for the budget-side of Oklahoma.

Policy-makers must also include into their planning the proposed on-again / off-again CMS rules, which have the possibility of being high impact to state agencies and certain provider groups.



The nation is undergoing an information technology revolution, with some of the most promising activities taking place in the health care system. Health care is rapidly transforming through the implementation and use of electronic health records, telemedicine, and new medical technologies, all of which provide opportunities for improving access to and quality of care as well as increasing the effectiveness of the funds spent on health.

These advances have not been widely deployed to improve the administration of public health insurance programs though there are many benefits to doing so. Technology can be deployed to overcome the main barriers to enrollment and retention while at the same time strengthening the integrity of the programs.

Technology can make it significantly easier for individuals to learn about, apply for, enroll in, and retain health insurance coverage. Complex and burdensome enrollment processes are a barrier for coverage; this problem is uniquely receptive to technology solutions. Electronic applications and automation can replace paper and manual processes. Technology can also improve data collection and quality control and, in a world of limited resources, ensure that services reach those in need. Technology has the ability to provide automated data-matching against other databases and to perform necessary eligibility calculations, thereby increasing the reliability of the enrollment process and improving quality control. In addition, technology can speed up the submission of an application and database checks can fill in any missing details or update data for a renewal.

High Up-Front Investment. The greatest hurdle to expanded use of technological innovations in health care enrollment is funding; technology advances can require substantial up-front investment. As such, it is often the case that interim solutions are relied upon that are cheaper but ultimately lead to a patchwork system that is not interconnected or easily built upon. The initial high price tag must instead be viewed within the context of the longer-term payoff in cost-savings, added efficiency and better service provision.

Cultural Change. Technological advances require people to fundamentally change the way they do their work. This is particularly true in the public sector. Oftentimes the hardest obstacle to implementing technology is making the cultural shift with staff. In addition, it can be difficult to align new technology with current business processes and differing government agencies' goals.

The bottom line: (technology)

While its benefits can be impressive, technology is not a silver bullet. Instead, it is a tool for increasing efficiency and effectiveness. But like any tool, it must be used correctly for ultimate impact. Critical challenges will include high up-front investments and cultural changes.



States are taking initiative. In the presence of federal gridlock, states are taking the lead on such divisive issues as covering the uninsured, funding stem cell research, and regulating pharmaceutical marketing.

Consumers are starting to get engaged in quality information. To help consumers make more informed health care decisions, organizations will need to disclose more information about the cost and quality of the services provided. The move is to adopt programs that address interoperability standards, quality measurements, price transparency for public use, and incentives promoting quality and efficiency in health care.

It is time to walk the talk on technology. The formation of a digital information backbone is continuing slowly with new governmental standards and a focus on patient identifiers. The Federal Administration has challenged the health industry to adopt electronic health records by 2014.¹⁰ EHRs enable patient information to be captured, processed, accessed and shared with greater speed and efficiency, thereby increasing accuracy and patient safety while reducing duplication.

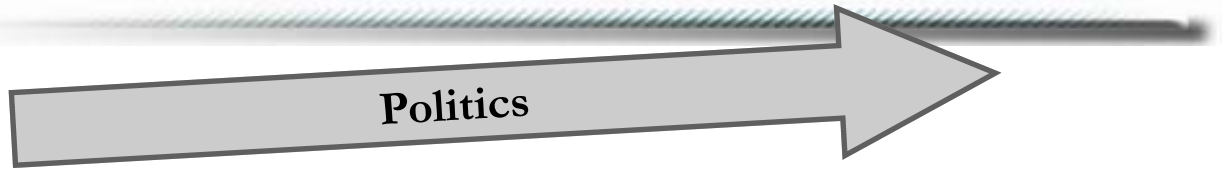
Grandmother is not asked for health advice; the internet is. The majority of adults (78 percent) go online to find health information, searching most often for details on symptoms and treatments.¹¹ Women are twice as likely to use online resources as men. Changes in the source of health information are just one of the trends in health care in the beginning of the 21st century.

The workforce shortage is particularly acute in the health care industry. The large number of baby boomers are affecting the health care system at the same time the industry is experiencing a dramatic shortage of qualified workers.

Obesity is the new smoking. When smoking was raised as a costly public health issue, the government started with education, then moved to regulation and mandates. The efforts worked. The percentage of U.S. smokers declined from 30 percent to 22 percent over the past 20 years. Will government or private sector payers attempt to similarly force Americans who are obese to lose weight? Obesity is projected to lead to 400,000 deaths annually, and individuals who are classified as obese have 30 to 50 percent more chronic medical problems than those who smoke or drink heavily.¹²

The bottom line: (industry trends)

Combining medical technology and the human touch, the health industry continues to grow in response to the needs of millions of people from newborns to seniors. Many trends are converging to make the entrance of this industry into the 21st century anything but “business as usual”. These trends need to be kept in mind as policy-makers plan for Oklahoma’s health and OHCA.



Presidential Outlook for Health Care Reform

One of the underlying big issues in the unfolding health reform debate is whether most Americans should continue to get insurance through an employment situation, or purchase it themselves in the individual private health insurance marketplace. Senator McCain promotes moving to individual insurance and having individuals rather than employers make coverage decisions. Democrats and liberals would take steps to create a more structured market for individual insurance -- allowing people to buy into a purchasing pool like the Federal Employees Health Benefits Program or a public plan like Medicare, as well as requiring insurers to accept all comers regardless of pre-existing health conditions.

Oklahoma Political Landscape

The Oklahoma Health Care Authority and the state Medicaid program continue its positive strides in effective communications with legislative and executive branches of government. Legislators continue to bring a welcome desire to become more knowledgeable of the Medicaid program. This new knowledge base has equipped state leaders to move the health care needs of the state to the forefront of debated priorities.

New efforts are evolving to find different strategies to tackle the issue of the uninsured and to ensure health care dollars in the system are spent wisely. In the 2008 election cycle, the battle for sole leadership of the Oklahoma State Senate will take place. Term limits and early exits have also allowed for many new faces to emerge ready to take leadership roles in developing state policies for the next generation. It will be critical to the Oklahoma Health Care Authority to continue its development of tools to educate and inform legislators, specifically members in leadership and members on related committees, about the activities of the agency and our role in the health care system.



SoonerCare, as well as, Insure Oklahoma / O-EPIC, must compete in the marketplace as far as provider rates and reimbursement are concerned. Current federal regulations cap the upper payment a state can pay Medicaid providers at 100 percent of the Medicare rates, when Medicare rates are available. In addition, payments made to hospitals are limited by the federal government to an “upper payment limit” (UPL).¹³ The limit applied by UPLs is the estimated amount that would be paid for Medicaid-covered services under Medicare payment principles. Oklahoma recognizes the need to be a responsible player in the health care market and has made a conscious effort to pay 100 percent of Medicare and up to the UPL.

The bottom line: (competition / marketplace)

In order for OHCA to be a realistic part of the health care industry marketplace, an important emphasis should always be placed on paying responsible rates to the providers who serve the SoonerCare and Insure Oklahoma / O-EPIC members.



Internal Environment & Workforce Plan

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

The Oklahoma Health Care Authority currently needs all of the existing jobs within the statutory FTE limit, in addition to those requested in the budget request. As new efforts continue to evolve to find different strategies to tackle the issues of the uninsured and as programs evolve, the agency will continue to analyze and assess the current jobs and develop specific jobs as needed. 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?

Supervisors at OHCA have been working on an individual basis to train existing workers to increase their skills and prepare them for future vacancies. Several years ago, the agency implemented a tuition reimbursement program to encourage workers to attend college (in pursuit of undergraduate or advanced degree), and executed a contract with Oklahoma State University to provide quality management training to workers to improve their skills.

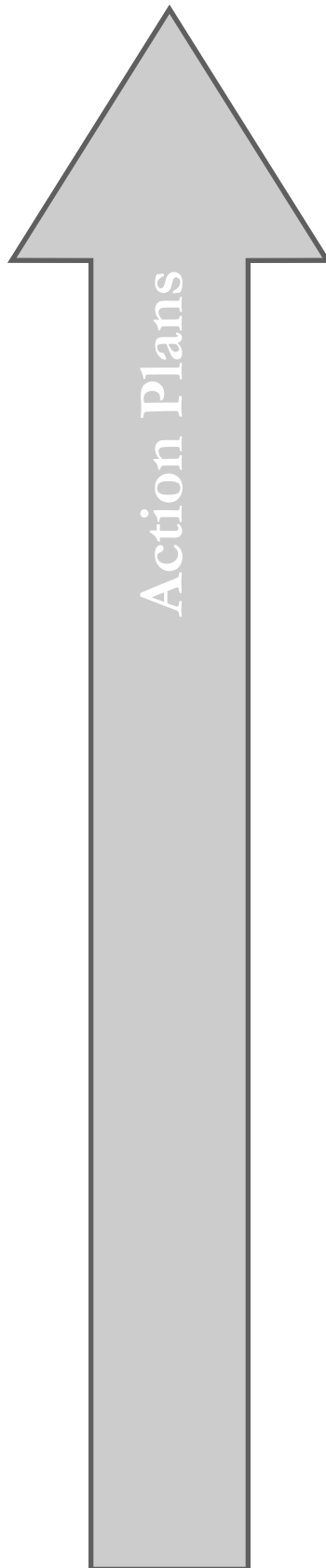
New efforts are evolving to find different ways to continue to improve the skills of existing workers so they can better address future needs of the agency. At this time the agency is considering adding several programs to help increase worker skills.

What strategies should the agency use to retain these skills?

The agency continues to work with the HayGroup to develop a compensation program to remain competitive in the marketplace. Being competitive in the job market allows us to attract and retain workers with skills that are needed. The Oklahoma Health Care Authority has also adopted an alternate work schedules which helps attract and retain workers with skills that are needed.

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

Past retirements, reduction in work force and/or hiring freezes have had a limited impact on our ability to get work done. The major concern is the impact impending and future retirements will have on the agency and the loss of historical knowledge and experience.



Action Plans

From a modest effort whose goals were to provide limited health insurance coverage to low-income single women and their children and the disabled and elderly, SoonerCare has grown and changed into a broad program offering health care coverage to more than 797,000 Oklahomans on an annual basis.

Over these 40+ years of the program, the role of management has evolved from that of passive, regulated bill payers to active, informed purchasers demanding quality performance from provider communities. The action plans set forth in the strategic plan further reflect this evolution of agency priorities.

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 action plans address five major themes.

Eligibility - Plans to design programs, enrollment tools and outreach efforts that increase the availability and access of eligibility to those populations who could not otherwise obtain or afford health care coverage.

Benefits - Plans to provide a limited number of services / benefits to the members whom receive their health care coverage through OHCA.

Financing - Plans to review, make recommendations and / or implement changes in payment methodologies and reimbursements in order to ensure fair compensation to our providers.

Program Administration - Plans to move forward with compliance efforts, development and implementation of new initiatives, and enhanced quality assurance efforts.

Opportunities for Living Life (OLL) - Plans to enhance the quality of services provided, as well as systems designed to help members meet their care needs, and continue to satisfy all federal requirements.

Not in Priority Order		
<i>(alphabetical by short description)</i>		
MANDATES		
Short Description	Report Reference	Category
Claims Requirement for Wheeled Mobility	1	Program Administration
Consumer Choice Feasibility Study (per HB 2713)	2	Program Administration
Health Management Program (HMP)	3	Benefits
Insure Oklahoma Expansions	4	Eligibility
OTHER		
Short Description	Report Reference	Category
Behavioral Health Collaborative	5	Eligibility
Dual Eligibles / Care Coordination - Research	6	Financing / Program Administration
Health Care Infrastructure in Local Communities - Research	7	Program Administration
Electronic Health Information Exchange Collaborative	8	Program Administration
Emergency Room (ER) Diversion Grant	9	Program Administration
Internet / Electronic Provider Enrollment and Re-contracting	10	Program Administration
Licensed Behavioral Health Practitioners (LBHP) – Direct Contracts	11	Financing
Living Choice (Money Follows the Person Demonstration)	12	Opportunities for Living Life
Medical Home Model	13	Financing
No Wrong Door	14	Eligibility
Oklahoma Health Insurance Survey 2008 (SHADAC)	15	Program Administration
Outreach Efforts: SoonerCare & Insure Oklahoma / O-EPIC	16	Eligibility
Residential Treatment Centers – Substance Abuse Services	17	Benefits
Self-Directed Services Model	18	Opportunities for Living Life
SoonerCare Coverage to 19 and 20 year olds - Expansion	19	Eligibility
Telemedicine	20	Financing
Tribal Medicaid Administrative Match (TMAM)	21	Financing
Trust Model Options - Research	22	Financing / Program Administration



1. Claims Requirement for Wheeled Mobility

Current SoonerCare policy allows for the purchase of wheelchairs when accompanied by a prescription from a physician, physician's assistant or advanced practice nurse; prior authorization and in some cases, a certificate of medical necessity (CMN). Current policy also allows any Medicaid contracted Durable Medical Equipment (DME) provider to fit and distribute wheelchairs as long as all prescription and prior authorization requirements are met.

House Bill 2703 (HB 2703) passed in May of 2008, otherwise known in Oklahoma Statute as 56 O.S.§.1015.1-3, addresses additional quality concerns of proper evaluation and fitting of wheeled mobility devices. Scheduled for implementation April 1, 2009, this new legislation will require a specialty evaluation by either (1) a physician, (2) a physical or occupational therapist with specific training and experience in wheelchair evaluations, or (3) the DME supplier must be a RESNA (Rehabilitation Engineering and Assistive Technology Society of North America) certified assistive technology supplier or practitioner.

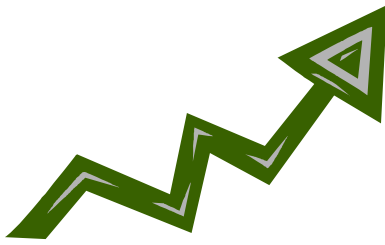
Action plans include making the necessary rule revisions which will need Medical Advisory Committee (MAC) consideration, Board approval, and Governor approval, information systems changes, provider education and training, as well as changes to the prior authorization forms and processes.

2. Consumer Choice Feasibility Study (per HB 2713)

House Bill 2713 (HB 2713) amended paragraph 2, section 1011.3, Chapter 315, O.S.L. 2006 (56 O.S. Supp 2007, sections 1011.2 and 1011.3). The development of the program, required under the new state law, will include sections on consumer education and consumer choice. The consumer education component is to promote health literacy and include an education component that is intended to promote utilization of the health care system. Consumer choice is to enable SoonerCare consumers to opt out of their current SoonerCare program and purchase health care coverage through their employer-sponsored health insurance plan. This alternative also includes the option to implement a personal health account. Additionally, the legislation requires that there may be no negative effects upon the Indian Health Service facilities, tribally operated health facilities, or urban health program, as a result of the program.

This amendment requires a feasibility study be conducted to determine if SoonerCare members should be allowed the choice of opting out of SoonerCare to purchase employer-sponsored or commercial insurance. The study would also recommend potential opportunities to defray the high cost of current commercial insurance packages.

Actions plans include researching a variety of information from sources including, but not limited to: SoonerCare, the Oklahoma Insurance Department, private sector partners, and data from other state programs. The OHCA may also engage the expertise of policy experts for study input and guidance. The information will then be compiled into a final feasibility study report.



3. Health Management Program

Amid rising health care expenditures, states have had to step back, review program expenditures, and determine what options are available to make more appropriate use of the dollars available. One option which is now being more widely adopted by states is to develop disease management programs that are designed to contain costs by improving health among the chronically ill. This trend has led the Oklahoma Health Care Authority (OHCA) to initiate development of the SoonerCare Health Management Program (HMP). In conjunction with HMP development, the Medicaid Reform Act of 2006, otherwise known as House Bill 2842 passed in May of 2006 (Title 56 O.S. 1011.6) mandated the development and implementation of this program to include, but not be limited to the following diagnosis: asthma, diabetes, chronic obstructive pulmonary disease, renal disease and/or congestive heart failure.

Recently, the disease management community has shifted its emphasis away from the traditional approach of enrolling patients based on a specific set of diagnoses or conditions towards programs that provide holistic interventions for those patients at highest risk for utilization of medical services. The OHCA has built a new Health Management Program (HMP) based on this newer philosophy. The OHCA has implemented a system that targets members with chronic conditions who have been identified by predictive modeling to have a high risk of incurring significant medical cost. The HMP provides patient education and care management services to participants. The HMP also develops provider collaboration focused on holistic health management and evidence-based guidelines, and one-on-one practice facilitation for some primary care providers provided by the OHCA's contractor, the Iowa Foundation for Medical Care.

The OHCA issued a second RFP to procure the following services: 1) provide a comprehensive program evaluation of the HMP based on cost reductions and outcome measures; 2) measure participant and provider satisfaction with the HMP; and 3) provide ongoing program performance monitoring and consulting.

4. Insure Oklahoma, Oklahoma Employer and Employee Partnership for Insurance Coverage (O-EPIC) Expansions

In September 2005, the Centers for Medicare and Medicaid Services (CMS) approved Oklahoma's HIFA (Health Insurance Flexibility and Accountability) waiver, authorizing the implementation of the Insure Oklahoma, Oklahoma Employer and Employee Partnership for Insurance Coverage (O-EPIC) program. The program currently provides a means to affordable health coverage for over 14,000 working Oklahomans. This waiver is funded by tobacco tax collections and therefore is limited in funding. The OHCA estimates that a total of approximately 324,000 Oklahomans could be eligible for health insurance coverage under this waiver. Due to the fact that the Insure Oklahoma, O-EPIC program is not an entitlement program like SoonerCare, enrollment may be limited based on available funding. At current levels and projections, tobacco tax collections would provide funding for only 37,000 to 40,000 adults qualified for Insure Oklahoma, O-EPIC programs.

Phase one of the program, otherwise known as 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 (56 O.S. 1011.1 through 1011.11) authorized the program to be offered to small businesses with 50 or fewer employees. This was implemented in October of 2006. The program pays for part of the private health plan premiums for qualified employees working for small businesses. Insure Oklahoma, O-EPIC ESI has shown increased enrollment over the last fiscal year. In order to continue the upward trend, Insure Oklahoma, O-EPIC announced a co-op advertising opportunity for insurance agents. Co-op advertising is a cost-sharing arrangement between the program and the private business to purchase newspaper, radio, and television ads. The agency has also partnered with the Oklahoma Insurance Department (OID) to hire three insurance agent liaisons. Recently the OHCA has awarded a marketing contract to Griffin Communications; advertising for Insure Oklahoma, O-EPIC began in mid-October of 2007 and to date has more than doubled the existing membership of the Insure Oklahoma, O-EPIC program.

Phase two of the Insure Oklahoma, O-EPIC program, the Individual Plan (IP), is designed as a health care coverage program for people who cannot access private health coverage through their employer. The Insure Oklahoma, O-EPIC IP program kicked off in January 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 can not exceed 5 percent of household income.



~Adults

With both the Insure Oklahoma, O-EPIC ESI and IP programs running successfully, the OHCA is ready to take on the new opportunities provided by recent legislation. In 2007 the legislature revised the Medicaid Reform Act of 2006 (56 O.S. 1011.1 through 1011.11), which expanded the eligibility for Insure Oklahoma, O-EPIC to businesses with 250 employees or less and workers with total household incomes of 250 percent of the Federal Poverty Level (FPL) or less. This will greatly expand the number of businesses and employees qualified for coverage in the program.

The first phase of the adult expansion was implemented in November 2007. OHCA's existing waiver currently allows income guidelines to be 200 percent of the FPL and business size guidelines to remain at 50 or fewer employees. The second phase of the adult expansion will occur upon federal waiver approval, increasing business size guidelines with the use of a phased in approach allowing the smallest businesses with 50 or fewer employees the first opportunity to enroll, medium size businesses with fewer than 100 employees the second opportunity to enroll, and larger businesses with up to 250 employees the third opportunity to enroll. While the state legislation allows for adults to be covered with incomes up to 250 percent of the FPL, federal guidance from the August 17, 2007 State Health Care Official letter, as well as new interpretation of policies, dictated to states by CMS, allow adults to be covered only to 200 percent FPL. The OHCA continues to negotiate with its federal partner to alleviate this barrier to coverage. The Insure Oklahoma, O-EPIC adult expansion is anticipated to become operational upon federal waiver approval.

~College Students

The Medicaid Reform Act of 2006 (56 O.S. 1011.1 through 1011.11), directs the OHCA to provide health care benefits to qualified students up to the age of twenty three, if the person is enrolled as a full-time student at an accredited college or university in the state of Oklahoma. Under current federal law, this group is not qualified for SoonerCare coverage. National statistics show that 30.6 percent of individuals aged 19-23 are uninsured. Due to the historically high rate of uninsured, this age group has been nicknamed the "young immortals" by the insurance industry. As a result, this age group has become the target of many efforts to decrease the overall numbers of uninsured.

The college student expansion is anticipated to begin upon federal waiver approval with the first phase including income guidelines of up to 200 percent of the FPL at businesses with fewer than 250 employees. While the State legislation allows for college students to be covered with incomes to 300 percent of the FPL, federal guidance from the August 17, 2007 State Health Care Official letter, as well as new policies dictated to states by CMS, which considers this group adults, allow adults to be covered only to 200 percent FPL. The OHCA continues to negotiate with its federal partner to alleviate this barrier to coverage.

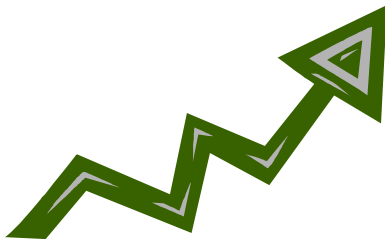
~Children

Children will also be qualified to participate in the Insure Oklahoma, O-EPIC program as a result of the “All Kids Act”, Senate Bill 424 passed in May 2008. As part of the “All Kids Act” (56 O.S. 1009.1 and 1009.2), children between 186 percent and 300 percent of the FPL, whose parents work for a small business, may be qualified to participate in either Insure Oklahoma, O-EPIC ESI or IP. Through the program these families will receive premium assistance in a manner similar to current Insure Oklahoma, O-EPIC members. This will give families the opportunity to maintain a single source of health care coverage, within the private market. Children in households with income less than 185 percent of the FPL may continue to enroll in SoonerCare coverage.

The “All Kids” expansion is anticipated to begin upon federal waiver approval with the first phase increasing income guidelines to 250 percent of the FPL, for families with parents working at businesses with fewer than 250 employees. The OHCA chose to phase in the “All Kids” program due to ongoing federal debate over SCHIP reauthorization and guidance received in an August 17, 2007 State Medicaid Director letter which added additional administrative monitoring and reporting of states expanding programs above 250 percent FPL. Children in families with parents working at any size business and with incomes between 251 percent and 300 percent of the FPL will be phased in contingent upon federal approval and available funding.

~Parents of SoonerCare Children

The Medicaid Reform Act of 2006 (56 O.S. 1011.1 through 1011.11), called for parents of SoonerCare children to become qualified for Insure Oklahoma, O-EPIC in the event the program was not consuming more than 75 percent of its dedicated revenue source (i.e. tobacco tax). This law was to take effect in January of 2008. However, House Bill 1225 passed during the 2007 legislative session (56 O.S. <1010), contained language moving the effective date of this initiative to January 2012. In the interim, many of these uninsured parents will be qualified for the adult Insure Oklahoma, O-EPIC expansion, given that seventy percent of Oklahoma’s businesses are considered small businesses, and over 324,000 uninsured Oklahoman’s at or below the income guidelines of 200 percent of the FPL. As a result it is expected that the adult expansion will fill the coverage gap for many of our SoonerCare parents. OHCA will continue to monitor Insure Oklahoma, O-EPIC program participation and conduct targeted outreach to parents and children alike.



~Foster Parents

House Bill 2713 passed in the 2008 legislative session (56 O.S. Supp 2007, sections 1011.2 and 1011.3), called for foster parents, meeting the income guidelines of 200 percent of the FPL, and employed by employers of any size to become qualified for Insure Oklahoma, O-EPIC if funding for the premium assistance program is available. This law is to take effect January of 2012. In the interim, many of these uninsured foster parents will be qualified for the adult Insure Oklahoma, O-EPIC expansion, due largely to the fact that over 324,000 uninsured Oklahoman's are at or below the income guidelines of 200 percent of the FPL. As a result, it is expected that the adult expansion will fill the coverage gap for many of our foster parents. OHCA will continue to monitor Insure Oklahoma, O-EPIC program participation and conduct targeted outreach to foster parents and children alike.

~Not-For-Profit Businesses

Senate Bill 1404, passed in the 2008 legislative session (56 O.S. 1010.1), called for not-for-profit employers with 500 employees or fewer, and their employees meeting the income guidelines of 200 percent of the FPL, to become qualified for Insure Oklahoma, O-EPIC. This expansion is to be made available to the extent existing funding resources allow. A "not-for-profit employer" shall mean an entity which is exempt from taxation pursuant to the provisions of Section 501(c)(3) of the Internal Revenue Code. To be tax-exempt under section 501(c)(3) of the Internal Revenue Code, an organization must be organized and operated exclusively for exempt purposes set forth in section 501(c)(3), and none of its earnings may effect any private shareholder or individual. In addition, it may not attempt to influence legislation as a substantial part of its activities and it may not participate in any campaign activity for or against political candidates. Organizations described in section 501(c)(3) are commonly referred to as *charitable organizations*. OHCA will continue to monitor Insure Oklahoma, O-EPIC program participation and conduct targeted outreach to not-for-profit businesses.

Progress to date for all Insure Oklahoma, O-EPIC expansion groups (i.e. adults, college students, and children) includes a waiver submitted to CMS in August 2007. After being considered by the federal review team at CMS for over a year, this CMS amendment request marks the longest waiver review process in OHCA's history. The state has submitted three revisions, has responded to numerous questions and has attended monthly teleconferences with CMS. Draft rules have been created and were approved by the Medical Advisory Committee (MAC) in March 2008 these rules will be submitted for approval to the OHCA Board to coincide with systems implementation. Teams are currently working on development of marketing and outreach efforts, as well as testing system modifications to incorporate these new populations. Implementation of the next phase of Insure Oklahoma, O-EPIC expansions is anticipated upon federal waiver approval.

5. Behavioral Health Collaborative

Oklahoma's behavioral health system is undergoing a transformational change. The OHCA is currently looking at different ways to provide a variety of services to a broad range of members. These services may be rendered in an assortment of settings.

In collaboration with the Partnership for Children's Behavioral Health, and the Adult Recovery Collaborative of Oklahoma and in partnership with Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), Oklahoma Department of Human Services (OKDHS), Oklahoma State Department of Health (OSDH), Oklahoma Juvenile Authority (OJA), Oklahoma Coalition on Children and Youth (OCCY), Federation of Families, and Oklahoma State Department of Education (OSDOE), OHCA is developing a behavioral health system to serve Oklahoma. Through care coordination services, consumers and their families will participate, along with a team from the community, to develop a treatment plan that meets the needs of the children. Community teams may include behavioral health providers, friends, educators, religious officials and others who can contribute to recovery. Through this system, the state hopes to improve families' freedom of choice and access to resources and to provide them and their communities support in caring for the behavioral health needs of children.

The leadership of ODMHSAS, OHCA and OKDHS entered into a partnership in 2002 that is committed to the development of a higher quality behavioral health system. This system is designed to be consumer oriented and takes advantage of established best practices to assist mental health consumers and substance abuse clients on their road to recovery. This partnership led to the establishment of the Adult Recovery Collaborative of Oklahoma and is comprised of senior staff from the three agencies that are responsible for carrying out the mission of the inter-agency collaborative. In addition to the agency staff, a group of behavioral health consumers and advocacy organizations meet on a regular basis to review activities and advise members of the collaborative. They provide meaningful feedback about the effects the proposed program and system changes will have upon consumers. Through the system, the state hopes to respond to the needs of the adult public health consumers by providing coordinated care, focused on recovery, with an emphasis on evidence-based practices.

In coordination with ODMHSAS, OKDHS, and other agencies the OHCA, is developing a claims payment system designed to accommodate all behavioral health providers. All providers will submit claims to the same system, streamlining administrative requirements. Through data sharing capabilities with other agencies, the system will determine appropriate funding sources based on the patients' eligibility profile. Data sharing among the agencies will support the state's commitment to transforming the state's behavioral health system, simplifying access to behavioral health services, avoiding duplication, and improving outcomes. The agency has submitted to the Centers for Medicare and Medicaid Services (CMS) an Advanced Planning Document outlining the program and approval has been obtained.



Action plans include expansion of a state agency level care coordination system to serve high risk children with severe emotional disturbance (SED), defining services covered, limitations, and acceptable treatment plans. Action plans also include developing and implementing systems requirements necessary to begin claims processing, developing and revising policy and procedures relating to behavioral health, developing data sharing activities and agreements with collaborating agencies, and obtaining funding from the legislature to cover development needs as well as current gaps in the continuum of services.

6. Dual Eligibles / Care Coordination—Research

The Oklahoma Health Care Authority served over 90,000 members dually eligible for both Medicaid and Medicare programs in state fiscal year 2008. Generally speaking, members who are dually eligible for both programs are reported under the Aged, Blind and Disabled or Other categories, and are more likely to carry chronic conditions requiring more care. Often times these members fall within roughly 20 percent of the population accounting for an estimated 80 percent of health care costs. For these members Medicaid pays a portion of their health care expenses, the other portion is paid by Medicare. Often times the services given to these members are not coordinated between Medicaid and Medicare. As a result, inefficiencies both in service delivery and payments exist.

Other states including North Carolina have approached our federal partner, CMS, with a waiver amendment proposing a better system of care coordination for the dual eligible population. The North Carolina model specifically outlined a plan to move the state's higher-cost Medicare members into a primary care Medicaid management program, saving their state millions of dollars over a 5 year period. The NC model relied heavily on the medical home concept, population health management, community-based networks and case-management services to deliver high-quality and efficient care.

Moving forward, the OHCA plans to explore the opportunities that exist to better serve our dual eligible population. Several questions have been presented for which answers will be sought. How would the OHCA incorporate care coordination with Medicare? What cost savings could be achieved? What role might CMS play? In addition, the OHCA plans to capitalize on the expertise of other states as well as utilize other resources, such as the Center for Health Care Strategies that may assist the OHCA to develop a care coordination plan for Oklahoma's dual eligibles.

7. Health Care Infrastructure in Local Communities - Research

The topic of health care infrastructure in Oklahoma local communities is a subject that is in need of research to determine the level of access and the level of availability of the health care system. This type of research will look into all aspects of a community's health and health care infrastructure, as well as include demographic information on the uninsured within the communities. The overall goal of this research is to take a "snap-shot" of the existing health care infrastructure within the local communities. Currently, there is no single-source of Oklahoma information identifying "what" a sound health care infrastructure "should" look like. As a first step, this research is intended to allow various stakeholders including, but not limited to: local community leaders, chambers of commerce, health care providers, public health, legislative leaders, etc. to see both the small and large scale pictures of the existing health care infrastructure within their communities. It is hoped that this research may help community leaders make informed decisions about future planning.

The personnel that will perform this research will need to interact with staff from other agencies and organizations as well as discover and compile any studies, whether in whole or in part, that identify the health care infrastructure at the local level. The research is expected to come from a variety of sources including but not limited to the Oklahoma Insurance Department, the Oklahoma Economic Development Council, the Oklahoma Department of Commerce, the Office of Rural Health, the Oklahoma Hospital Association, universities, medical and professional associations, and other valuable resources. It is expected that at the conclusion of the research a final report will be prepared and distributed to stakeholders across the state.

8. Electronic Health Information Exchange Collaborative

Leaders in Oklahoma recognize the importance of taking action in the arena of Health Information Exchange (HIE). Over the past decade OHCA has steadily increased electronic transactions with health care providers with such tools as e-Prescribing and the SoonerCare Secure Site, which allows providers to view and access claim information online.

The Electronic Health Information Exchange collaborative provides the capability to electronically move clinical information between separate health information systems while maintaining the meaning of the information being exchanged. The goals of HIE are to improve the quality of care given to patients, improve overall population health, and improve administrative efficiencies in the health care system which will lead to cost savings for everyone.

The foundation of HIE is built on the common principles to create practical and sustainable initiatives that will be flexible and adaptive to change and to ensure initiatives are consumer focused. The OHCA commits to promote a comprehensive approach to accelerating health information exchange by involving providers and consumers, establishing state agency trust, developing sustainable funding sources, providing capable business services and operations, developing technical capabilities and consulting with state officials.



Action plans include developing a Health Information Organization (HIO) housed and operated within the OHCA that will give a complete picture of all state delivered services. Plans are also being made to pilot a claims based electronic health record (primarily with OHCA claim information) to OHCA contracted providers who have an electronic health record. A next step will be to add other state agency claims data and lab data and make the electronic health record available to all providers. Finally the electronic health record pilot will be expanded statewide and preparations will be made for interstate sharing of information.

9. Emergency Room (ER) Diversion Grant

Emergency room (ER) over-utilization is a recognized and pressing issue not only in Oklahoma but nationwide. The Oklahoma Health Care Authority (OHCA) has received a two year grant from the Centers for Medicare and Medicaid Services (CMS) for an ER diversion program. The grant proposal was prepared by the Community Health Centers, Inc. (CHCI) and submitted to the OHCA. After review by the OHCA, the grant proposal was submitted to our federal partner, CMS. This CMS grant opportunity required the OHCA, as the single state Medicaid agency, to submit the grant proposal, on behalf of CHCI. The primary focus area of this program will be access to a full array of primary and preventive health care for Oklahoma County Medicaid members. Specifically this project addresses the overuse of hospital emergency room use.

The OHCA submitted the grant proposal for the establishment of alternate non-emergency services providers. The agency submitted an acceptance letter to the Centers for Medicaid and Medicare Services (CMS) on April 30th, 2008 accepting the grant funding of \$1,030,536 for the establishment of alternative non-emergency service providers. This grant is to fund the project over the course of the two-year grant period. This project is in collaboration with Community Health Centers, Inc. (CHCI) and OHCA. This focus will provide a two-pronged educational approach emphasizing healthy behaviors and navigating the health care system to establish a medical home. The projected outcomes are decreased emergency room visits and improved health status.

The program is projected to vastly decrease emergency room over-utilization of the two area hospitals participating in the project, thereby creating direct correlative cost savings to the Oklahoma SoonerCare program. If successful, nearly one-half million dollars per year could be saved annually using this program. Outcomes will also determine the cost-savings to the state and the local hospitals. Any savings realized could be used to continue or expand the program, as its initial grant funding is limited in amount and duration.

The CHCI will benefit from the program by introducing members, currently without a medical home or primary care provider, to their facilities. This introduction will result in increased CHCI clinic utilization, for both initial and repeat visitors.

The project will allow CHCI to hire a Health Educator and four Community Health Workers (CHWs) onto their staff to develop an Emergency Department Reduction Pathway and a Medical Home Pathway in conjunction with (COINS) Project Access. COINS will be the vehicle that will provide the CHW training at Metro Technology Centers. This is a four week training to develop competencies in pathway development, health care system operations, social services, communication skills, motivational interviewing, health education and self-management of chronic diseases.

The CHCI's Health Educator will provide ongoing guidance to the CHWs, monitor progress, evaluate the outcomes and offer educational classes for SoonerCare members suffering from chronic illness such as diabetes, hypertension, COPD, obesity, etc. The CHWs will work directly with an already identified SoonerCare population known to frequently utilize the emergency department. Once identified the reasons behind elevated ER use will be discerned and those patients who have an identified medical home will be assisted in navigating their primary care system. If the SoonerCare member does not have a medical home and is in need of alternate non-emergency services, they will be referred to, and assisted in establishing a medical home. CHW's will also make referrals and offer case management.

Action plans will include finalizing the contractual agreement between OHCA and CHCI, Inc., as well as CHCI developing a summary of performance measures and an evaluation of the program. CHCI will compile the data gathered from the CHW's and the Health Educator to verify the effectiveness of this program. The data will be shared with the OHCA and results will be compared to the current OHCA ER utilization program. The measured outcomes of this program will determine its effectiveness. The program may be expanded to other areas experiencing high ER utilization. The decision to expand this program and its funding will depend on a variety of factors. Funds could come from savings resulting from the program's efforts or if expanded grant funding becomes available through CMS. The decision to continue or to expand will be made at the conclusion of the pilot program and when additional funding sources are identified.



10. Internet / Electronic Provider Enrollment and Re-Contracting

Internet provider enrollment and re-contracting allows SoonerCare providers the opportunity to contract and recertify their provider eligibility with OHCA online. The resulting ease and efficiency will be more attractive to SoonerCare providers. This project will allow SoonerCare providers real-time internet access to view and change their account information, subject to approval from OHCA staff. Significant staff time will be saved in data entry and phone inquiries allowing the redistribution of two full-time employees elsewhere in the agency as needed.

This project has widespread beneficial impact on numerous other OHCA programs. This program also incorporates a consolidated SoonerCare provider directory for use by members for Primary Care Provider (PCP) selection and a conduit for provider referrals. The decision was made by OHCA leadership to provide the necessary resources for this program with a “go live” date of November 1st 2008, coinciding with final implementation efforts of the OHCA medical home initiative. Action Plans include final information system coding and testing of the web-enabled application and provider directory. Additionally, OHCA is developing the appropriate media and methods to educate providers on the new contracting process and consolidated provider directory capabilities.

11. Licensed Behavioral Health Practitioners (LBHP) - Direct Contracts

There is much evidence to support the value and cost effectiveness of psychotherapy in the treatment of various behavioral problems. Currently, SoonerCare members access these services through contracted agencies, mental health centers or licensed psychologists.

OHCA’s current rules do not allow direct provider contracting with many categories of licensed clinicians, collectively known as Licensed Behavioral Health Practitioners (LBHP). This includes Licensed Clinical Social Workers (LCSW), Licensed Professional Counselors (LPC), Licensed Marriage and Family Therapists (LMFT), Licensed Behavioral Practitioners (LBP) and Licensed Alcohol and Drug Counselors (LADC).

Action plans include adding Licensed Behavioral Health Practitioners (LBHP) as contracted providers for the Insure Oklahoma, O-EPIC Individual Plan and the SoonerCare program. Rules will be revised and submitted to the Medical Advisory Committee (MAC) for consideration, the Board for approval and final approval from the Governor upon resource allocation. The agency will monitor utilization of these providers to determine the cost effectiveness and if access to care issues are relieved by this initiative.

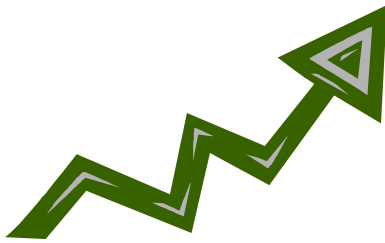
12. Living Choice (Money Follows the Person Demonstration)

In the summer of 2006, the Centers for Medicare and Medicaid Services (CMS) issued a competitive grant opportunity to states offering a total of \$1.75 billion over five years to develop programs that offer seniors and those with disabilities more options in types of long-term care services. Enacted by the Deficit Reduction Act of 2005, the Money Follows the Person (MFP) Rebalancing Demonstration is part of a comprehensive, coordinated strategy to assist States, in collaboration with stakeholders, to make widespread changes to their long-term care support systems. With the history and strength of the Real Choice Systems Change grants as a foundation, this initiative will assist States in their efforts to reduce their reliance on institutional care while developing community-based long-term care opportunities, enabling the elderly and people with disabilities to fully participate in their communities.

After submitting an MFP grant proposal, Oklahoma was awarded a total of \$45,331,786, in January of 2007, for administrative and operational service costs. The Oklahoma MFP grant initiative, otherwise known as Living Choice, will use enhanced federal matching funds to provide a total of 2,100 elderly, developmentally disabled, and physically disabled Oklahomans the choice of returning to a home-based community residence.

Oklahoma's rebalancing effort will consist of providing a robust package of home and community based services to individuals participating in the Living Choice project during their first year of community living. This ensures all individuals have access to the same medical services in the community as they would have had in an institution. Upon conclusion of an individual's participation in the Living Choice demonstration, they will transition to home and community based waivers which will contain the same services offered during the demonstration. Funds to be used for these waivers are the direct result of rebalancing funds coming from long-term care institutions to be used by individuals who, as an alternative, choose to receive their care in a community-based setting. OHCA staff, as well as various other stakeholders, have put forward a concerted effort to finalize the implementation plan for the Living Choice project. The implementation plan, which for CMS purposes is also known as the operational protocol document, details all aspects of the members' transition into a community-based setting. CMS approved the Living Choice operational protocol on July 29th, 2008.

Action plans include: modifying stakeholder information systems and finalizing program policy for the Living Choice program which will need Medical Advisory Committee (MAC) consideration, Board approval and Governor approval. Additionally, OHCA will submit and administer two new waivers with the intent to continue the Living Choice services after participants leave the demonstration. The Living Choice demonstration implementation is anticipated in the first quarter of State Fiscal Year (SFY) 2009 and continuing through the first quarter of SFY 2012.



13. Medical Home Model

The American Academy of Pediatrics (AAP) introduced the medical home concept to the United States health care system in 1967, initially referring to a central location for archiving a child's medical record. This early development led to an emphasis being placed on the importance of a medical home for children with special health care needs. Today many state medical home models focus exclusively on children with special health care needs. Over time, the medical home concept has evolved into a more general application of the term to mean "a regular source of care for all populations" that closely resembles the characteristics of a primary care orientation. In 2002, the concept was expanded to include certain operational characteristics. These characteristics define a comprehensive primary health care delivery approach, focusing on comprehensive, accessible, continuous, family-centered, compassionate, coordinated, culturally-effective, physical and behavioral health care. In March of 2007, four leading health care provider groups released a medical home concept paper entitled "Joint Principles of the Patient-Centered Medical Home". The four groups are the AAP, the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA). These groups have defined the primary care – medical home as an approach to providing comprehensive primary care for children, youth and adults. The primary care – medical home is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.

In February of 2007, under guidance of the OHCA Medical Advisory Team (MAT), the OHCA began exploring ways to incorporate the medical home concept into SoonerCare programs, as a method to reward high performing providers who deliver excellent patient care. Discussions began as a result of interest, both inside and outside the OHCA, in refining the current partially capitated arrangement to resemble one of primary care case management. Extensive other state research was conducted and a variety of approaches were identified from other states such as Alabama, North Carolina, Oregon and Pennsylvania. Using knowledge gained from other state practices, the National Center for Quality Assurance (NCQA) quality improvement initiatives, Medicare, and others, the OHCA put together a medical home approach for all SoonerCare Choice populations.

The medical home financing approach includes three basic elements, (1) a monthly care coordination payment based upon a PCP's panel characteristics (seeing adults, children, both) and the PCP's self-designation of meeting the requirements of either an entry-level, advanced, or optimal medical home level; (2) services rendered by the PCP are paid at the usual fee-for-service rate; and (3) a performance-based payment otherwise known as "SoonerExcel". In addition, some PCP's may qualify for a transitional payment in the first year, as their practice makes the transition from a partially capitated payment system to one of fee-for-service.

Another aspect of the medical home model gives PCP's the ability to participate within a Health Access Network (HAN) whereby the HAN provides additional resources to the PCP's practice, enhancing quality and providing additional support to SoonerCare Choice members. The PCP's participation with the HAN entity would be voluntary and established via an affiliation agreement, or by direct employment in some instances. The HAN would also have the option, dependent upon available funding, of contracting with a pay-for-performance provider, as was delineated in House Bill 2713, passed by the state legislature in May of 2008 (56 O.S. Supp 2007, sections 1011.2 and 1011.3). This program is to test a program's value proposition that offers financial incentives to both the health care provider and the patient for incorporating evidence-based medicine guidelines and information therapy prescriptions in the rendering and utilizing of health care. The member as well as the provider may be offered a financial reward for responding to the information therapy and the understanding of the health condition involved. It is anticipated that the additional PCP resources made possible through the HAN will result in services to SoonerCare members yielding improvement in overall health outcomes.

The OHCA sought input on the overall medical home model from various provider groups, conducting over 70 presentations and discussions on the new medical home approach. The input received was very valuable and used to shape the final medical home approach. In September 2008, with support of the MAT and OHCA leadership, a waiver amendment request was submitted to our federal partner, CMS, with approval anticipated on or before January of 2009.

Action plans include continued work on the operational aspects of implementing the new medical home approach. These include provider contracting and education, quality assurance protocols, member education, financial processing and reporting, information systems changes, policy revisions, Governor approval, waiver amendment approval by CMS, continued education of providers, advocates, stakeholders, and legislators, and ongoing reporting and monitoring of specific outcomes directly related to the new medical home criteria.



14. No Wrong Door

Oklahoma has the eighth highest uninsured rate in the nation. 54 percent of the uninsured are low income at less than 200 percent of the federal poverty level (FPL). At this income level most of the uninsured are qualified for SoonerCare or Insure Oklahoma, O-EPIC. In 2006, an estimated 85,000 children aged 18 and under had household incomes that qualified them for SoonerCare benefits, yet they were not enrolled. In an effort to reach those potentially qualified for coverage and improve SoonerCare efficiency, an online enrollment process called No Wrong Door (NWD) is in development. The NWD project was made possible by a transformation grant from the Centers for Medicare and Medicaid Services (CMS). The total, federal grant award exceeded \$6 million dollars, with no matching funds required from the state, and is to be used over a 2 year period which began in October of 2007. Oklahoma's grant proposal outlined an innovative way to incorporate technological advances in the enrollment process, which was recognized by CMS as being cutting-edge and worthy of grant funding.

No Wrong Door is an online enrollment process that creates a single-point-of-entry eligibility intake that results in the applicant's SoonerCare eligibility determination. This process will remove many obstacles and "open the door" for thousands of low-income, uninsured Oklahomans. It will inform the public not only about SoonerCare but other state services they may be eligible for and allow access to much needed health care coverage. It is anticipated that the No Wrong Door project will help to create a technological infrastructure within Oklahoma, allowing future health care initiatives across the state to utilize or learn from the advancements made by the No Wrong Door project. The No Wrong Door project, along with the long list of partners helping to develop and promote it, may be used as a vehicle to provide Oklahomans additional access to health care coverage, enrolling individuals in a variety of coverage options, and thereby reducing the uninsured rates.

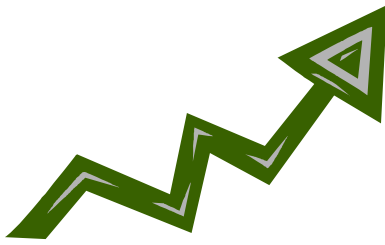
A phase-in approach has been defined by SoonerCare aid category for the extensive transition to an online enrollment process. Phase I of the project entails the Family Planning program, behavioral health, and the SoonerCare population of children, pregnant women, adults with minor children, and transitional medical. Behavioral health services will include prevention, treatment, and recovery for those affected by mental illnesses, substance abuse disorders, and domestic and sexual violence. Phase I also includes the conceptual framework for the initiative in which early policy and system design decisions are being made. The phase in approach creates an infrastructure for future healthcare initiatives the state may embark on in efforts to improve healthcare access, enroll individuals, and reduce uninsured rates.

The involvement of partner state agencies, such as the Oklahoma State Department of Health (OSDH), Indian Health Services (IHS), and the Oklahoma Department of Human Services (OKDHS), plays an important role in the implementation process. Their input and participation have an impact on the creation and success of the web-based application and eligibility determination system. The collaboration with partner agencies entails interfacing, exchanging data, and the compatibility of the NWD rules engine with their information systems. Discussions with partner agencies have been positive and those that are systematically ready to interface in Phase I will go live with NWD in October of 2009. Many other partner agencies have either been identified as potential partners or have contacted OHCA about becoming a partner agency. These new partnerships are currently being fostered and will be pursued in later phases of the project.

Later phases of the project include additional SoonerCare aid categories and will gradually be transitioned into No Wrong Door. Phase II populations consist of the Aged, Blind, Disabled (ABD) and the Insure Oklahoma, O-EPIC groups. Phase III will include the Breast and Cervical Cancer (BCC) population. Phase IV is planned to include Opportunities for Living Life and special eligibility groups such as foster care and custody children. These phases are scheduled for development and implementation through 2010. Future phases of NWD face the obstacle of development without the Medicaid Transformation Grant funds, which are only available for Phase I of the project.

OHCA is also in the process of pursuing a change regarding SoonerCare qualification for individuals with disabilities from a 209b state to 1634 status. Currently individuals with disabilities must apply for both Supplemental Security Income (SSI) and SoonerCare benefits, via separate applications at separate agencies. Conversion to a 1634 state would eliminate the need for a separate SoonerCare application, as qualification for SSI would be sufficient. The conversion to a 1634 state, which has a 2011 goal date, would increase the number of persons enrolled in SoonerCare due to ABD and SSI status by 10,000 members per year. There will also be a potential budget impact on OKDHS through Supplemental Security Payments to members and an increased impact to OHCA through additional claims.

Action plans for NWD include requesting additional funding to develop, implement, and maintain future phases of No Wrong Door. This may include an Advanced Planning Document (APD) to request a higher federal match for development efforts. As development of the online process progresses, NWD plans to use focus groups to understand member perspective and build the application according to the users. These sessions and future member focus groups will be conducted as more content and definitions of required fields are known. The current application development process remains flexible and allows for continued quality improvement in future phases. Marketing efforts are underway and will target potential members through organizations such as provider offices, libraries, county offices, and other community partners. Action plans also include information system changes, provider education and training, member education, modifications to operational processes as well as staff education, both at OHCA and OKDHS, and changes to interagency agreements.



15. Oklahoma Health Insurance Survey 2008 (SHADAC)

Conducted by the Oklahoma Health Care Authority with a grant from the U.S. Health Resources and Services Administration State Planning Grant (SPG) Program, the 2004 Oklahoma Health Care Insurance and Access Survey was the most comprehensive survey on health insurance ever fielded in Oklahoma. The survey was conducted between March 2004 and June 2004. For Oklahoma residents of all ages, the survey estimated that 17.3 percent were uninsured (584,931 Oklahoma residents). The survey identified various groupings, or sub-populations, that were important in the development of coverage expansion options because of their disproportionately high rates of uninsurance. For children ages 0- 18, the uninsurance rate was 12.7 percent; and for adults ages 19- 64, the rate was 23.1 percent. With this survey data from 2004, Oklahoma better understood the characteristics of the uninsured, thus enhancing the focus of its programs, policies, and outreach activities, and increasing its ability to identify currently uninsured individuals who are qualified for private or public health insurance coverage. The information from the survey was also to be used as a baseline for monitoring changes over time.

In 2008 the OHCA leadership made the decision to invest in another Health Care Insurance and Access Survey. As a result, the University of Minnesota SHADAC staff was engaged to oversee the second Oklahoma-specific survey, with a final report due in the fall of 2008. It is anticipated the results of the 2008 survey will be used to help guide policy-makers in making informed decisions with regards to Oklahoma's coverage issues during the upcoming legislative session.

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

16. Outreach Efforts for SoonerCare / Insure Oklahoma, O-EPIC

While the debate continues over how to get health care to everyone who needs it, the number of people in Oklahoma living without health insurance remains one of the highest in the nation at 640,000 or 18.2 percent of Oklahoma's total population (US Census Bureau, 2007 data collected in 2008). SoonerCare and Insure Oklahoma / O-EPIC, the major sources of public insurance coverage for low-income children and adults, have played critical roles in holding the line on health insurance coverage. Over the past few years, the OHCA has taken important steps toward eliminating unnecessary barriers; now, OHCA intends to pursue improving program outreach which could achieve additional – and substantial – reductions in the number of uninsured.

The term outreach is commonly used in public health insurance programs to describe efforts to increase enrollment in a particular program. It is most often applied to efforts that increase awareness of the existence and purpose of a program through targeted campaigns designed to help people actually receive the services for which they are qualified.

OHCA action plans for outreach are comprised of three main components:

1. Targeting those potentially qualified by increasing public awareness that our programs exist and motivating individuals to take action to find out more about, or enroll in, the program.
2. Assisting with enrollment and retention in the program. OHCA intends to create or strengthen relationships with groups or agencies like the Department of Education, Department of Human Services, Community Action Programs, the Oklahoma State Medical Association, Tribal Agencies, and United Way, to name a few.
3. Develop culturally competent, consumer-driven marketing strategies. Outreach should be tailored to meet the needs of different groups within Oklahoma's population, especially those who are hardest to reach. The message must be responsive to concerns in the specific communities.



17. Residential Treatment Center (RTC) Co-Occurring Integrated Mental Health and Substance Abuse Services for Children and Adults

Substance abuse, including both alcohol and illicit drugs, results in over \$1.4 billion in expenditures annually in the State of Oklahoma. Oklahoma employers will spend approximately \$600 million per year in additional medical costs for 200,000 workers abusing alcohol or managing the consequences of depression. The number of adolescents, aged 12-17 years, who admitted to substance abuse treatment increased 20 percent between 1994 and 1999. The OHCA would like to provide additional benefits to members in RTC's with substance abuse service needs. This initiative aims to enhance child and adult benefits provided under SoonerCare for inpatient treatment and to include prevention and early intervention programs, along with appropriate treatment and recovery support services.

Action plans include continued partnership and collaboration with outside agencies and groups such as the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), etc., defining services covered, limitations, acceptable treatment and requesting appropriate funding to provide services. Action plans will also include developing agency rule revisions which will require Medical Advisory Committee (MAC) consideration, Board approval and the Governor's approval. A state plan amendment will also be developed for approval by our federal partner, CMS.

18. Self-Directed Services Model

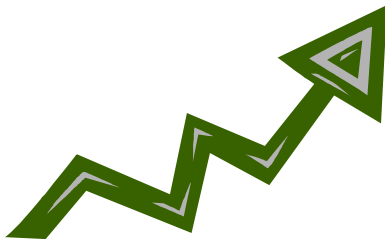
Self-directed services are a philosophy and practice that assumes that members and/or their caregivers have the right and ability to assess their own needs, determine how and by whom those needs are met, and evaluate the quality of the services they receive. Provided to individuals living in a home or community setting, self-directed services are a means by which individuals with physical and developmental disabilities are empowered to gain control over their selection of services and supports to meet their own day-to-day needs. By participating in a self-directed service program, the member has control over the decisions and resources required to meet the objectives in his or her individual service plan.

The self-directed services model is an umbrella project to address the issues arising from the addition of self-directed services in some of our current partnership projects. In order to ensure the efficient operation of the projects and enable the accurate detailed reporting needed for federal compliance, this project will evaluate and identify the impact self-directed services have on Oklahoma Health Care Authority (OHCA) systems, policy and procedure. Working to meet the current and future needs of self-directed services, this project will create the model that will allow the inclusion of self-directed services in not only the current projects identified, but also in future projects that may incorporate a self-directed service component.

The three partnership projects so far identified to include self-directed services are:

~CD-PASS is a currently approved Advantage waiver service. The Oklahoma Department of Human Services (OKDHS) contracts with a program administrator and billing agent. The billing agent submits the billing and pays the individual personal care assistants. The program administrator submits a separate electronic report listing in detail the particulars of the personal care claims that have been adjudicated. CD-PASS is currently limited to a federally approved pilot program limiting participation to ADvantage waiver members in Tulsa County only. Funding for the CD-PASS program is provided by a combination of OKDHS state dollars and federal matching funds.

~DDSD Self-Direction The Developmentally Disabled Services Division (DDSD) is currently working on an amendment to the In-Home Supports Waiver (IHSW) to add a self-direction option. Using a fiscal agent, this option adds a new provider type (community service worker) and additional goods and services, such as respite care. Currently, DDSD is operating a small pilot program with state only dollars, but is also seeking waiver approval from the Centers for Medicare and Medicaid Services (CMS) for federal matching funds. Once the waiver amendment has been approved, these services will qualify for federal matching funds, with the state portion continuing to be paid by DDSD.



~MFP The CMS Money Follows the Person (MFP) demonstration project (also known as Living Choice) established the goal of providing alternatives to long-term care and rebalancing Medicaid dollars. Self-directed services will be an option for all Living Choice members and will be offered prior to their transition from the long-term-care facility. Each member transitioned using the MFP funds are entitled to use the grant funds for a period of 365 days, after which, they will continue to receive similar services through either the ADvantage waiver or one of two new waivers that have been submitted to CMS for approval. Because self-directed services in the ADvantage waiver are limited to the CD-PASS pilot program in Tulsa County, the first cohort of MFP participants will not include those wishing to participate in self-direction. Once the new waivers have received CMS approval, MFP will begin to transition those wishing to participate in self-directed services.

Action plans include the self-directed services model workgroups continuing to meet to identify common threads in the three partnership projects, and establishing overarching guidelines for current and future self-direction projects to follow. Action plans also include making the necessary rule revisions which will need Medical Advisory Committee (MAC) consideration, Board approval, and Governor approval, information systems changes, provider education and training, member education, modifying interagency agreements and establishing contracts with service providers, as well as modifying business practices to ensure compliance with new federal reporting requirements. The waivers for MFP and the waiver amendment for the IHSW are both pending federal approval.

19. SoonerCare Coverage to 19 and 20 year olds—Expansion

The coverage of 19 and 20 year olds in the SoonerCare program used to exist prior to 1995. At that time the decision was made to discontinue coverage to these age groups due to budget limitations and funding shortfalls.

OHCA, to operate within monies appropriated for Fiscal Year (FY) 1996, revised rules effective August 1, 1995 to eliminate coverage of the optional group of individuals who were 18, 19 and 20 years of age and not categorically related to Aid to Families with Dependent Children, Disability, or Pregnancy Related Services. However, based on federal law, the Agency was able to permit individuals to continue to be eligible for Title XIX who were in this age group, but not categorically related, if they were in foster care or private institutions while in the custody of a public agency or individuals in this group whose adoptions were subsidized by a public agency. At that time, the Department of Human Services had indicated it would pay the State share for members whose medical coverage would otherwise be paid entirely with State dollars through their Agency. OHCA was expected to save \$1,084,009 (10 months) because of the rule change.

In September of 2001, 18 year olds were added back to the eligibility rolls of SoonerCare up to 185 percent of the Federal Poverty Level (FPL). However, 19 and 20 year olds remained ineligible for SoonerCare. During the OHCA Annual Board Retreat in August of 2008, the recommendation was made to reverse the previous action of discontinuing qualification of 19 and 20 year olds in the SoonerCare program.

The inclusion of 19 and 20 year olds into the entitlement program would increase the number of persons enrolled in SoonerCare. These individuals would use the same enrollment processes as currently exist for members. An estimated 25,000 individuals, aged 19 and 20 years, who were previously uninsured could now have access to coverage through the SoonerCare program. As a result of these young Oklahomans receiving coverage under the SoonerCare program, funding for their coverage would not be restricted as it has been in the Insure Oklahoma, O-EPIC program which uses revenues from the tobacco tax collections. Coverage for 19 and 20 year olds through the SoonerCare program comes as an entitlement meaning that all of those currently uninsured, and meeting SoonerCare qualifications, could obtain health coverage. This reduction in the number of uninsured could cut in half the uninsured rate of those between the ages of 19 and 24 years.

Under the current federal regulations, the State Plan is now a current option for states as an alternative to the use of waivers. At the present time, no waivers would have to be submitted or approved by our federal partner, CMS. The State Plan option provides states a more structured process whereby programmatic changes may be requested by states and reviewed according to a time-limit set forth in federal regulation.

Action plans include submitting a budget request for State Fiscal Year (SFY) 2011 to the state legislature for this reinstatement of coverage for 19 and 20 year olds, modifying the state plan and policy, educating members, staff, and partners, and making the necessary system changes to accommodate the change in qualification.



20. Telemedicine

Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve patients' health status. Closely associated with telemedicine is the term "telehealth," which is often used to encompass a broader definition of remote health care that does not always involve clinical services. Videoconferencing, transmission of still images, remote monitoring of vital signs and continuing medical education are all considered part of telemedicine and telehealth.

By providing a means by which providers can bill for telemedicine services OHCA hopes to reduce costs, improve quality and improve access. Telemedicine will also provide patients with increased access to providers, better continuity of care, reduction of time off from work and transportation costs. OHCA recognizes that telemedicine does not replace health care providers but that it can augment primary care services with necessary specialty care.

Currently, only telemedicine services provided utilizing an OHCA approved network are eligible for reimbursement. The health care practitioner who has the ultimate responsibility for the care of the member must obtain written consent from the SoonerCare member stating they agree to participate in the telemedicine-based visit. Authorized distant site specialty physicians and practitioners are: physicians, nurse practitioners, physicians assistants, licensed behavioral health professionals and dieticians. OHCA plans to offer an originating site fee for rural or medically underserved areas with telemedicine technology. The originating site means the location of the SoonerCare member at the time the service is being performed by a contracted provider via audio/video telecommunications.

Action plans include researching and identifying a wider array of services that can be offered via telemedicine. Action plans will also include developing agency rule revisions which will require Medical Advisory Committee (MAC) consideration, Board approval and the Governor's approval.

21. Tribal Medicaid Administrative Match (MAM)

Medicaid Administrative Match (MAM) is a federal program that is administered individually by each state as part of the “State Plan” for medical assistance programs. It involves the state’s Medicaid agency contracting with local health agencies, such as tribal organizations, to assure access to and availability of medical assistance to those who are qualified or potentially qualified for Medicaid. This is accomplished by three mechanisms: (a) outreach to potential Medicaid enrollees to inform them about the availability of Medicaid coverage for health services and assist them with enrollment and periodic re-enrollment; (b) facilitating the access of individual Medicaid clients to Medicaid-covered services by means of case management; and (c) coordinating service delivery systems to reduce barriers in accessing Medicaid-covered services and to troubleshoot access problems.

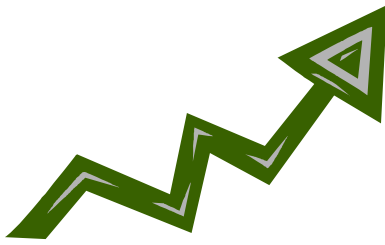
Federal financial participation (FFP) to support the costs of Medicaid administrative activities requires that the local funds that are matched by federal funding must be “non-federal dollars”. Therefore, most federal grants, as well as income from Medicare and Medicaid services are not allowable as the local portion of match. But under federal statute (Section 2 of the Indian Self-Determination Act), tribally-managed IHS and Bureau of Indian Affairs (BIA) funds are specifically allowed to be used to meet matching or cost participation requirements for other federal programs.

It must be emphasized that MAM functions as a performance contract, meaning that tribes will be reimbursed only for documented outreach and linkage activities and actual costs. The five states that are currently contracting with tribes each require quarterly documentation of Medicaid administrative activities, which involves conducting a weeklong time-study at least once each quarter, with a timesheet for each person on staff for whose activities reimbursement will be claimed.

Benefits for tribal organizations include intensified attention to Medicaid outreach and linkage for patients and the community, increased Medicaid reimbursements due to increased Medicaid enrollees, and new administrative dollars.

Benefits for the State of Oklahoma include supporting the proper and efficient operation of the State Medicaid Plan, leveraging already-existing local outreach operations, facilitating culturally appropriate and effective outreach and linkage, and demonstrating recognition and appreciation of tribally-managed health services.

A combined benefit for the State and the tribes is a manifestation of an appropriate government-to-government relationship.



The OHCA submitted the original tribal MAM proposal via State Plan Amendment (SPA) to our federal partner, CMS, in October of 2005. Initially, OHCA was told by CMS that similar proposals from the states of Washington and California respectively, were being considered by the federal review team. Since tribal MAM programs were relatively new to CMS and federal review teams, CMS officials indicated to Oklahoma staff that consideration of only one state's proposal would happen at a time. The area of Oklahoma's tribal MAM proposal causing specific concern to CMS was the cost allocation plan. OHCA staff consulted numerous times with CMS staff on appropriate methods and approaches to cost allocation, submitting several draft proposals to CMS, only to be rejected. The latest proposed Oklahoma MAM cost allocation plan was submitted to CMS in June of 2006. It has not yet been approved, nor has Oklahoma been allowed to implement a MAM program. Most recent communications with CMS regarding the MAM proposal have indicated the state of Montana has received approval for their MAM initiative. As a result, CMS has encouraged Oklahoma to research Montana's approach to MAM, incorporating similar elements, such as their cost allocation methods.

Action plans include modifying and finalizing the procedures and controls necessary to implement a tribal Medicaid administrative match. A state plan amendment (SPA) has been developed and submitted for approval by our federal partner, CMS. Current status from CMS indicates they are now reviewing the state of Montana's proposal. The agency will continue to negotiate and monitor progress with CMS regarding plan approval. Action plans also include developing agency rule revisions which will require Medical Advisory Committee (MAC) consideration, Board approval and the Governor's approval.

22. Trust Model Options—Research

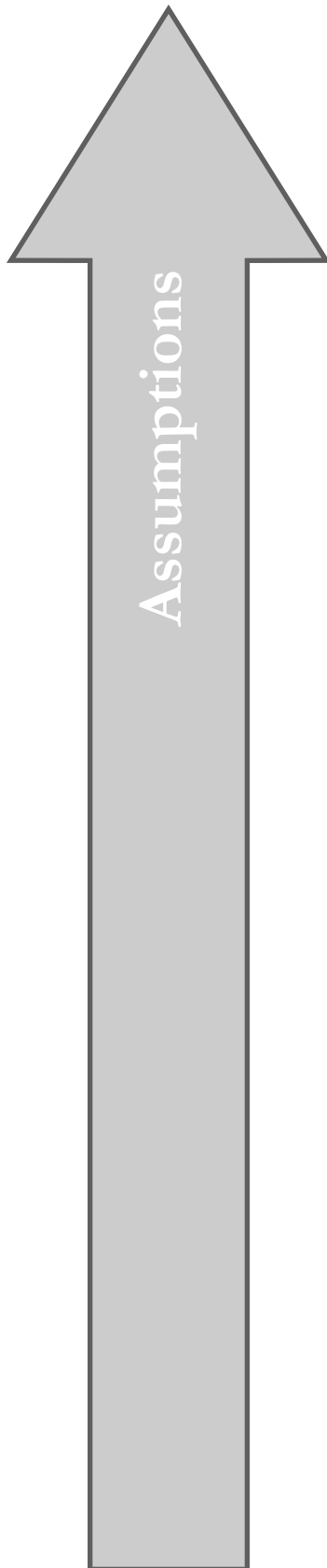
It is the vision of the Oklahoma Health Care Authority (OHCA) for Oklahomans to enjoy optimal health status through having access to quality health care. The mission statement says that the agency is to purchase state and federally funded health care in the most efficient and comprehensive manner possible and to study and recommend strategies for optimizing the accessibility and quality of health care. Oklahoma, through its many collaborations and partnerships—both private and public— has the opportunity to make available affordable private health coverage to thousands of working families who lack it today. A potential strategy to be used to further enhance the Insure Oklahoma program could be the creation of a trust to be the program administrator. The overall objective of the trust could be to reduce the number of uninsured working families, while strengthening the private health insurance market, through introduction of new, affordable coverage options and reinvestment of trust income into the health care system.

The Oklahoma Insurance Department (OID) and the Oklahoma Health Care Authority (OHCA) are developing a market-oriented strategy to reduce the number of uninsured working families. OID, through its State Coverage Initiative, is recommending expansion of the “Insure Oklahoma” program, which is administered by the OHCA under a federal Medicaid waiver. Insure Oklahoma/O-EPIC offers premium assistance to qualifying employees and spouses of participating small firms with access to private health insurance, and an Individual Plan option to others.

The success of the State Coverage Initiative will be dependent on changing the way Insure Oklahoma works. Under its current structure, the program has provided premium assistance to about 14,000 adults statewide. Many more employers and working families who lack access to affordable coverage are beyond the program’s reach. The OHCA is restricted under the waiver from using federal dollars to provide assistance to mid-size employers or working families above 200 percent of the federal poverty level. Solving the problem of Oklahoma’s uninsured may ultimately require introduction of new coverage options for families who cannot afford the products being offered by existing health insurers.

The trust could provide the means for Insure Oklahoma to greatly expand the availability of affordable health coverage while strengthening the private insurance market. The trust’s nonprofit status and greater operational flexibility could provide the means for offering more affordable coverage than is available in the marketplace today. The OHCA could continue to serve as the state’s Medicaid agency and would pay federally-matched premium assistance dollars to the Trust to cover qualifying families. The trust could reinvest income from operations into additional premium assistance for groups not covered by the federal waiver, and as a result, not eligible for federal matching funds.

Action plans include initiating discussion and planning with identified stakeholders and researching options and developing pro/con statements.



Assumptions

Projections from the Congressional Budget Office (CBO) indicate an estimated annual average growth of 8 percent in health care spending through 2017.

Oklahoma's uninsured rate is an estimated 18.2 percent; the national average is 15.4 percent.

Health insurance premiums have more than doubled since 1999. During that same time period, workers' wages increased by 34 percent and general inflation rose by 29 percent.

The uninsured are less likely to receive preventive care and services for major health conditions.

Most of the uninsured in Oklahoma are in working families making below 300 percent of the federal poverty level (FPL).

Every day, 11,000 baby boomers turn 50. Boomers are living longer and will need more long-term care after retirement.

Of the 40 percent or more of those who need long-term care during their lives, about two-thirds of all of these individuals depend on Medicaid for financing at some point.

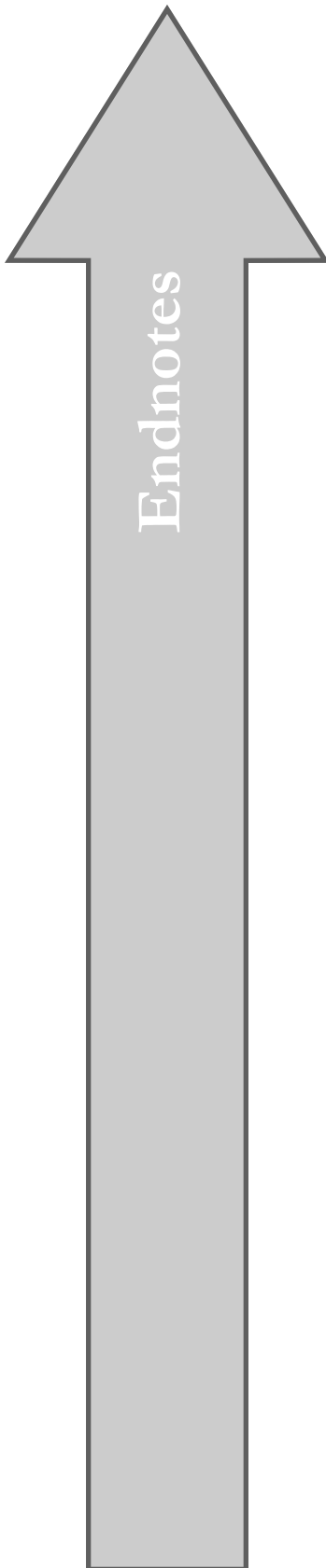
Oklahoma's federal medical assistance percentage (FMAP) has continued to decrease for over five years.

The nation is undergoing an information technology revolution, with some of the most promising activities taking place in the health care system.

The workforce shortage is becoming particularly acute in the health industry.

Consumers are starting to get engaged in quality information regarding health care.

States are taking the lead, in the presence of federal gridlock, on such divisive issues as covering the uninsured, funding stem cell research, and regulating pharmaceutical marketing.



End Notes

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²CNN Money.com, Uncle Same: \$407 billion in the hole, September 9, 2008.

³The Oklahoma Economy, 2008 Economic Outlook, Oklahoma State University, William S. Spears School of Business, August 6, 2008; April 4, 2008.

⁴Medical News Today, Medicaid Spending Projected to Increase by 5.8% in FY2008, According to Survey, CQ HealthBeat Reports, June 8, 2007, www.medicalnewstoday.co/articles/73400.php.

⁵L. Clemans-Cope, B. Garrett, and C. Hoffman, 2006, "Changes in Employees Health Insurance Coverage 2001-2005," Kaiser Commission on Medicaid and the Uninsured (#7570 October), <http://www.kff.org/uninsured/7570.cfm>.

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⁷S.Dorn, 2008, "Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality," Urban Institute, <http://www.urbanorg/publications/411588.html>.

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⁹H.R. 2642: Fiscal 2008 War Supplemental Appropriations, Sec. 7001 (P.L. 110-252). H.R. 2642 was signed by the President June 30, 2008.

¹⁰Top Seven Health Industry Trends in '07, PricewaterhouseCoopers' Health Research Institute.

¹¹Industry trends include online research, self-care, workforce shortage, Columbia Business Times, Jim Gann, May 30, 2008.

¹²Top Seven Health Industry Trends in '07, PricewaterhouseCoopers' Health Research Institute.

¹³66 Fed. Reg at 3154, 3173 and 67 Fed. Reg at 2610.