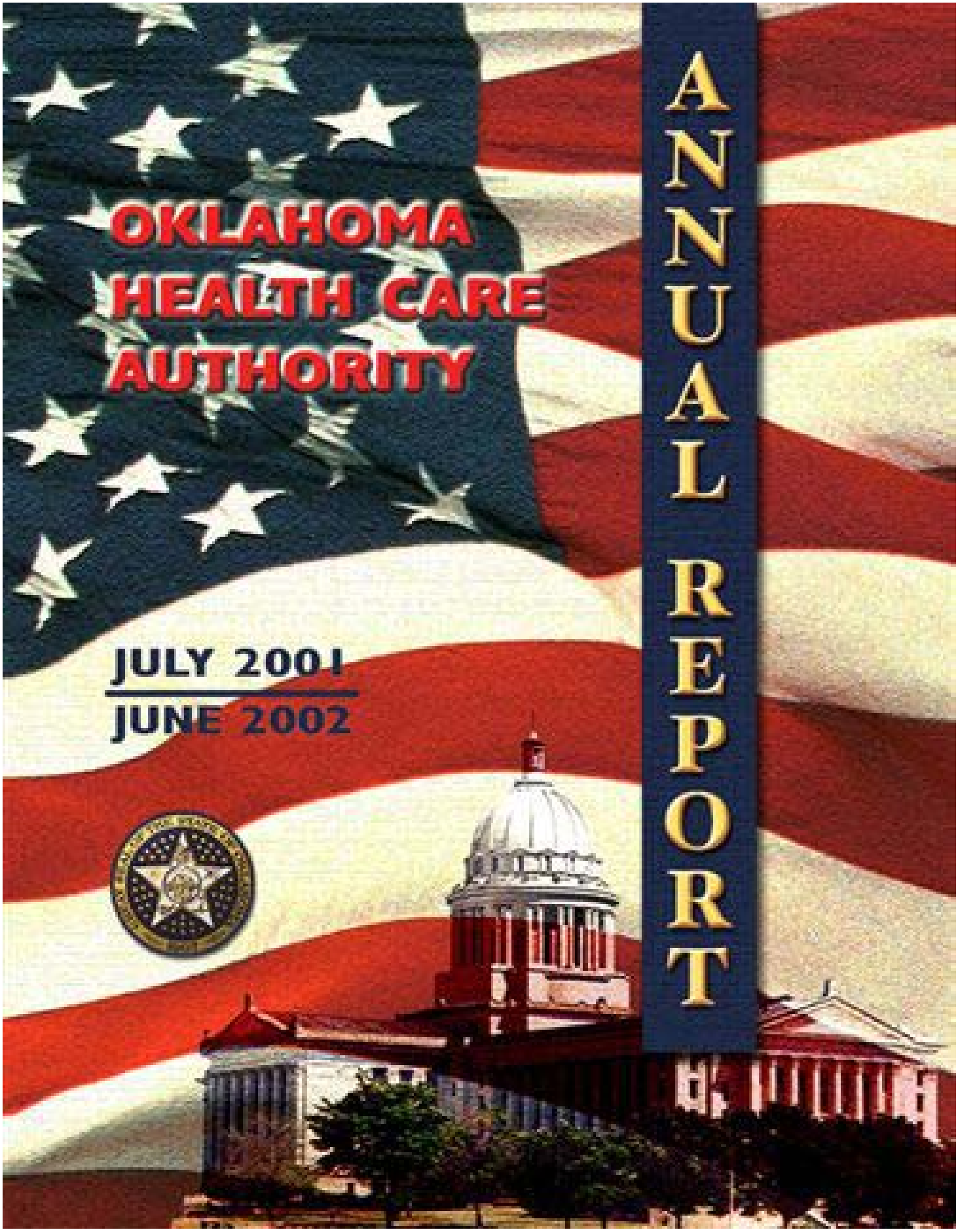
OKLAHOMA HEALTH CARE AUTHORITY

ANNUAL REPORT

JULY 2001
JUNE 2002



Our Mission Statement

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

Our Vision

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

Our Values and Behaviors

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

STATE OF OKLAHOMA

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Governor
State of Oklahoma

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Jerry Regier
Cabinet Secretary 2001

Howard Hendrick
Cabinet Secretary 2002

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48th Legislature (2002-2003)

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Lyle Roggow
Appointed by the Governor

Message from the Oklahoma Health Care Authority…

"The gem cannot be polished without friction, nor man perfected without trials."
– ***Chinese Proverb***

The Oklahoma Medicaid program is near collapse. People are being tossed off the program. Benefits and provider rates are being slashed. Sound familiar? It was the Oklahoma Medicaid program 10 years ago. Oklahoma's economy was in recession and the per-client cost of Medicaid benefits was skyrocketing more than 10 percent annually. The governor and legislature sought to fix Medicaid.

A task force was formed in 1992 and for two years brought business people, health care professionals, consumers, policy makers and other individuals with interest and expertise to the task of thinking "outside the box" for a solution. The findings became the basis for legislation that created the Oklahoma Health Care Authority (OHCA) to focus attention and resources to change the way Oklahoma purchases health benefits.

As we complete our seventh year managing the now $2.3 billion program, it is a long way from 1993 when the task force projected Medicaid would, if left unchecked, approach $4 billion by the year 2000. OHCA has successfully contained the per-client cost to a 3.3 percent annual growth, half the national average of 6.6 percent. One-third of the $2.3 billion pays for nursing home quality initiatives, medical education and programs administered by other state agencies.

Although costs have been contained, needs have not. In response to a growing uninsured population, state lawmakers expanded the program in 1997 to cover more children. Since 1997, the average number of children covered has grown 96 percent.

There has been much talk of an “audit” of the agency, as if to threaten or punish. Internal and external audits are a management tool we currently use to ensure program integrity. We routinely host auditors from state, federal and private sources to review operations and finances to better manage the program. We welcome any additional audit and trust people will conclude their review of the facts before they conclude their opinion. Since the agency’s creation, we have invested staff and resources to ensure public dollars are being spent correctly and to recover any funds inappropriately billed.

Declining state revenue and rising health care costs are a source of great frustration. OHCA cut $1.6 million from the administrative budget in November before considering program cuts. The fact is, if the entire annual payroll of $14.7 million was eliminated it would pay for about two days of program costs. Operating a publicly funded health insurance program covering more than a half million lives with zero cash reserves is treacherous. Unforeseeable events, such as the recent economic downturn and astronomical increases in the price of pharmacy products, create immediate funding crises.

This year a new task force was formed, chaired by state Secretary of Health and Human Services Howard Hendrick. After analyzing the Health Care Authority, the task force issued a report with recommendations to avoid future funding difficulties such as creating a cash reserve. The task force found that solutions may exist, “however, the choices required to do it are very difficult and will require tremendous political will, a lot of money or both.”

Oklahoma joins nearly all states as we grapple with the economic realities of growing costs and shrinking state revenue. Many states are considering cuts in eligibility, benefits and provider rates. We thank the legislature and governor for expressing the peoples’ commitment to the program by approving supplemental appropriations to keep most services intact.

We take seriously our responsibility to use tax dollars appropriately. We have and will look for efficiencies that provide the best service to the 600,000 Medicaid clients at the least expense to the taxpayer. We will work with anyone who wants to continue making improvements and provide the best Medicaid program this state can afford.

Contents

Figures

OHCA's State Fiscal Year 2002 Accomplishments

Aged, Blind and Disabled Population Finding Satisfaction

A majority of people categorized as aged, blind and disabled (ABD) enrolled in an Oklahoma managed care plan are more satisfied with the overall quality of health care services provided under managed care vs. traditional Medicaid fee-for-service, according to a recent study funded by the Center for Health Care Strategies (CHCS). To gauge the progress of ***SoonerCare***, CHCS commissioned a study by Schaller Anderson, Inc. to assess the service to special needs populations. It examined a group of 538 individuals covered under the Heartland Health Plan and compared costs, quality of care and member satisfaction levels prior to managed care enrollment and one year following enrollment.

The study found that managed care:

- Increased satisfaction: 61 percent of members surveyed were more satisfied with the overall quality of health care services provided under managed care vs. fee-for-service.
- Improved access to care and continuity of care compared to fee-for-service.
- Resulted in 15 percent savings over fee-for-service.

A copy of the study is available at www.chcs.org.

EPSDT Screening Rate Reaches New High

According to a report released in state fiscal year 2002, the rate at which Oklahoma children on Medicaid accessed health care to prevent or treat any illnesses hit an all-time high in state fiscal year 2001. The preventive health care package known as Early Periodic Screening, Diagnosis and Treatment (EPSDT) recorded a 62 percent compliance rate, an all-time high for the state Medicaid program. Children age 20 and younger enrolled in Medicaid take part in EPSDT services. The push toward regular screenings has been a collaborative effort involving Health Care Authority staff, public schools, health care providers, health plans and the Oklahoma Department of Human Services (OKDHS).

EPSDT services involve screenings, or exams, for children at recommended intervals in their lives. In these screenings, a doctor, nurse practitioner or physician assistant will perform a full physical, which includes checking a child's growth rate, diet, teeth, eyes and ears. Any needed immunizations or lab tests also are performed according to a recommended schedule.

Accomplishments (continued)

Hospital Funding Formula Changes, Equalizes

Approved in April 2002, OHCA changed the way funding is divided among the hospitals that participate in the Graduate Medical Education (GME) program. Payments are currently based on the share of each hospital's resident physicians per month. The change will incorporate new factors in the formula, including total Medicaid days, acuity levels and the number of residents per month. Acuity defines the different levels of care from routine to emergency care. This change becomes effective on July 1, 2002.

The Hospital Funding Task Force and OHCA recognized the need to change the formula to achieve more equality and a truer reflection of the Medicaid service efforts of each hospital's GME programs. GME is a fund to support medical training in qualifying hospitals and to recognize the loss of revenue in serving the uninsured and Medicaid populations.

Medicaid Eligibility Expanded to 18-Year-Olds

In 2001, individuals age 18 who are related to TANF/AFDC and are at 185 percent or below the federal poverty level, are eligible to enroll in the Medicaid program. A federal mandate required this new policy be in effect by October 1, 2001. OHCA estimates this has added approximately 12,000 people into either the ***SoonerCare*** Plus or Choice programs.

OHCA Joins Health Agencies' Fight Against Tobacco

In an unprecedented partnership, the Oklahoma Health Care Authority joined other state leaders and private advocacies to address Oklahoma's leading cause of preventable death – tobacco addiction. Tobacco kills more Oklahomans than alcohol, auto accidents, AIDS, suicides, murders and illegal drugs combined and costs more than $1 billion in medical expenses and lost productivity each year.[1]

Joining with other state agencies including the Oklahoma State Department of Health, Oklahoma Department of Mental Health and Substance Abuse Services and the Oklahoma ABLE Commission, the partnership announced four key policy recommendations:

- Increase the excise tax on a pack of cigarettes by $1 per pack. This tax is currently 23 cents in Oklahoma.
- Provide increased funding for youth compliance checks in retail outlets to reduce sales to minors.
- Repeal the preemption language from our state's tobacco laws so citizens in cities and towns can enact stronger tobacco control ordinances than state law allows.
- Provide smoke-free public places to protect all Oklahomans from the health hazards of secondhand smoke.

Nearly 400 million packs of cigarettes are sold in Oklahoma each year. Conservative estimates suggest revenue from an increase in tobacco tax could raise more than $215 million per year. This revenue could be used to pay for health care costs such as increases in Medicaid provider rates. Funds could also pay for tobacco cessation programs and pay for tobacco prevention efforts.

[1] Source: Oklahoma Department of Health, Tobacco Use Prevention Service. www.health.state.ok.us/program/tobac/index.html

Accomplishments (continued)

OHCA Awarded Medicaid Infrastructure Grant

The Medicaid Infrastructure Grant (MIG) is a planning mechanism to help people with disabilities become active participants in the workforce. The Ticket to Work and Work Incentives Improvement Act of 1999 allows state Medicaid programs to establish Medicaid income and asset guidelines and implement co-payments, fees, premiums or other cost sharing for disabled workers who may not be able to afford adequate health insurance through their jobs. Through Ticket to Work, disabled workers can purchase their Medicaid benefits at pre-established affordable rates. Oklahoma received a grant in the amount of $500,000 for the period from January 1, 2002, through December 31, 2002. The grant may be used to research implementation options and establish mechanisms for consumer and provider input and information exchange with other state Medicaid programs that have or are exploring the Ticket to Work option. OHCA may not use the grant funds for services to clients. As part of the infrastructure development process, OHCA has partnered with several groups, including the Department of Rehabilitation Services, Oklahoma ABLE Tech, Oklahoma Developmental Disabilities Council, Oklahoma Office of Rural Health, Progressive Independence and the Department of Human Services Developmental Disabilities Services Division.

OHCA Receives Olmstead Grant

In 1999 a case was filed in Georgia under the American's with Disabilities Act (ADA). It was related to services provided to persons with disabilities. Based on the findings of this case, the Supreme Court determined that:

- if community placement is deemed appropriate,
- if the individual is not opposed to transitioning from institutional care into the community, and
- if the services the individual needs are available,

the individual should be served in the most integrated and appropriate setting. This decision is referred to as the "Olmstead Decision". OHCA was awarded an Olmstead Grant in January 2002. The $50,000 grant is to be used to assess a sample of persons residing in nursing facilities to study the impact and determine potential "gaps" in Medicaid services and supports should they transition into the community.

Secure Internet Access Begins Testing

OHCA has launched tests of its new secure website. Beginning in July 2002, the agency will present the first phase which will give providers secure access to their Medicaid data electronically. Initially, the site will offer access to specific claim information and status as well as prior authorization inquiries. The site will also include a global messaging system for better communication from OHCA to providers.

Once the second phase of the site is completed in January 2003, authorized users will be able to submit claims, edit claims, verify client eligibility, request prior authorization (fee-for-service providers), download HIPAA 835 payment/remittance advice statements and search pricing and limitations on procedures and drugs. The site will also allow drug manufacturers to download the current quarter's drug rebate invoice files and will let providers make adjustments to their claims online.

SFY2002 Highlights

- Overall Medicaid eligibles increased by 37,986 (or 9 percent) from June 2001 to June 2002.
- The number of children enrolled in Medicaid increased by 29,825 (or 10 percent) from June 2001 to June 2002. Children accounted for 79 percent of the overall growth during SFY2002.
- The number of aged, blind and disabled (ABD) individuals enrolled in Medicaid increased by 3,647 (or 3 percent) from June 2001 to June 2002.
- During SFY2002, 83 percent of clients had unlimited prescription drug benefits.
- 75 percent of Medicaid clients' benefits included unlimited physician visits.
- There were 108 provider appeals filed, resulting in seven of OHCA's decisions being overturned in SFY2002.
- An extremely low number of appeals were filed by clients regarding appropriate and accessible services (less than ¼ of 1 percent of total eligibles).
- 38 percent of Medicaid clients were enrolled in ***SoonerCare*** Plus, the richest benefit package.
- 37 percent of Plus members and 39 percent of Choice members actively chose their health care providers.
- ***SoonerCare*** Plus and Choice complaints represented only 1 percent of the total ***SoonerCare*** populations.
- 100 percent of ***SoonerCare*** program complaints were addressed within 72 hours.
- The ***SoonerCare*** health plan providers all received 100 percent quality ratings.
- The agency processed 27 emergency rules and seven permanent rules during SFY2002. This was a decrease of 51 percent from the previous year.
- The OHCA also submitted 13 state plan amendments; a 43 percent decrease from the previous year.
- Dollars recovered from post payment reviews totaled $3,614,759 a 28.6 percent increase from SFY2001.
- Dollars recovered from third party liability activities totaled $8,813,430, a 23 percent increase from SFY2001.
- Drug rebate collections increased by 21 percent to $48,348,254. Collections as a percentage of pharmacy expenditures remained constant at 20 percent.
- The OHCA assessed $53,672,433 in Quality of Care fees and $257,447 in penalties/interest. 100 percent of assessed fees were collected during SFY2002.

Oklahoma Medicaid

What is Medicaid?

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

Medicaid is three programs in one:

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

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

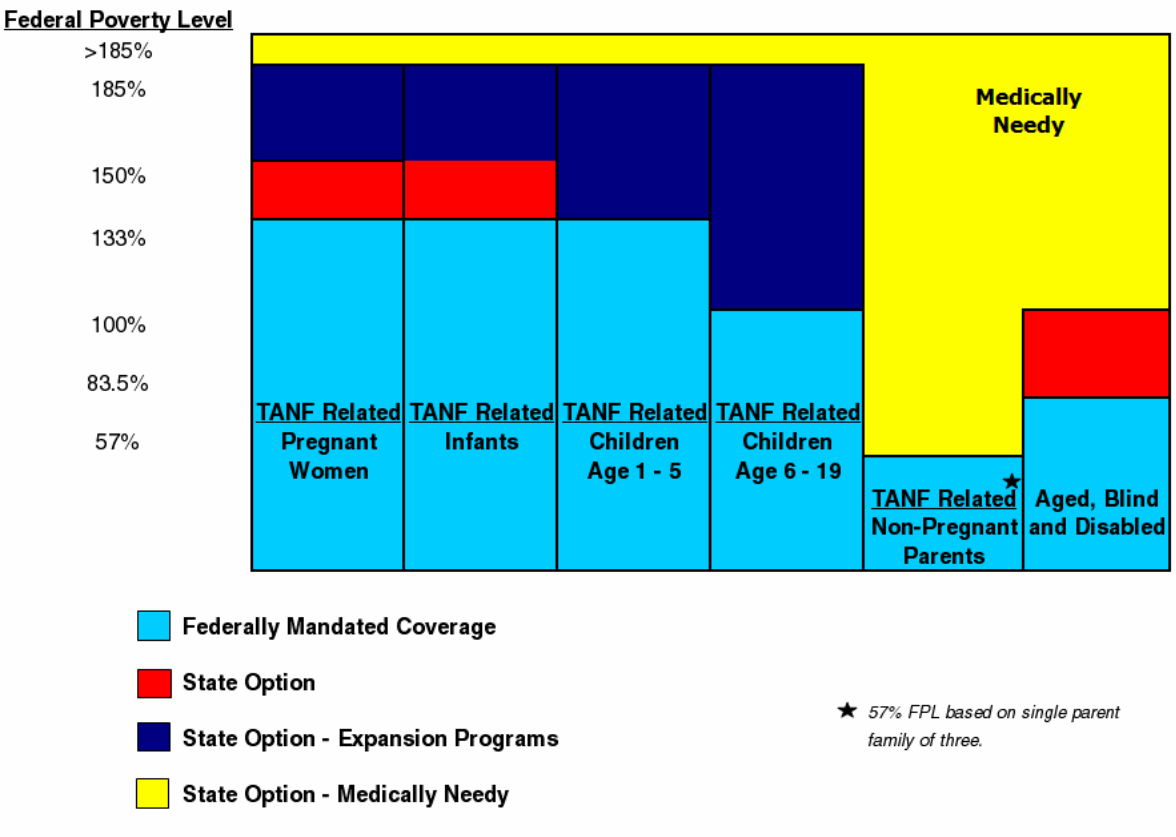
Who is Eligible for Medicaid?

As required by state law, Oklahoma Medicaid eligibility is determined at the Department of Human Services county offices. Each is governed by federal and state eligibility criteria. Most Medicaid eligibility criteria related to income levels are determined by federal poverty (FPL) guidelines established by the U.S. Department of Health and Human Services. Medicaid serves as an insurance plan for many Oklahoma women of childbearing age and children. Women and children qualify for Medicaid based on income, resources and "categorical" status, that is, they are in a certain category such as TANF-related or low income pregnant women, hereafter referred to as the Temporary Assistance for Needy Families (TANF/AFDC) population. Preventive and acute primary care services constitute the majority of Medicaid service needs for the TANF/AFDC clients. As of the end of the June 2002, children age 18 and under alone comprised 66 percent of the total 480,373 Oklahoma Medicaid population.

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

The Medically Needy program provides Medicaid benefits for individuals and families whose income exceeds the Medicaid standard income but is not enough to meet their medical expenses. Typically, eligibles are required to spend down the excess income or "incur" a certain amount of medical expenses before Medicaid will pay for covered services. Currently, there are 1,938 people categorized as Medically Needy in the Oklahoma Medicaid program.

Figure 1 Medicaid Eligibility Standards, Federally Mandated and Oklahoma Optional



Who is Eligible for Medicaid? (continued)

Figure 2 General Age Breakdown of Medicaid Eligibles (as of June 2002)[2]

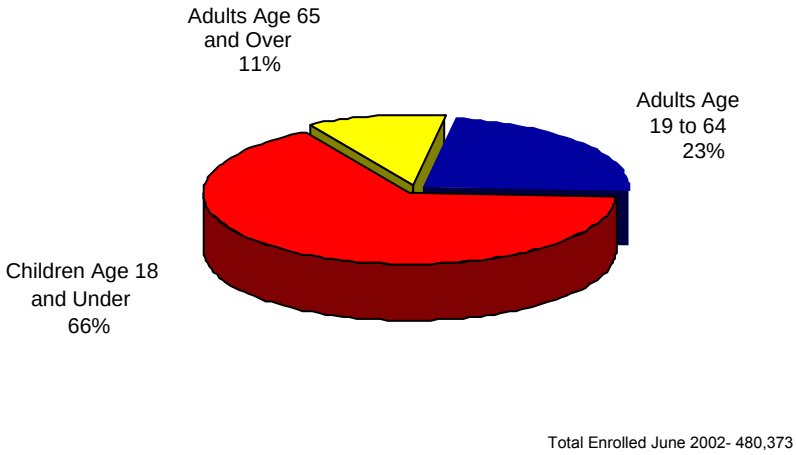


Figure 3 Eligibles by Aid Category (Adult and Child*), SFY1999 through SFY2002

Aid Category	Adult/Child*	June 1999	June 2000	June 2001	June 2002	% Change from Prior SFY
ABD	Adult	88,784	88,492	98,341	101,422	
	Child*	10,517	10,099	9,991	10,557	
	Subtotal	99,301	98,591	108,332	111,979	3%
TANF/AFDC	Adult	40,148	36,865	38,616	43,395	
	Child*	232,797	265,103	286,963	316,330	
	Subtotal	272,945	301,968	325,579	359,725	10%
Other	Adult	16,557	15,743	7,987	8,288	
	Child*	681	483	489	381	
	Subtotal	17,238	16,226	8,476	8,669	2%
Totals		**389,484**	**416,785**	**442,387**	**480,373**	**9%**
Medicaid Enrollment by Adult/Child*						
	Adult	145,489	141,100	144,944	153,105	6%
	Child*	243,995	275,685	297,443	327,268	10%
Totals		**389,484**	**416,785**	**442,387**	**480,373**	**9%**

Percent of Total Medicaid Population by Adult/Child*

Adult	37%	34%	33%	32%
Child*	63%	66%	67%	68%

[2] Source: June 2002 data extracted from client eligibility files on July 8, 2002. Numbers frequently change due to retro-certifications and other factors. This figure is based on data within the system prior to July 8, 2002.

* "Child" for this table refers to individuals under age 21.

Who is Eligible for Medicaid? (continued)

Figure 4 State of Oklahoma Population by Race[3]

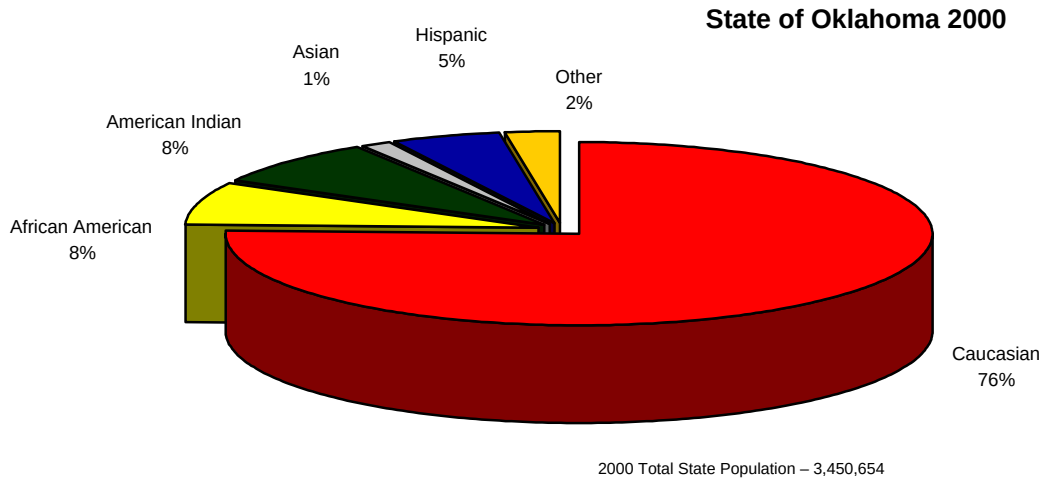
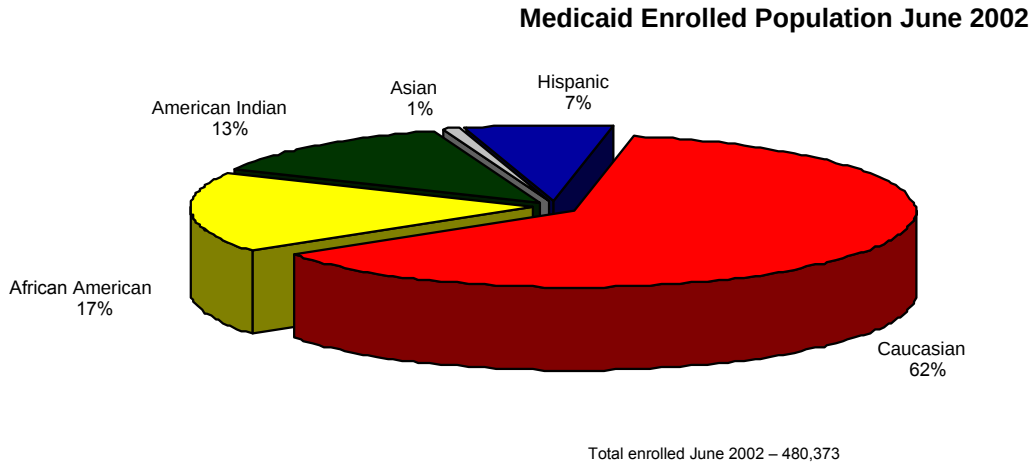


Figure 5 Oklahoma Medicaid Population by Race[4]



Nearly 1 in 6 Oklahomans Enrolled for Services

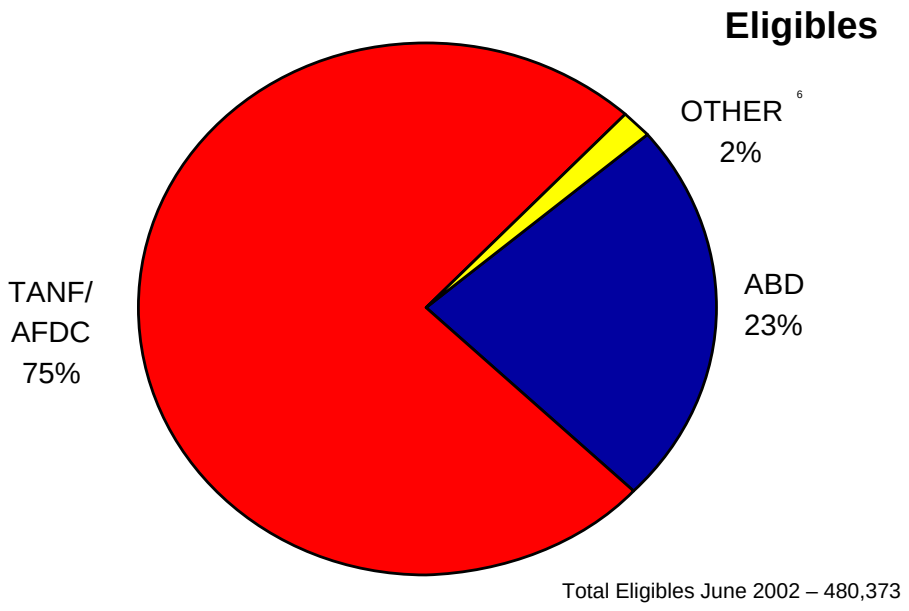
Most of the population figures contained in this annual report represent a "point in time" reference such as June 2002. The state Medicaid program assisted 626,077 individuals during the entire fiscal year. This is referred to as an unduplicated count. On average, approximately 469,000 individuals were enrolled each month of the fiscal year.

[3] Source: Population by Race Alone and Hispanic Origin: 2000 Public Law 94-171 – U.S. Bureau of the Census Oklahoma State Data Center – Oklahoma Department of Commerce http://www.odoc.state.ok.us/index.html

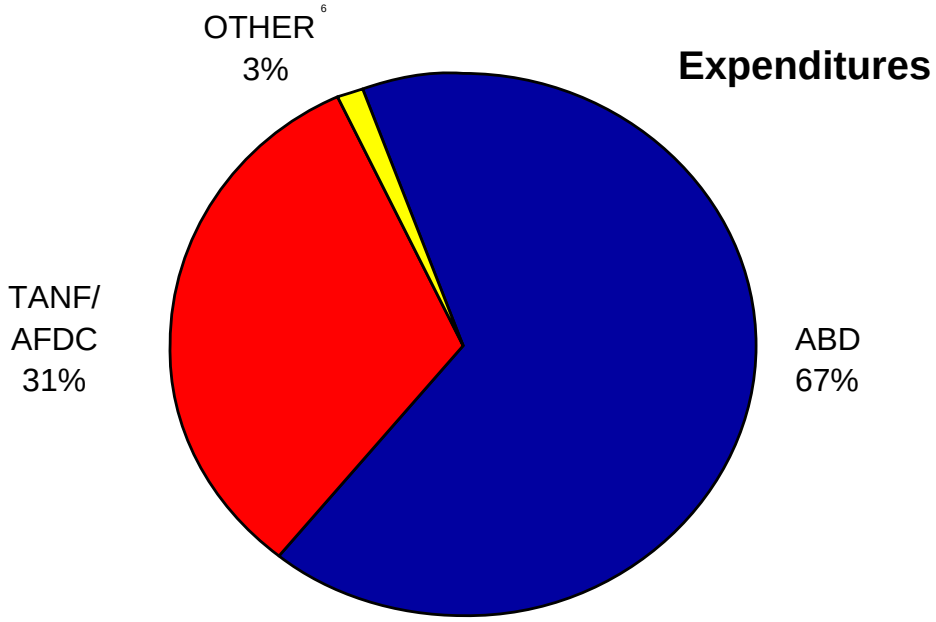
[4] Data extracted from client eligibility files on July 8, 2002. Numbers frequently change due to retro-certifications and other factors. This figure is based on data within the system prior to July 8, 2002.

Who is Eligible for Medicaid? (continued)

Figure 6 Breakdown of Medicaid Eligibles and Expenditures by Aid Category (as of June 2002) [5]



Total Eligibles June 2002 – 480,373



Total Expenditures SFY2002 – $2,256,187,080

[5] Source: June 2002 data extracted from client eligibility files on July 8, 2002. Numbers frequently change due to retro-certifications and other factors. Expenditure data is based upon data extracted through the claims payment system (MMIS). Financial amounts reported may be higher due to expenditures that are not processed through MMIS.

[6] OTHER Eligibility group encompasses Medically Needy, Tuberculosis patients, Qualified Medicare Beneficiaries, Special Low Income Medicare Beneficiaries, Refugees and Developmentally Disabled Supported Living.

How is Medicaid Financed?

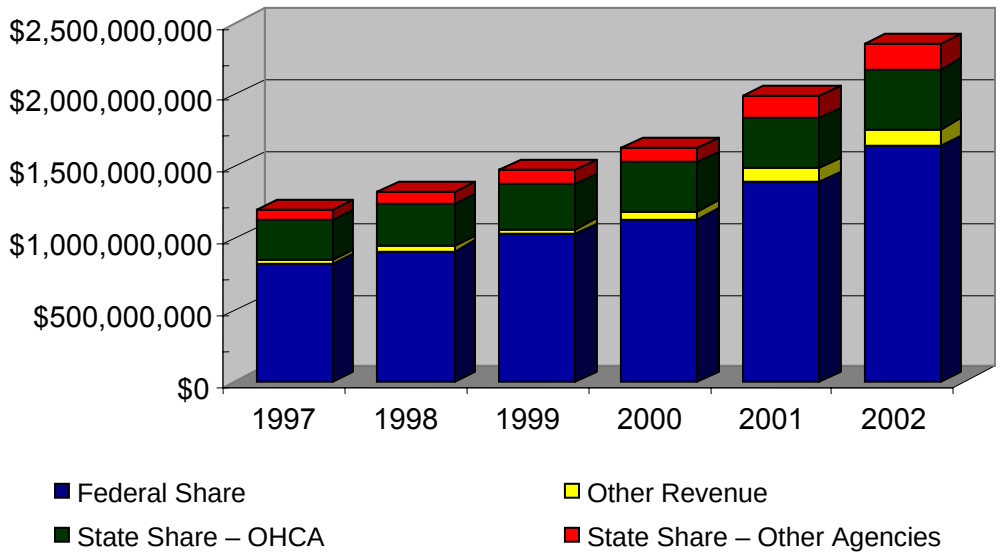
The federal and state governments share Medicaid costs. For program administration costs, the federal government contributes 50 percent for each state with enhanced funding provided for some administrative activities such as fiscal agent operations. For medical services provided under the program, the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

Figure 7 Condensed Summary of OHCA Revenues[7]

As of June 30, 2002

REVENUES	SFY02 Budget YTD	SFY02 Actual YTD	% Over/ (Under)
State Appropriations	$ 430,492,314	$ 430,492,314	0.0%
Federal Funds – OHCA	1,225,698,526	1,241,104,295	1.3%
Federal Funds for Other State Agencies	428,074,417	410,059,617	(4.2)%
Refunds from Other State Agencies	181,804,392	167,656,503	(7.8)%
Other Revenue	122,605,657	121,272,095	(1.1)%
TOTAL REVENUES	**$ 2,388,675,306**	**$ 2,370,584,824**	**(0.8)%**

Figure 8 Summary of Expenditures and Revenue Sources – Oklahoma Medicaid[8]

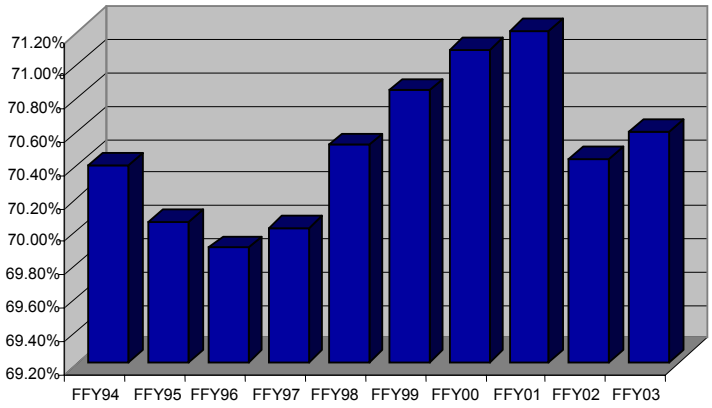


[7] Source: OHCA Finance Division (08/2002)
[8] Source: Annual NASBO Survey as prepared by OHCA Finance Division (08/2002)

How is Medicaid Financed? (continued)

Figure 9 Historical Federal Medical Assistance Percentage (FMAP)[9]

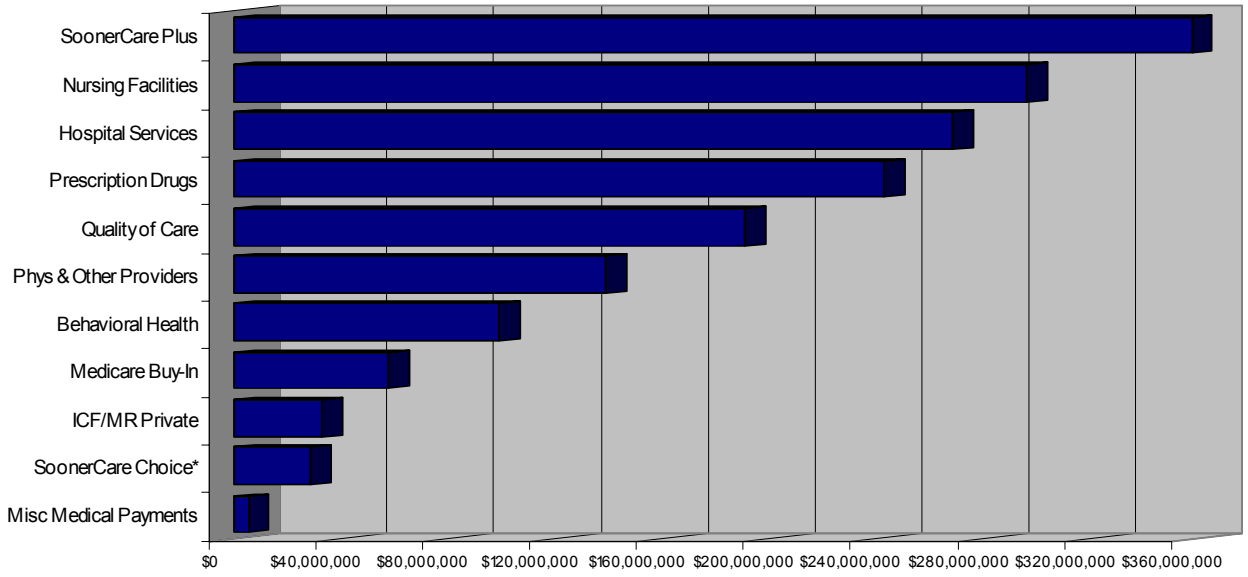
Federal Fiscal Year	FMAP Rate	SCHIP‡
FFY94	70.39%	
FFY95	70.05%	
FFY96	69.89%	
FFY97	70.01%	
FFY98	70.51%	79.36%
FFY99	70.84%	79.59%
FFY00	71.09%	79.76%
FFY01	71.24%	79.87%
FFY02	70.43%	79.30%
FFY03	70.56%	79.39%



(The Federal Fiscal Year is October 1st through September 30th. The shaded area is the current year.)

Where are the Medicaid Dollars Going?

Figure 10 Oklahoma Medicaid Actual Expenditures SFY2002[11]



[9] Source: OHCA Finance Division (07/2002)

[11] Source: OHCA Finance Division (08/2002). Unless stated otherwise expenditures are State and Federal dollars combined.

‡ SCHIP: State Children's Health Insurance Program; see additional information on Page 25.

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

Where are the Medicaid Dollars Going? (Continued)

Figure 11 Condensed Summary of OHCA Expenditures SFY2002[12]

As of June 2002 EXPENDITURES	FY02 Budget YTD	FY02 Actual YTD	% (Over)/ Under
ADMINISTRATION	**$ 69,010,614**	**$ 65,283,846**	**5.4%**
ADMINISTRATION – QUALITY OF CARE	**821,886**	**821,886**	**0.0%**
OHCA MEDICAID PROGRAMS			
Managed Care:			
SoonerCare Plus	363,586,324	358,088,015	1.5%
SoonerCare Choice*	31,499,835	28,564,617	9.3%
Acute Fee-for-Service Payments:			
Hospital Services	264,022,914	268,774,138	(1.8)%
Behavioral Health	98,762,558	99,416,279	(0.7)%
Physicians & Other Providers	129,087,290	138,827,955	(7.5)%
Prescription Drugs	236,731,256	243,047,769	(2.7)%
Miscellaneous Medical Payments	5,121,606	5,451,517	(6.4)%
Other Payments:			
Nursing Facilities	295,984,580	296,430,041	(0.2)%
ICF-MR Private	33,456,622	32,888,817	1.7%
Medicare Buy-In	56,023,506	57,829,757	(3.2)%
Quality of Care Payments:			
Nursing Home Rate Adjustment	149,620,616	149,620,616	0.0%
NET – ***SoonerRide***	521,437	521,437	0.0%
Personal Allowance Increase	4,055,420	4,055,420	0.0%
Coverage for DME and supplies	2,366,275	2,366,275	0.0%
Coverage of Qualified Medicare Beneficiaries	14,537,920	14,537,920	0.0%
ICF/MR Rate Adjustment	19,011,720	19,011,720	0.0%
	$ 1,704,389,879	**$ 1,719,432,293**	**(0.2)%**
OTHER OHCA MEDICAL PROGRAMS	**$ 6,274,112**	**$ 7,388,528**	**(17.8)%**
Total OHCA	**$ 1,780,496,491**	**$ 1,792,926,553**	**(0.7)%**
OTHER STATE AGENCY PROGRAMS			
Non-Medicaid Programs	$ 20,659,710	$ 10,575,905	48.8%
Dept. of Human Services Medicaid (OKDHS)	407,981,712	416,617,906	(2.1)%
Oklahoma State Dept. of Health (OSDH)	3,000,000	633,755	78.9%
Office of Juvenile Affairs Medicaid (OJA)	7,534,980	6,230,056	17.3%
Dept. of Mental Health Medicaid (DMHSAS)‡	24,064,182	17,843,318	25.9%
Department of Health Medicaid (OSDH)‡	1,900,000	1,299,918	31.6%
Department of Education Medicaid (DOE)‡	15,000,000	8,985,161	40.1%
Supplemental DSH Payments	2,292,711	892,779	61.1%
Education Payments	127,445,514	116,003,544	9.0%
Total Other State Agency Programs	**$609,878,809**	**$579,082,342**	**5.0%**
TOTAL ALL EXPENDITURES	**$ 2,390,375,300**	**$ 2,372,008,895**	**0.8%**

[12] Source: OHCA Finance Division (08/2002). Unless stated otherwise expenditures are state and federal dollars combined.
*_**SoonerCare**_ Choice figures represent capitated payments only. Noncapitated services are not included in this amount.
‡ Figures shown for DMHSAS, OSDH and DOE represent the federal share only of Medicaid program expenditures.

OHCA and Medicaid

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

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

Figure 12 Oklahoma Medicaid Breakout of *SoonerCare* and Fee-for-Service (June 2002)[13]

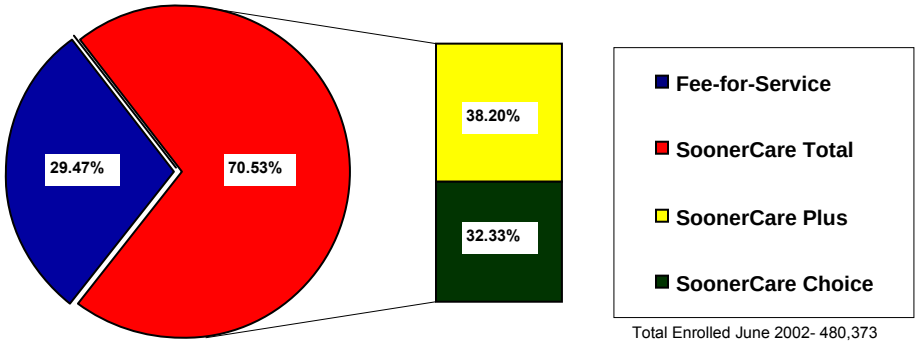


Figure 13 Eligibles by Delivery System (Adult and Child), SFY1999 through SFY2002

Delivery System		June 1999	June 2000	June 2001	June 2002	% Change from Prior SFY
***SoonerCare* Plus**	Adult	27,313	28,223	30,426	35,009	15%
	Child	66,871	114,304	131,957	148,494	13%
Total		94,184	142,527	162,383	183,503	13%
***SoonerCare* Choice**	Adult	12,437	24,602	23,271	26,135	12%
	Child	83,235	112,076	113,618	129,181	14%
Total		95,672	136,678	136,889	155,316	14%
Fee-for-Service	Adult	105,739	88,275	91,247	91,961	.8%
	Child	93,889	49,305	51,868	49,593	(4%)
Total		199,628	137,580	143,115	141,554	(1%)

[13] Source: OHCA ***SoonerCare*** Operations Division. Percents may not sum due to rounding.

OHCA and Medicaid (continued)

OHCA works in partnership with many other organizations and individuals. OHCA interacts with federal and tribal governments, hundreds of contractors, thousands of providers of care (including health plans, practitioners and facilities), in addition to clients and their families.

OHCA employs more than 275 persons directly and provides funding for more than 750 eligibility workers employed by the Department of Human Services.

These employees work in partnership with:

- Other state agencies and employees that provide program and administrative services for the Medicaid program.
- Private sector agents who conduct research and demonstration projects to advance important aspects of health care, including the development of new payment systems, delivery systems, and the improvement of quality.

OHCA staff perform an array of critical functions necessary for program administration, such as providing funds to Medicaid contractors; developing Medicaid payment policies; managing programs to fight waste, fraud and abuse; maintaining the operating systems that support Medicaid payments; developing more efficient operating systems; developing cost-effective health care purchasing approaches; monitoring contractor and provider performance; promoting and preserving client rights and protections; and disseminating information to the Oklahoma Legislature, clients and the general public.

Strategic Planning

Medicaid is a program of many faces. It covers healthy children whose families have very limited incomes; newborns, children and adults with severe medical problems; pregnant women with no other source of coverage; and elders who rely on Medicaid for prescription drugs and long-term care. Medicaid affects many people and a wide range of interests.

Medicaid is also a major player in the health care market. It provides support to major health care institutions in cities, suburbs and rural communities and plays a significant, but often hidden, role in local economies.

The Oklahoma Health Care Authority (OHCA) is responsible for overseeing the Medicaid program in Oklahoma. Oklahoma Medicaid has become an indispensable program for the most vulnerable segments of the population.

In carrying out our responsibilities, OHCA strives to be a leader in improving the delivery of cost-effective, appropriate, high quality health care for all of our clients, and in meeting the highest standards of administrative performance.

In order to be a leader, OHCA must continually plan. Changes in environmental forces are now so volatile a proactive planning stance is necessary for advantage rather than just for survival. Societal needs and expectations, technological advances, demographic and economic change – all indicate an opportune time for OHCA to take stock, assess its current position and strengths and build for the future. OHCA will set forth its goals and objectives for carrying out this work over the next five years in a Strategic Plan.

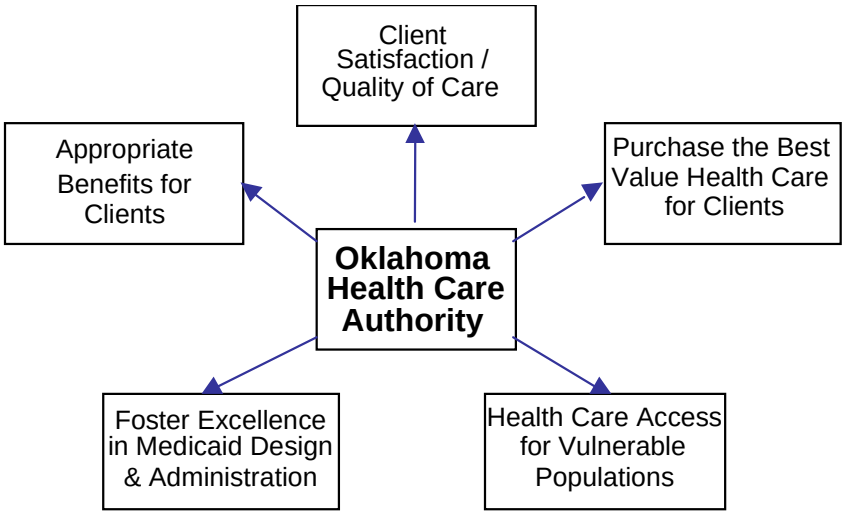
Strategic Planning (continued)

How seriously we take our responsibilities, how willing we are, as a state, to come together 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.

Broadly Stated Goals

The heart of the Strategic Plan is the statement of our primary strategic goals – - that short list of our 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 informed by a common set of agency values.

- Improve health care access for the underserved and vulnerable populations of Oklahoma. (Medicaid Eligibles)
- Protect and improve client health and satisfaction, as well as ensure quality, with programs, services and care. (Client Satisfaction/Quality of Care)
- Ensure that programs and services respond to the needs of clients by providing necessary medical benefits to our clients. (Benefits)
- Purchase the best value health care for clients by paying appropriate rates and training our medical providers to ensure access to medical services by our clients. (Purchasing Issues/Provider Relations)
- Foster excellence in the design and administration of the Medicaid program.



Operating Principles

As an adjunct to our Strategic Plan, the Oklahoma Health Care Authority developed a set of "operating principles" for the agency to clarify for ourselves and others how we need to operate in order to achieve our goals and objectives. In other words, the goals and objectives state what we aim to achieve as an agency and the operating principles state how we will work together to get there. These principles affirm that OHCA is committed to a culture that will support its mission.

Our Client Focus

- We will act based on the knowledge that clients are our primary customers and that OHCA's "reason for being" is to understand and respond to clients' needs for health care, for program-related information and for prompt, courteous service.
- We will use our market presence to actively seek high value health care for clients and encourage other purchasers of care to do the same.
- We will work toward the highest standards of service to clients, their families, and the public, providing clear information, prompt and accurate processing of claims, appeals, and correspondence.
- We will act, with appropriate partners, to help assure that clients receive equitable and nondiscriminatory services.

How We Work with Others in the Health Care System

- We will strive to be an even-handed and reliable business partner with plans, providers, states, contractors and other stakeholders in our programs.
- We will work collaboratively with our colleagues throughout the Oklahoma and federal government and territories, tribes, with accrediting bodies, beneficiary and provider advocacy groups and elsewhere to achieve mutual goals.
- We will demonstrate leadership in the public interest, consistent with our position as one of the largest public purchasers of health care in Oklahoma, including the effective use of our administrative and clinical data resources to improve health outcomes and services to the public.
- We will build on our record of successful implementation of legislated program changes to become more flexible and responsive to other changes in the health care environment.

How We Operate Within OHCA

- OHCA staff operates as members of the same team, with a common mission, and each with a unique contribution to make to our success.
- We will be open to new ways of working together, including creating project teams within and across agency divisions and units.
- We will become more consistent in our use of qualitative and quantitative data to guide and evaluate our actions and improve our performance in a purposeful way over time.

How We Want to be Recognized by Our Customers, Partners, and the Public

- We want to be recognized as the champion of OHCA program clients.
- We want to be recognized as an effective and efficient administrator of programs and a good steward of the funds entrusted to us by the taxpayers.
- We want to be recognized as a leader in the health care system, working toward access to high quality, high value health care for all.

Medicaid and the Economy

Most people do not think of Medicaid health care services beyond the critical role they play in meeting the needs of the vulnerable and underserved Oklahomans. Health care services are a substantial economic presence in Oklahoma. The health care sector affects the economy in much the same way a manufacturing plant does by bringing in money, providing jobs and wages to residents and providing an opportunity to keep health care dollars circulating within the state economy. Health care businesses, in turn, have an additional impact through the purchases of utility services and cleaning supplies, as well as the payment of property taxes. Just like the changes in a manufacturing plant or farm operations, changes in the health care sector influence the rest of the Oklahoma economy.

When we look at health care and the economy, there are several indicators we can consider. Traditionally, Medicaid funded health care services are evaluated by the number of individuals who are Medicaid eligible, provider rates, hospital utilization rates, the number of nursing facility home beds available or the number of participating medical providers. However, if we are going to compare the health care sector to the rest of the economy, we need to find numbers that are comparable to other sectors. There are three key indicators that could be reviewed total revenue, employment and personal income.

By looking at total revenues, we are able to gain some insight about the total economic activity that is occurring with the specific sector, as well as how it relates to the total economic activity of the state. Employment refers to the number of jobs in the state. Personal income is the wages earned from employment within various sectors. It gives us an idea of how much money an employee has to spend on goods and services, like housing, taxes, groceries and health care.

When indirect and induced effects are included, this analysis suggests that public dollars for health care support as many as 90,366 total jobs and $1.98 billion in personal income.

Figure 14 Estimated Direct and Indirect Impact of Oklahoma Medicaid Dollars[14]

	Public Expenditures*	Direct Jobs	Direct Income*	Total Jobs	Total Income*
Doctors and Dentists	$ 227,465,307	2,518	$ 139,263,524	5,885	$ 213,200,875
Nursing and Protective Care	612,985,934	24,634	359,738,619	33,627	548,441,791
Hospitals	548,156,471	10,445	333,905,031	18,318	503,752,677
Other Medical	983,491,176	19,763	430,118,188	32,536	716,360,419
Total	$ 2,372,098,888	57,360	$ 1,263,025,362	90,366	$ 1,981,755,762

* Dollars in millions.

[14] Model for the estimated economic impact associated with public expenditures for health care developed by the Oklahoma Department of Commerce.

Reader Notes

Oklahoma Medicaid Services

What is a Waiver?

Before Oklahoma could transition its Medicaid program to one of managed care, the state had to request a waiver from the federal Centers for Medicare and Medicaid Services (CMS).

States apply for waivers of Medicaid rules to test innovative approaches to benefits, services, eligibility, program payments and service delivery. The federal government allows states to request waivers specifically to "waive" certain federal requirements of the program. CMS waivers allow for some state flexibility in the design of its managed care delivery system; and, managed care models can vary based on available community resources, geographic location and experience in managed care practices. Oklahoma operates under a Section 1115(a) waiver. Section 1115(a) demonstrations allow states to test new approaches to benefits, services, eligibility, program payments and service delivery, often on a statewide basis. These approaches are frequently aimed at saving money to allow states to extend Medicaid coverage to additional low-income and uninsured people. Under its current waiver, Oklahoma has chosen to develop and implement two, distinct managed care delivery systems within its Medicaid program – ***SoonerCare*** Plus and ***SoonerCare*** Choice.

Family Planning Waiver

Oklahoma is requesting a five-year Research and Development Waiver to expand Medicaid eligibility for family planning benefits to Oklahoma women, men and couples with incomes at-or-below 185 percent of the federal poverty level. Without this waiver, these individuals would otherwise be ineligible for family planning services under the current Medicaid program.

OHCA received a letter July 9, 2001 from the new Commissioner of Health and State Health Officer, Leslie M. Beitsch, M.D., J.D, expressing support of the 1115(a) Waiver and requesting OHCA to begin the submission process. On July 26, 2001, OHCA hosted an organizational meeting with Oklahoma State Department of Health (OSDH) and Oklahoma Department of Human Services (OKDHS) to discuss necessary modifications to the original draft and coordination issues that will be required for processing the waiver application. OHCA has submitted the waiver application to the federal partner, Centers for Medicare and Medicaid Services, and is awaiting its decision. If approved, this program could be started in SFY2004. This project is a collaborative effort between OHCA, OSDH, OKDHS and the Oklahoma State Medical Association.

What is a Waiver? (continued)

Home and Community-Based Services (HCBS) Waivers

Medicaid Home and Community-Based Services (HCBS) waivers afford states the flexibility to develop and implement creative alternatives to placing Medicaid-eligible individuals in hospitals, nursing facilities (NF) or intermediate care facilities for persons with mental retardation (ICF/MR). The HCBS waiver program, authorized under §1915(c) of the Social Security Act, recognizes that many individuals at risk of being placed in these facilities can be cared for in their own homes and communities, preserving their independence and ties to family and friends at a cost no higher than that of institutional care. The state of Oklahoma operates four Home and Community-Based Services waivers (HCBS). Three waivers serve people with mental retardation and, under the provisions of the State's Alternative Disposition Plan (ADP), certain persons with "related conditions". The fourth waiver serves the frail elderly and adult disabled.

The Home and Community-Based Services waivers operated by Oklahoma are as follows:

Community Waiver: Serves approximately 3,180 clients with mental retardation and certain persons with "related conditions". This waiver covers children and adults, with the minimum age being 3 years old.

In-Home Supports Waiver for Adults: This waiver is designed to assist the state in removing adult individuals (ages 18 years of age and older) with mental retardation from a waiting list. This waiver serves approximately 700 adults.

In Home Supports Waiver for Children: This waiver is designed to assist the state in removing children ages 3 through 17 years with mental retardation from a waiting list. This waiver serves approximately 280 children.

ADvantage Waiver: This waiver serves the "frail elderly" (Oklahomans whose age is 65 years and older) and adults with physical disabilities. The "frail elderly" comprise approximately 80 percent of this waiver's consumer population and the remaining 20 percent are adults with physical disabilities. Approximately 13,900 persons receive services through this waiver program.

Services through these waiver programs are available to individuals when the client can be served safely in the community setting and the cost of providing waiver services to waiver clients is less than the cost of providing institutional services in a long-term care facility (NF or ICF/MR). Waiver services are specifically defined in each Waiver Agreement, and, depending on each person's needs as identified in his or her individual Plan of Care, could include skilled nursing, prescription drugs (in excess of the State Plan limit), adult day care services, specialized equipment and supplies, home delivered meals, comprehensive home health care, personal care, respite care, architectural modifications, habilitation services, vocational and pre-vocational services, adaptive equipment, supported employment and various therapies.

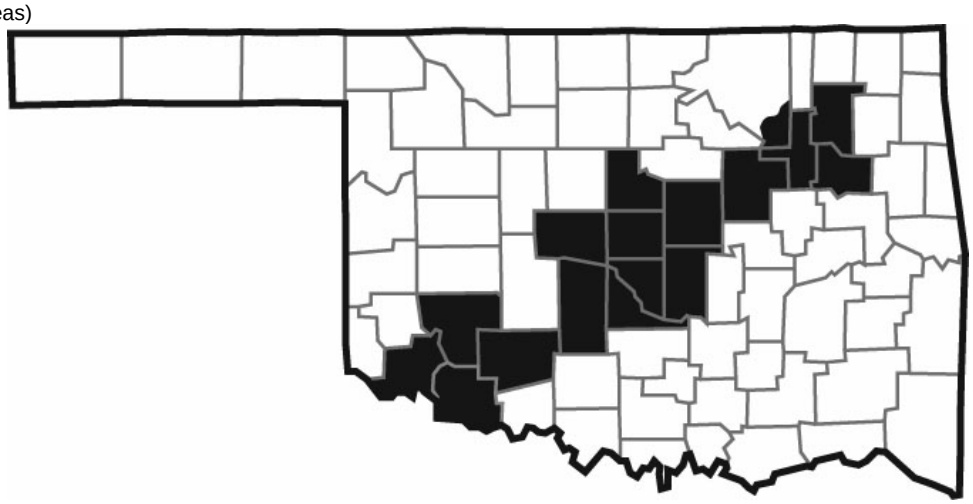
Oklahoma Managed Care-*SoonerCare* Plus

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

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

Figure 15 *SoonerCare* Plus Catchment Areas[15]

(Darkened Areas)



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

Southwest – 15,791 Enrolled*	**Central - 105,100 Enrolled***	**Northeast – 62,612 Enrolled***
Comanche	Canadian	Creek
Jackson	Cleveland	Rogers
Kiowa	Grady	Tulsa
Tillman	Lincoln	Wagoner
	Logan	Osage (limited)
	McClain	
	Oklahoma	
	Pottawatomie	

SFY2002 Specific Information…

- The $358,088,015 ***SoonerCare*** Plus dollars accounted for 20 percent of the total OHCA Medicaid dollars expended in SFY2002.
- As of June 30, 2002, the ***SoonerCare*** Plus program had 183,503 persons enrolled.

[15] Source: OHCA ***SoonerCare*** Operations Division. Effective January 1, 2001.
* Enrolled figures are for the month of June 2002, as of June 30, 2002.

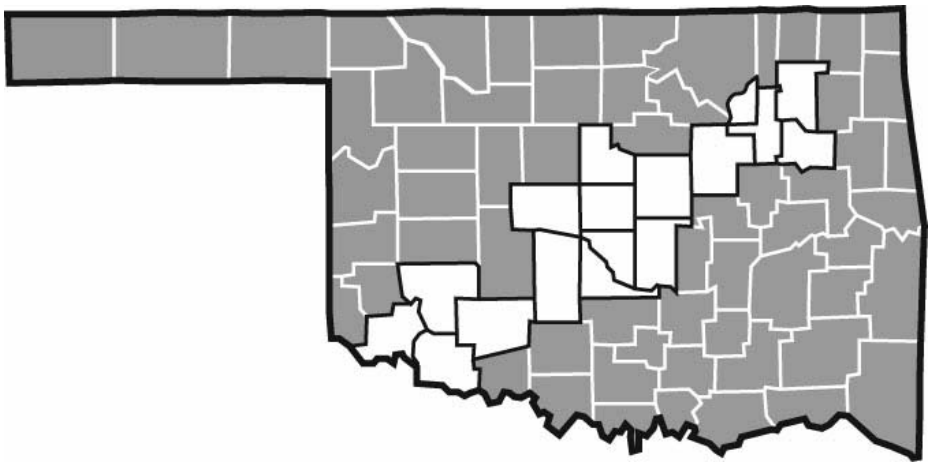
Oklahoma Managed Care-*SoonerCare* Choice

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

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

Figure 16 *SoonerCare* Choice Catchment Areas[16]

(Darkened Areas)



Identifying the need to coordinate care for ***SoonerCare*** members with complex medical needs, the ***SoonerCare*** program created a Care Management Team. This team is composed of medical and social professionals who support the Oklahoma Medicaid provider networks in both ***SoonerCare*** Choice and Plus programs and fee-for-service areas through research, collaboration and problem resolution as related to members' care.

This is a personalized feature of the ***SoonerCare*** program where experienced and caring individuals directly interact with both members and providers by timely facilitating and coordinating members' care to the most appropriate facility, utilizing the most appropriate resources.

SFY2002 Specific Information…

- Dollars expended in capitated payments during SFY2002 on behalf of ***SoonerCare*** Choice members totaled $28,564,617 or 1.6 percent of the total OHCA Medicaid expenditures.
- As of June 30, 2002, the ***SoonerCare*** Choice program had 155,316 persons enrolled.

[16] Source: OHCA ***SoonerCare*** Operations Division. Effective January 1, 2001.

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

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

And Then Came SCHIP…
Subsequently, the Federal Budget Act of 1997 made numerous Medicaid changes and also created the State Children's Health Insurance Program (SCHIP). The optional program, referred to as SCHIP or Title XXI, is designed to help states cover additional uninsured low-income children with a higher federal match assistance percentage (See Figure 9 Historical Federal Medical Assistance Percentage, Page 13).

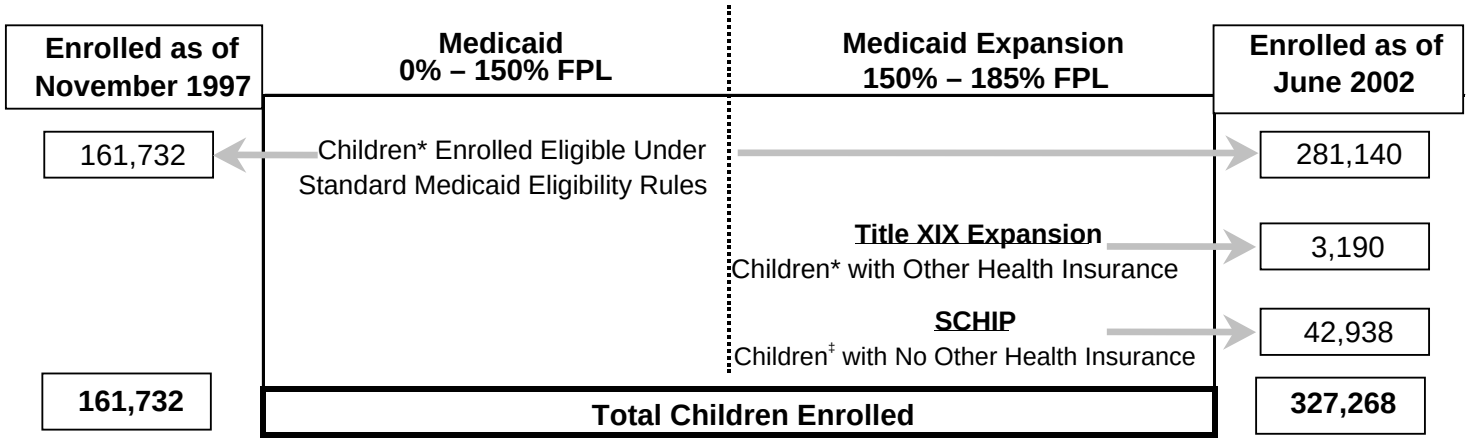
Oklahoma SCHIP defines eligibility for "targeted low-income children" as children who meet all of the following criteria:

- Have no creditable insurance;
- Family income below 185 percent of federal poverty (FPL) guidelines;
- Under age 19; and
- Not eligible for Medicaid under eligibility criteria in effect prior to November 1997 or any other federal health insurance program. Uninsured children who meet previous eligibility standards must be enrolled in Medicaid, not SCHIP.

With SCHIP, the federal poverty guidelines for Oklahoma children were raised from 150 percent to 185 percent. This increased the allowable monthly income from $1,735 monthly gross to the current $2,316 monthly gross (both based on a family size of three).

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

Figure 17 Increased Enrollment of Children Since Implementing Expansion Programs*



*Children as defined above are enrolled children under the age of 21, except for SCHIP eligibles.
‡ Only children 19 and under are eligible for SCHIP as of June 2002.

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

Most Federal SCHIP Dollars Unattainable for Oklahoma…

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

Behavioral Health Services

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

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

SFY2002 Specific Information…

- Expenditures for the behavioral health program totaled $99,416,279 for SFY2002

Early Periodic Screening, Diagnosis and Treatment (EPSDT)

The federally mandated Early Periodic Screening, Diagnosis and Treatment (EPSDT) package is a set of comprehensive health services for children up to age 21. EPSDT is designed to provide access to health care and help parents of Medicaid-eligible children use these resources.

Regular health exams help to ensure that health problems are diagnosed and treated early. The main goal is to help parents receive preventive care for their children rather then just rely on acute or emergency care. This program allows families to identify potential health problems early. Services under EPSDT include physicals, eye and hearing exams, dental exams, immunizations, nutritional review, lead screening, lab tests and screening for speech, behavioral health and substance abuse problems.

Graduate Medical Education (GME)

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

Payments are made to the major colleges of medicine based on the number of managed care clients where Primary Care Physicians (PCP) are qualified participants. The state matching funds are transferred to OHCA from the University Hospital Authority.

Specific SFY2002 Information…

- Graduate medical education payments, under the ***SoonerCare*** program, totaled $31,710,192; this accounted for 8 percent of the SFY2002 ***SoonerCare*** expenditures.
- Payments made to GME qualified colleges of medicine:

	SFY2002
University of Oklahoma – OKC	$ 14,241,728
University of Oklahoma – Tulsa	$ 13,784,817
Oklahoma State University College of Osteopathic Medicine – Tulsa	$ 3,683,647

Hospitals

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

Disproportionate Share Hospital (DSH) Payments

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

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

Indirect Medical Education (IME)

Acute care hospitals that qualify as major teaching hospitals receive an indirect medical education (IME) payment adjustment that covers the increased operating or patient care costs associated with approved intern or resident programs. Currently, the only qualifying hospitals are the OU Medical Center in Oklahoma City and the Hillcrest health system hospitals in Tulsa.

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

- Be licensed in the state of Oklahoma;
- Have 150 or more full-time equivalent residents enrolled in approved teaching programs using the 1996 annual cost report; and
- Belong to the Council of Teaching Hospitals or show proof of affiliation with an approved Medical Education Program.

Hospitals (continued)

Direct Medical Education (DME)

In-state hospitals that qualified as teaching hospitals received a supplemental payment adjustment for direct medical education (DME) expenses based on resident-months. These payments were made in order to encourage training in rural hospital and primary care settings and to recognize the loss of support for GME due to the advent of managed care capitation programs.

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

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

These payments are made by allocating a pool of funds by the share of residents per month to total residents per month in all qualifying hospitals. The state matching funds are transferred to OHCA from the University Hospital Authority.

DME Qualified Hospitals	SFY2002
(1) Integris Baptist Medical Center	$ 3,240,736
(2) Integris – Bass Baptist Health Care Center	$ 97,392
(3) Integris – Southwest Medical Center	$ 787,994
(4) Bone and Joint Hospital – OKC	$ 223,571
(5) Deaconess Hospital	$ 743,210
(7) St. Michael's Hospital – OKC	$ 2,117,698
(8) Hillcrest Medical Center – Tulsa	$ 6,286,140
(9) Laureate Psych Hospital	$ 92,451
(10) Medical Center of Southeastern Oklahoma	$ 487,513
(11) St. Anthony	$ 3,008,456
(12) Saint Francis	$ 3,570,556
(13) St. John	$ 4,076,536
(14) Tulsa Psych Center	$ 300,038
(15) Tulsa Regional Medical	$ 8,573,898
(16) University Health Partners	$ 26,890,477
(17) Jane Phillips Hospital	$ 153,156
(18) Comanche County Memorial Hospital	$ 225,672
(19) Shadow Mountain/Brown Schools Hospital	$ 8,752
Total	**$ 60,884,246**

SFY2002 Specific Information…

- Hospital expenditures, $268,774,138 accounted for 15 percent of OHCA's total Medicaid expenditures.
- During SFY2002, the Oklahoma Medicaid program had individual contracts with 374 hospitals.
- Disproportionate Share Hospital payments were made to 13 hospitals for a total amount of $16,770,682 in SFY2002.

Long-Term Care

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

While much is being said about the future consequences of an aging population on society, Medicaid programs are facing significant long-term health care challenges today. The elderly growth rate is predicted to remain steady until 2010; however, by 2030 one in five Americans will be elderly. More significantly, the oldest population (85 years and over) is predicted to double between 1990 and 2010, and more than double again by 2040.[17] Because Medicaid is a major payer of long-term care services, states will face a much greater financial burden than they do today.

Quality of Care

The Quality of Care Program is intended to improve the quality of care received by long-term care residents. A fee per patient day is collected from long–term care facilities and placed in a revolving fund. Monies from this fund are used to pay for the higher facility reimbursement rate; increased staffing requirements; program administrative costs; and expanded Medicaid benefits that include non-emergency transportation (***SoonerRide***) and attendants; eyeglasses and dentures; and personal needs allowance increases for long-term care Medicaid clients. The fund also provides for coverage of expanded durable medical equipment and supplies services for adults and Medicaid services for Qualified Medicare Beneficiaries.

Additionally, funds are being used by other state agencies such as the Oklahoma State Department of Health to increase staff dedicated to investigations and on-site surveys of long-term care facilities as well as the Department of Human Services for 10 regional ombudsmen.

Level of Care Evaluations – Long-Term Care Clients

In order to ensure that those individuals applying for nursing home care are appropriately placed, the federal Pre-Admission Screening and Resident Review (PASRR) Program provides a Level I screening to all persons, private pay and Medicaid, entering a long-term care facility for possible developmental disability or mental retardation (MR) and/or mental illness (MI). Furthermore, federal requirements also require that a higher level evaluation (Level II) be performed for those applicants who appear to be either mentally ill or developmentally disabled. The Level II assessment insures that the client requires a long-term care facility and receives proper treatment for their MI and/or MR diagnosis.

SFY2002 Specific Information…

- Expenditures for nursing facilities (NF) serving adults were $296,430,041; expenditures for private intermediate care facilities for the mentally retarded (ICF/MR) were $32,888,817.
- Total long-term care expenditures accounted for 18 percent of the total OHCA Medicaid expenditures.
- Medicaid clients living in long-term care facilities represented an estimated 3 percent of the total Medicaid clients.
- Medicaid funded 6,337,054 long-term care facility bed days; this represents 77.3 percent of the total actual bed days for SFY2001 (last available cost report data).
- Total Quality of Care Program revenues were $53,672,433 and the state share of the total $190,674,227 Quality of Care expenditures was $56,304,159.
- OHCA performed 15,824 Level I screens, resulting in a subsequent 1,769 Level II evaluations.

[17] Source: Kaiser Commission on *Medicaid and the Uninsured,* November 1999.

Medicare "Buy-In" Program

In order to help protect low-income Medicare beneficiaries from the Medicare program's cost-sharing requirements, Congress has enacted several programs. Under the Medicare Catastrophic Coverage Act (MCCA) of 1988, Congress required each state's Medicaid program to "buy-in" to Medicare for low-income beneficiaries and persons with disabilities by paying for Medicare premiums, deductibles and coinsurance. Medicare is made up of two parts, hospital insurance (Part A) and supplementary medical insurance (Part B). Subsequent legislation was also passed in order to cover individuals with slightly higher income levels. Individuals eligible for both Medicare and Medicaid coverage through any of the Medicare assistance programs are collectively known as the dual eligible populations, or "dual eligibles".

The Oklahoma Health Care Authority recently acted to reduce Medicaid expenditures because of declining state revenues and increased program costs. One action included the reduction of Medicare Part B coinsurance payment for Part B services to a level consistent with current Medicaid fees. This reduction will eliminate payment of Part B coinsurance and reduce the payment for Part B deductible to 75 percent. Since the combined payment from Medicare and Medicaid will be comparable to the Medicaid fee schedule, the patient cannot be billed for any unpaid coinsurance and/or deductible. The change applies to services provided on or after February 1, 2002.

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

1. Qualified Medicare Beneficiary (QMB)
   - For Medicare beneficiaries with incomes below 100 percent of the federal poverty level who have limited financial resources.
   - Pays for Medicare beneficiaries' share of Medicare Part A and Part B premiums.
2. Specified Low-income Medicare Beneficiary (SLMB)
   - For Medicare beneficiaries whose incomes are at least 100 percent, but less than 120 percent of the federal poverty level who have limited financial resources.
   - Pays for beneficiaries' share of Medicare Part B premiums.
3. Qualifying Individuals (QI)

   QI-1's (Qualifying Individual Group 1):
   - For Medicare beneficiaries whose incomes are at least 120 percent, but less than 135 percent of the federal poverty level who have limited financial resources.
   - Pays the Medicare Part B premiums for beneficiaries who are not otherwise eligible for Medicaid.

   QI-2's (Qualifying Individual Group 2):
   - For Medicare beneficiaries whose incomes are at least 135 percent, but less than 175 percent of the federal poverty level who have limited financial resources.
   - Pays for a portion of the Medicare Part B premiums for beneficiaries who are not otherwise eligible for Medicaid.

SFY2002 Specific Information…

- Medicare "Buy-In" expenditures accounted for 3.2 percent of the total Medicaid expenditures.
- "Buy-In" expenditures totaled $57,829,757 for SFY2002.
- An average of 3,538 Part A premiums and 67,418 Part B premiums were paid each month.

Medicaid and Native Americans

The state of Oklahoma is home to 39 tribal governments.[18] Thirty-eight are federally recognized as sovereign nations and another has applied for federal recognition. According to the 2000 Census, Oklahoma is home to a population of more than 380,000 tribal members. The Cherokee Nation, located in Tahlequah, is the second largest tribe in the United States with more than 222,000 members.

Some tribes still obtain all of their health care services for tribal members through Indian Health Services (IHS). However, the role of IHS in Oklahoma is being increasingly changed and diminished through the evolution of some very sophisticated individual tribal health care systems such as the Cherokee, Chickasaw, Creek and Choctaw Nations. None of these systems are exactly alike and each system needs different types of resources and levels of support from OHCA. CMS central office initiated several policies that give tribes a greater role in the development and operations of the state Medicaid program as they affect tribal members. CMS has structured the implementation of these policies in such a way that the responsibility for day-to-day operations has been shifted from the federal government (CMS) to individual state Medicaid programs.

In response to the CMS policies regarding Native Americans, representatives from 15 state Medicaid programs with large numbers of tribal members, including Oklahoma, formed an informal "Indian Health Work Group". OHCA also participates in quarterly meetings of the Oklahoma City Area Inter-Tribal Health Board. Additionally, OHCA has a tribal consultation process that allows both formal and informal comment from tribal leaders on matters that have a direct impact on their health care delivery systems such as the submission of a family planning waiver.

SoonerCare *and Native Americans*

Since Oklahoma Medicaid began a managed care system in 1995, Native Americans have been included in the ***SoonerCare*** Choice managed care program. However, they retain the option to self-refer to any Indian Health Service facility, Tribal health facility or Urban Indian Clinic (I/T/U) for services that are available on site. This model was developed through the collaboration of OHCA and I/T/U providers and allowed Native Americans the option to continue to seek services through these "traditional providers."

Though this model initially served to facilitate member access to I/T/U facilities, it also created an administratively cumbersome coordination and referral process. OHCA worked in collaboration with IHS, tribal leaders and CMS to develop a new managed care model for the ***SoonerCare*** Choice program, which would allow I/T/U providers to serve as primary care physicians (PCPs). Under this new model, I/T/U providers can provide culturally sensitive case management to Native American ***SoonerCare*** Choice members. The I/T/U providers act as PCPs and make referrals and coordinate additional services such as specialty care and hospitalization when patients access care facilities that are not operated by tribes or IHS. This model was approved by CMS in March 2001 and was implemented in July 2001.

SFY2002 Specific Information…

- The state of Oklahoma has an estimated tribal population of 380,000.
- For the month of June 2002 there were 60,391 persons categorized as Native American enrolled in Medicaid.
- Oklahoma Indian Health Service providers received approximately $6,880,989 in Medicaid payments.

[18] Source: Oklahoma Indian Affairs, August 8, 2001.

Pharmacy Program

Although coverage is optional under federal law, prescription drugs are currently covered by every state's Medicaid program. States have opted to cover pharmaceuticals because their use may prevent illness or delay complications from chronic diseases, provide an alternative to expensive surgery or result in shorter hospital stays. In spite of those benefits, treatment with prescription drugs can be costly. Federal law governing Medicaid prescription drug programs seeks to balance optimal use against cost-containment.

Expenditures are offset by the Federal Drug Rebate Program that guarantees that states pay the lowest cost for prescription drugs. In exchange for the rebate, states assure manufacturers that their products will be made available to Medicaid clients. Reimbursement to pharmacies is continuously monitored to assure a fair price is paid in exchange for goods and services provided by pharmacists.

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

SFY2002 Specific Information…

- Prescription drug program expenditures accounted for $243,047,769 or 14 percent of the total Oklahoma Medicaid expenditures.
- The average cost per prescription funded by Medicaid was $53.50.
- The average annual prescription cost per patient funded by Medicaid was $195.12.
- $48 million dollars were collected through the Drug Rebate program. For more information see page 39.

Physicians and Other Practitioners

Physicians and other practitioners are a crucial component in the delivery of health care to Oklahoma's Medicaid eligibles. This service to clients, as with all other Medicaid programs, is based on medical necessity, with physicians determining the need for medical care. Physicians provide this care directly and prescribe or arrange for additional health benefits. It is the physician who determines what drugs a patient receives, decides when a patient needs nursing facility or inpatient hospital care and controls the care of the patient in an institution. Participating providers are the cornerstone of the Medicaid program, coordinating and providing the health care needs of individuals in the Oklahoma Medicaid program.

SFY2002 Specific Information…

- Expenditures for physicians and other practitioners accounted for $138,827,955, or 8 percent of Oklahoma's total Medicaid expenditures.

School Based Services

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

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

One of the greatest challenges to the success of the programs and the prevention and detection of childhood illnesses is reaching children early and informing families about available comprehensive health services, such as Early Periodic Screening, Diagnosis and Treatment, or EPSDT.

Many school systems across Oklahoma are participating in EPSDT and other beneficial programs. With Medicaid program assistance, many schools can now afford to employ nurses and health programs to help keep children healthy and productive. Schools may receive reimbursement for Medicaid eligible children who are also eligible for services under the Individuals with Disabilities Education Act (IDEA). The Individual Education Program (IEP) is a treatment plan for a successful education for students with disabilities. The schools outline the treatment plan and OHCA funds any Medicaid compensable health services recommended in the plan for Medicaid eligible children.

OHCA is involved in the Early Intervention (EI/SoonerStart) program. The EI/SoonerStart program is focused on the early medical intervention and treatment of children age birth to 3 years that are developmentally delayed. Services for the EI program such as Targeted Case Management, speech and physical therapy are provided by the State Department of Education and the Oklahoma State Department of Health. OHCA offers provider training and reimbursement for this program.

SFY2002 Specific Information…

- OHCA contracted with 322 school based providers in 72 counties.
- During SFY2002, OHCA paid $1,261,078 for the Early Intervention (EI/SoonerStart) program.
- School based providers were reimbursed $13,467,815 for SFY2002.
- For more information regarding EPSDT, see page 26.

SoonerRide (Non-Emergency Transportation)

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

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

Nursing home residents in the Medicaid program receive non-emergency transportation benefits. This benefit for nursing home residents is funded by the Quality of Care fee (see Long-Term Care).

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

SFY2002 Specific Information…

- The non-emergency transportation program costs were $7,341,155; this represented less than 1 percent of the total Oklahoma Medicaid expenditures.
- Non-emergency transportation expenditures increased by 24 percent from SFY2001 to SFY2002.

Figure 18 Medicaid Program – Overview of Benefits (as of June 2002)

Benefit	Fee-For-Service	*SoonerCare* Choice	*SoonerCare* Plus	Benefit Notes and/or Limitations
Assistive Technology	**1**	**1**	**2**	**1)** Children only and requires a prior authorization. **2)** Does not require a prior authorization and includes cognitive and developmental aids and augmentative and communication aids.
Behavioral health services	**X**	**X**	**X**	
Case management services	**X**	**X**	**X**	
Dental services	**1**	**1**	**2**	**1)** Limited to emergency extractions. **2)** Adults are not covered except for reconstructive surgery and emergency extractions. ABD adult members of ***SoonerCare*** Plus limited to emergency dental care, extractions and dentures.
Diabetic supplies	**X**	**X**	**X**	One glucometer, one spring loaded lancet device and three replacement batteries per calendar year as well as 100 glucose strips and 100 lancets per month.
Durable medical equipment including medical supplies	**1**	**1**	**2**	**1)** Includes, but is not limited to, oxygen, oxygen concentrators, respirators and ventilators — (respirator and ventilator rentals require a prior authorization). **2)** Includes oxygen, oxygen concentrators, respirators and ventilators-aids for daily living and personal care, mobility and positioning aids, standing and walking aids, hearing aids and visual aids.
Early Periodic Screening, Diagnosis & Treatment (EPSDT) for children	**X**	**X**	**X**	6 visits before age 1; 2 visits between ages 1 and 2; 1 yearly visit for ages 2 though 5; 1 visit every other year for ages 6 through 20. **Includes:** Physical exam, eye and hearing exam, dental exam, nutritional review, lead screening, lab tests, speech screening and visit for behavioral health and substance abuse problems.
Educational classes			**X**	
Exceptional Needs Coordinator for ABD members	**1**	**1**	**2**	**1)** Provided by OHCA. **2)** Provided by the plans.
Family planning services	**X**	**X**	**X**	
Home health care services	**1**	**1**	**2**	**1)** Limited to 36 visits per calendar year. **2)** Unlimited when medically necessary.
Inpatient hospital services	**1**	**1**	**2**	**1)** Limited to 24 days per state fiscal year. (July 1 through June 30) **2)** Unlimited when medically necessary.
Laboratory and X-ray	**X**	**X**	**X**	

This overview represents the basic covered Medicaid services. Benefits are not necessarily limited to the above.

Figure 18 Medicaid Program- Overview of Benefits (continued)

Benefit	Fee-For-Service	*SoonerCare* Choice	*SoonerCare* Plus	Benefit Notes and/or Limitations
Long-Term Care	**1**		**2**	**1)** Includes various "routine services" such as dental exams, dentures, limited durable medical equipment, over-the-counter medications, eyeglasses and exams, transportation and other services not listed. **2)** Coverage for the first 30 days.
Maternity services	**X**	**X**	**X**	
Nurse Advice Line		**X**	**X**	
Nurse midwife services and birthing center services	**X**	**X**	**X**	
Outpatient hospital services	**X**	**X**	**X**	
Outpatient surgery	**X**	**X**	**X**	
Over-the-counter contraceptives	**X**	**X**	**X**	
Podiatry services	**X**	**X**	**X**	
Prescription drugs	**1**	**2**	**3**	**1)** Unlimited for children and limited to 3 per month for certain eligible persons over age of 21 years. **2)** Unlimited for children, adults limited to 3 per month. **3)** Unlimited.
Physician services	**1**	**2**	**3**	**1)** Adults are limited to 2 outpatient visits per month. **2)** Unlimited PCP/CM, specialty visits limited to 2 per month for adults. **3)** Unlimited.
Therapy services	**X**	**X**	**X**	Occupation Therapy, Physical Therapy and Speech Therapy.
Transportation	**X**	**X**	**X**	To covered Medicaid services only.
Vision services	**1**	**1**	**2**	**1)** For children. Adults are covered for treatment of eye injury or diseases of the eye only. **2)** Adults are covered for treatment of eye injury or diseases of the eye. ***SoonerCare*** Plus ABD adults ages 21 through 45 – one routine eye exam plus one pair of glasses each 24 months; age 46 or older – one routine eye exam and one pair of glasses each 12 months.

This overview represents the basic covered Medicaid services. Benefits are not necessarily limited to the above.

Program and Payment Integrity Activities

The Oklahoma Health Care Authority protects taxpayer dollars and the availability of Medicaid services to individuals and families in need by coordinating an agency-wide effort to identify, recover and prevent inappropriate provider billings and payments.

Improper payments in government health programs, such as Medicaid, drain vital program dollars, hurting clients and taxpayers. Such payments include those made for treatments or services that are not covered by program rules that were not medically necessary, that were billed but never actually provided or have missing or insufficient documentation to show whether the claim was appropriate. Improper Medicaid payments can result from inadvertent errors, as well as intended fraud and abuse. Unlike inadvertent errors, which are often due to clerical errors or a misunderstanding of program rules, fraud involves an intentional act to deceive for gain, while abuse typically involves actions that are inconsistent with acceptable business and medical practices.

Within Oklahoma, two major agencies share responsibility for protecting the integrity of the state Medicaid program. The OHCA is responsible for ensuring proper payment and recovering misspent funds, while the Attorney General's Medicaid Fraud Control Unit (MFCU) is responsible for investigating and ensuring prosecution of Medicaid fraud.

In addition to the OHCA and MFCU, other state and federal agencies assist in dealing with Medicaid improper payments. Because of their responsibility to ensure sound fiscal management in their states, state auditors may become involved in Medicaid payment safeguard activities through efforts such as testing payment system controls or investigating possible causes of mispayment. At the federal level, both the Centers for Medicare and Medicaid (CMS) and the Office of Inspector General of the Department of Health and Human Services (DHHS-OIG) oversee state program and payment integrity activities.

Actions as a result of the program and payment integrity efforts may include:

- Clarification and streamlining of OHCA policies, rules and billing procedures;
- Increased payment integrity, recovery of inappropriately billed payments and avoidance of future losses;
- Education of providers regarding proper billing practices;
- Termination of providers from participation in the Oklahoma Medicaid program;
- Referrals to the Attorney General's Medicaid Fraud Control Unit (MFCU).

Surveillance Utilization and Review Services (SURS)

The Medicaid agency is federally required (42 CFR 455-456) to provide methods and procedures to safeguard against unnecessary utilization of care and services. SURS staff utilize analytical tools, some of which involve computer-assisted reviews of all providers within a class to identify providers whose claims exceed pre-set thresholds or have abused specific Medicaid policies.

Pharmacy Audits

The Pharmacy Unit is responsible for auditing or performing desk reviews of pharmacy provider records. Audits and desk reviews are performed to determine that claims paid by the Oklahoma Health Care Authority for prescription drugs are valid and in compliance with applicable federal and state rules and regulations.

Program and Payment Integrity Activities (continued)

Audit, Design & Evaluation

Audit, Design and Evaluation staff perform audits and reviews of external providers with regard to inappropriate billing practices and noncompliance with OHCA policy and other applicable federal and state laws and regulations.

Risk-based approaches may be employed to determine potential areas for audit or review. Identification of erroneous payments may also take on more traditional forms. Staff can initiate reviews of providers based on complaints from other Medicaid providers or clients, concerned citizens and staff from other state agencies.

Peer Review Organization (PRO)

Some Medicaid services are subject to utilization review by a Peer Review Organization (PRO) under contract with OHCA. The PRO conducts a medical hospital retrospective random sample review on services provided to Medicaid clients in the fee-for-service program. The purpose of the inpatient hospital utilization review program is to safeguard against unnecessary and inappropriate medical care rendered to Medicaid clients. Medical services and/or records are reviewed for medical necessity, quality of care, appropriateness of place of service and length of stay. Three hundred hospital admissions are reviewed on a monthly basis.

Additionally, the PRO performs on-site inspection of care reviews for licensed psychiatric inpatient and day treatment facilities that provide services to Medicaid clients less than 21 years of age. These reviews include evaluation and monitoring of facility accreditation status, as well as evaluation of medical record documentation and program utilization. The PRO currently under contract with OHCA is the Oklahoma Foundation for Medical Quality (OFMQ). Additional information on OFMQ may be found at www.ofmq.com.

Figure 19 Program and Payment Integrity Recoveries, SFY1999 through SFY2002[19]

Provider Type	SFY1999	SFY2000	SFY2001	SFY2002
ADvantage Waiver	$ 4,821	–	$ 45,640	$ 58,765
Home and Community-Based Waiver	–	$ 55,693	$ 37,670	$ 81,005
Behavioral Health	$ 1,318,748	$ 1,655,210	$ 591,070	$ 1,239,265
DME Supplies	–	$ 12,500	$ 25,728	$ 109,145
Inpatient Hospital	$ 299,561	$ 323,531	$ 1,145,540	$ 337,391
Long-Term Care Facilities	$ 13,586	$ 73,826	$ 104,191	$ 1,293,931
Physician	$ 157,252	$ 20,798	$ 10,730	$ 8,523
Pharmacy	$ 235,137	$ 485,411	$ 438,892	$ 146,068
EPSDT	–	–	$ 17,560	$ 58,765
Other Practitioners	$ 19,669	$ 70,324	$ 58,186	$ 5,542
Client	–	$ 2,312	$ 14	–
HMO	–	$ 121,060	$ 113,314	$ 276,359
Total – OHCA Recoveries	**$ 2,048,774**	**$ 2,699,605**	**$ 2,475,221**	**$ 3,614,759**
Medicaid Fraud Control Unit	$ 123,329	$ 1,268,305	$ 832,423	$ 1,003,518
Total Medicaid Recoveries	**$ 2,172,103**	**$ 3,967,910**	**$ 3,298,644**	**$ 4,618,277**

[19] Figures are a combination of amounts recovered from SURS, Pharmacy, Audit, Design and Evaluation and PRO reviews.

Program and Payment Integrity Activities (continued)

Third Party Liability (TPL)

The Third Party Liability (TPL) program reduces costs to the Medicaid program by identifying third parties liable for payment of a client's medical expenses. States are federally required to have a system to identify medical services that are the legal obligation of third parties, such as private health or accident insurers. Such third party liability resources should be exhausted prior to the paying of claims with program funds (cost avoidance). Where a third party is established after the claim is paid, reimbursement from the third party should be sought (42 CFR Sections 433.135 – 433.154).

It should be noted that OHCA is responsible for pursuing third party payers for both the fee-for-service and ***SoonerCare*** Choice program areas. Under the ***SoonerCare*** Plus program area, the individual health plans are responsible for their own third party liability activities.

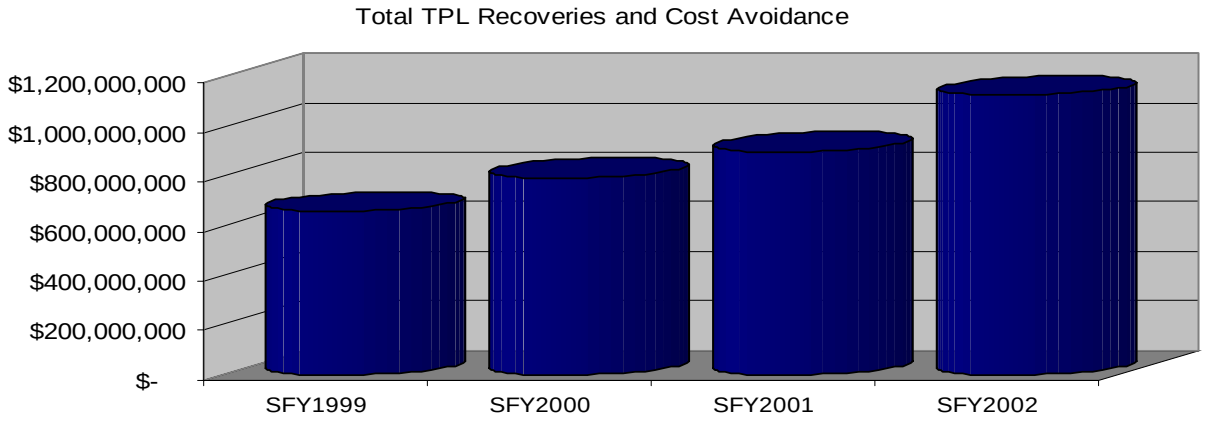
To do this, Medicaid uses a combination of data matches, diagnosis code edits and referrals from providers, caseworkers and clients to identify available third party resources such as health and liability insurance. The TPL program also ensures that Medicaid recovers any costs incurred when available resources are identified through liens and estate recovery programs.

Figure 20 Third Party Liability Recoveries, SFY1999 through SFY2002

	SFY1999	SFY2000	SFY2001	SFY2002
Estate Recoveries	N/A	$ 414,156	$ 793,886	$ 3,756,885
Credit Balance Reviews	N/A	N/A	$ 912,111	$ 437,658
Other	$ 4,229,507	$ 4,410,197	$ 5,462,911	$ 4,618,887
Total Recoveries	**$ 4,229,507**	**$ 4,824,353**	**$ 7,168,908**	**$ 8,813,430**

Figure 21 Third Party Liability Cost Avoidance, SFY1999 through SFY2002

	SFY1999	SFY2000	SFY2001	SFY2002
Medicare	$ 613,636,651	$ 665,670,727	$ 827,824,935	$ 1,050,191,256
Private Insurance	$ 43,889,308	$ 130,654,043	$ 68,163,756	$ 73,405,534
Total Cost Avoidance	**$ 657,525,959**	**$ 796,324,770**	**$ 895,988,691**	**$ 1,123,596,790**



Fees, Rebate and Penalty Collections

LTC Quality of Care Program Fees

In an effort to increase the quality of care received by long-term care clients, the Quality of Care (QOC) Program was put into place. A fee per patient day is collected from long-term care facilities and placed in a revolving fund. Monies from this fund are used to pay for the higher facility reimbursement rate; increased staffing requirements; program administrative costs and other increased client benefits. Additionally, funds are being used by other state agencies such as the Oklahoma State Department of Health to increase staff dedicated to investigations and on-site surveys of long-term care facilities and the Department of Human Services for 10 regional ombudsmen.

Facilities receive monthly invoices for fee payment based on their self-reported patient census and revenues. Quality of Care fees and/or reports not submitted timely are subject to a penalty.

Drug Rebate Program

The Drug Rebate Program (established by the enactment of the Omnibus Budget Reconciliation Act of 1990) was designed to allow the Medicaid program to receive rebates on reimbursed drugs so that the net cost to Medicaid would be equal to the lowest prices paid by other large purchasers or the lowest "best" charged by manufacturers.

Drug manufacturers are invoiced on a quarterly basis. Interest is assessed by the OHCA on late payments.

Figure 22 Fees, Rebate and Penalty Collection, SFY1999 through SFY2002

	SFY1999	SFY2000	SFY2001	SFY2002
Quality of Care Fees	N/A	N/A	$ 33,849,967	$ 53,672,433
Drug Rebates	$ 30,822,228	$ 36,346,124	$ 40,032,308	$ 48,348,254
Penalties/Interest	N/A	N/A	$ 391,379	$ 257,447
Total Collections	**$ 30,822,228**	**$ 36,346,124**	**$ 74,273,654**	**$ 102,278,134**

Other Program Savings Initiatives

Product Based Prior Authorization

The Oklahoma Health Care Authority (OHCA) implemented a Product Based Prior Authorization program, effective January 4, 2000. The goal of the Product Based Prior Authorization program is to optimize each patient's medical therapy with medication that best treats the patient's condition given his or her unique health status and circumstances.

The figure below focuses on savings the program achieved on two therapeutic classes, non-steroidal anti-inflammatory drugs (NSAIDs) and anti-ulcer drugs (H2 Antagonists/Proton Pump Inhibitors). These savings figures do not include the additional drug classes that were approved in SFY2002 (anti-hypertensive and anti-hypertensive/diuretic combinations). Each class of medication requires prior authorization. OHCA wants to stress that a patient with clinical exceptions or a patient that has not tolerated or did not achieve clinical success with a Tier 1 product previously can obtain a Tier 2 medication via the prior authorization process.

Figure 23 Product Based Prior Authorization Cost Avoidance[20]

SFY2000	SFY2001	SFY2002
$5,190,903	$12,199,677	$11,562,601

Medical Case Management

In order to ensure that Medicaid pays for only those services that are medically necessary and appropriate, OHCA's staff of medical professionals review requests for prior authorizations. Requests that are not medically necessary and/or appropriate are denied and "cost avoided".

Figure 24 Medical Case Management Cost Avoidance, SFY1999 through SFY2002

	SFY1999	SFY2000	SFY2001	SFY2002
MRI Denials	$ 104,344	$ 219,524	$ 190,306	$ 154,822
Ultrasound Denials	$ 101,175	$ 112,019	$ 50,001	$ 10,026
Other Claim Denials	$ 1,311,852	$ 3,557,028	N/A	N/A
Chemotherapy Adjustments[21]	$ 2,676,077	$ 1,139,300	N/A	N/A
Outpatient Exception Report	$ 856,606	$ 1,524,519	$ 139,831	$ 105,067
Total	**$ 5,050,053**	**$ 6,552,390**	**$ 380,138**	**$ 269,915**

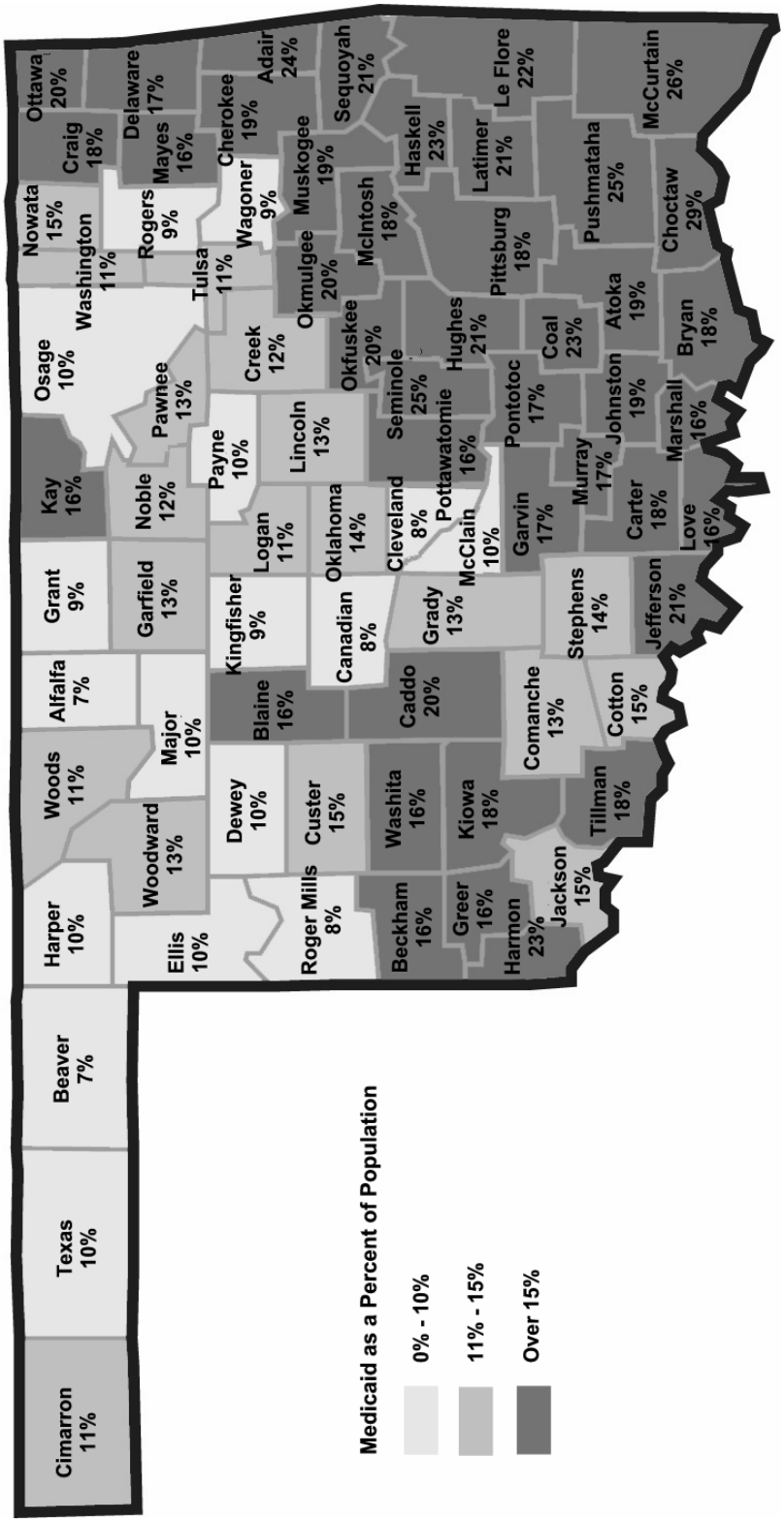
[20] Savings adjusted for inflation, utilization and population increases.

[21] Chemotherapy adjustment data only reported for October 2000. As of November 2000, chemotherapy adjustments automatically process through a MMIS system edit.

Reader Notes

Statewide SFY2002 Figures

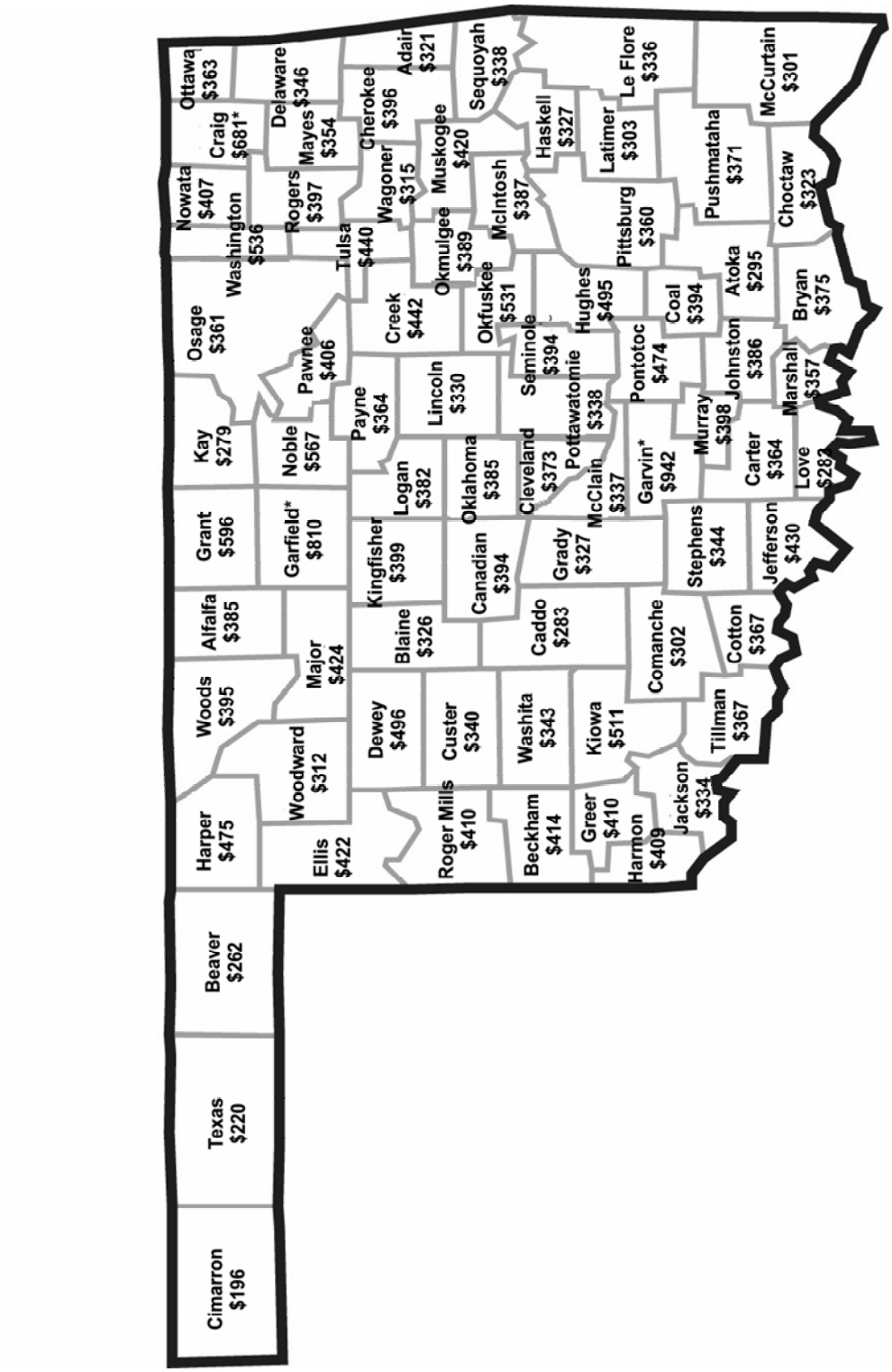
Figure 25 Percent of Oklahoma Population Enrolled in Medicaid (as of June 30, 2002)[22]



[22] Source: Data is based on persons enrolled in Medicaid in June of 2002, as a percent of year 2001 projected Census data from the Oklahoma Department of Commerce.

Statewide SFY2001 Figures (continued)

Figure 26 Average Dollars Spent per Medicaid Client per Month[23]



* Note: Garfield and Garvin counties have public institutions, and Craig County has eight private institutions for the developmentally disabled (ICF/MRs) causing the average dollars per Medicaid client to be higher than the norm.

[23] Source: Data extracted from client eligibility files on July 8, 2002. Numbers frequently change due to retro-certifications and other factors. Claim dollars were extracted from the claim history file for claims *paid* within the fiscal year.

Figure 27 Statewide Medicaid Figures

County	Proj. Population 2001 Census[24]	Rank	Clients [25]	Rank	Pop. Covered by Medicaid	Rank
ADAIR	21,118	38	4,967	31	23.52%	5
ALFALFA	6,005	68	438	72	7.29%	76
ATOKA	14,011	46	2,718	45	19.40%	18
BEAVER	5,640	70	409	73	7.25%	77
BECKHAM	19,846	39	3,265	40	16.45%	33
BLAINE	11,920	51	1,892	54	15.87%	40
BRYAN	36,477	26	6,427	21	17.62%	27
CADDO	29,966	32	6,121	25	20.43%	14
CANADIAN	89,978	5	6,885	18	7.65%	75
CARTER	45,909	17	8,348	11	18.18%	22
CHEROKEE	42,697	21	8,166	12	19.13%	19
CHOCTAW	15,169	44	4,360	34	28.74%	1
CIMARRON	3,023	77	337	76	11.15%	57
CLEVELAND	211,908	3	16,829	3	7.94%	73
COAL	6,074	67	1,400	61	23.05%	8
COMANCHE	112,466	4	14,160	4	12.59%	53
COTTON	6,528	66	965	66	14.78%	44
CRAIG	14,757	45	2,604	46	17.65%	26
CREEK	68,488	8	8,452	9	12.34%	54
CUSTER	25,358	36	3,696	38	14.58%	45
DELAWARE	37,699	25	6,278	22	16.65%	32
DEWEY	4,672	72	460	71	9.85%	66
ELLIS	3,952	73	399	74	10.10%	64
GARFIELD	57,114	12	7,648	15	13.39%	48
GARVIN	27,105	35	4,674	32	17.24%	29
GRADY	46,139	16	5,957	27	12.91%	50
GRANT	5,091	71	470	70	9.23%	69
GREER	5,883	69	934	67	15.88%	39
HARMON	3,155	76	731	68	23.17%	7
HARPER	3,464	74	358	75	10.33%	62
HASKELL	11,763	53	2,726	44	23.17%	6
HUGHES	13,927	47	2,986	41	21.44%	10
JACKSON	27,661	34	4,267	35	15.43%	42
JEFFERSON	6,623	65	1,383	63	20.88%	13
JOHNSTON	10,569	59	1,996	53	18.89%	21
KAY	47,541	15	7,395	16	15.55%	41
KINGFISHER	13,854	48	1,259	64	9.09%	70
KIOWA	9,945	60	1,751	57	17.61%	28
LATIMER	10,634	57	2,249	50	21.15%	12
LEFLORE	48,041	14	10,338	7	21.52%	9

[24] Source: County Population Estimates 2001, U.S. Bureau of the Census Oklahoma State Data Center – Oklahoma Department of Commerce http://www.odoc.state.ok.us/index.html

[25] Clients listed above represent an unduplicated count of individuals that were enrolled in Medicaid for the month of June 2002. The data does not represent the number of individuals eligible within the year.

Figure 27 Statewide Medicaid Figures (continued)

County	Total Annual Expenditures	Rank	Annual Per Capita	Rank	Monthly Per Client	Rank
ADAIR	$19,122,990	34	$906	19	$321	65
ALFALFA	$2,023,843	73	$337	74	$385	36
ATOKA	$9,622,521	50	$687	38	$295	71
BEAVER	$1,283,466	76	$228	77	$262	75
BECKHAM	$16,236,415	40	$818	26	$414	19
BLAINE	$7,406,853	58	$621	48	$326	63
BRYAN	$28,928,822	23	$793	30	$375	39
CADDO	$20,751,475	31	$693	35	$283	73
CANADIAN	$32,585,120	18	$362	71	$394	30
CARTER	$36,433,388	13	$794	29	$364	45
CHEROKEE	$38,817,033	11	$909	18	$396	28
CHOCTAW	$16,914,966	38	$1,115	9	$323	64
CIMARRON	$792,936	77	$262	75	$196	77
CLEVELAND	$75,377,435	3	$356	72	$373	40
COAL	$6,619,541	61	$1,090	10	$394	31
COMANCHE	$51,373,900	7	$457	64	$302	69
COTTON	$4,251,028	67	$651	46	$367	43
CRAIG*	$21,270,949	30	$1,441	2	$681	3
CREEK	$44,797,526	8	$654	44	$442	13
CUSTER	$15,097,452	43	$595	50	$340	54
DELAWARE	$26,034,340	26	$691	37	$346	51
DEWEY	$2,737,799	71	$586	53	$496	9
ELLIS	$2,018,929	74	$511	58	$422	17
GARFIELD*	$74,310,282	4	$1,301	3	$810	2
GARVIN*	$52,807,212	6	$1,948	1	$942	1
GRADY	$23,376,802	29	$507	60	$327	62
GRANT	$3,363,770	70	$661	41	$596	4
GREER	$4,589,991	66	$780	31	$410	21
HARMON	$3,588,273	69	$1,137	7	$409	22
HARPER	$2,039,504	72	$589	52	$475	11
HASKELL	$10,701,217	48	$910	17	$327	61
HUGHES	$17,744,803	35	$1,274	5	$495	10
JACKSON	$17,092,381	37	$618	49	$334	59
JEFFERSON	$7,131,500	60	$1,077	12	$430	15
JOHNSTON	$9,241,843	52	$874	20	$386	35
KAY	$24,746,618	27	$521	56	$279	74
KINGFISHER	$6,023,719	62	$435	67	$399	25
KIOWA	$10,740,965	47	$1,080	11	$511	8
LATIMER	$8,188,614	55	$770	32	$303	68
LEFLORE	$41,663,831	10	$867	21	$336	58

* Note: Garfield and Garvin counties have public institutions, and Craig County has eight private institutions for the developmentally disabled (ICF/MRs) causing the average dollars per Medicaid client to be higher than the norm.

Figure 27 Statewide Medicaid Figures (continued)

County	Proj. Population 2001 Census[26]	Rank	Clients [27]	Rank	Pop. Covered by Medicaid	Rank
LINCOLN	32,154	31	4,089	36	12.72%	52
LOGAN	34,209	28	3,811	37	11.14%	58
LOVE	8,863	62	1,423	60	16.06%	35
MCCLAIN	27,825	33	2,757	43	9.91%	65
MCCURTAIN	34,194	29	8,965	8	26.22%	2
MCINTOSH	19,522	41	3,504	39	17.95%	24
MAJOR	7,528	64	724	69	9.62%	67
MARSHALL	13,433	49	2,139	52	15.92%	38
MAYES	38,697	24	6,196	24	16.01%	36
MURRAY	12,721	50	2,143	51	16.85%	30
MUSKOGEE	69,887	7	13,221	5	18.92%	20
NOBLE	11,388	56	1,393	62	12.23%	55
NOWATA	10,634	57	1,630	59	15.33%	43
OKFUSKEE	11,781	52	2,392	47	20.30%	15
OKLAHOMA	662,153	1	90,947	1	13.74%	47
OKMULGEE	39,715	22	7,897	13	19.88%	16
OSAGE	45,034	18	4,627	33	10.27%	63
OTTAWA	33,046	30	6,469	20	19.58%	17
PAWNEE	16,845	43	2,255	49	13.39%	49
PAYNE	67,830	9	7,025	17	10.36%	61
PITTSBURG	43,779	19	7,800	14	17.82%	25
PONTOTOC	34,611	27	5,819	28	16.81%	31
POTTAWATOMIE	66,269	10	10,737	6	16.20%	34
PUSHMATAHA	11,706	54	2,959	42	25.28%	4
ROGER MILLS	3,331	75	261	77	7.84%	74
ROGERS	74,066	6	6,527	19	8.81%	72
SEMINOLE	24,652	37	6,235	23	25.29%	3
SEQUOYAH	39,262	23	8,357	10	21.29%	11
STEPHENS	42,970	20	5,986	26	13.93%	46
TEXAS	19,754	40	1,878	55	9.51%	68
TILLMAN	9,146	61	1,662	58	18.17%	23
TULSA	564,079	2	63,102	2	11.19%	56
WAGONER	59,059	11	5,322	29	9.01%	71
WASHINGTON	49,087	13	5,284	30	10.76%	60
WASHITA	11,473	55	1,831	56	15.96%	37
WOODS	8,832	63	969	65	10.97%	59
WOODWARD	18,392	42	2,354	48	12.80%	51
TOTAL	**3,460,097**		**477,388**		**13.80%**	

[26] Source: County Population Estimates 2001, U.S. Bureau of the Census Oklahoma State Data Center – Oklahoma Department of Commerce http://www.odoc.state.ok.us/index.html

[27] Clients listed above represent an unduplicated count of individuals that were enrolled in Medicaid for the month of June 2002. The data does not represent the number of individuals eligible within the year. Totals do not include custody children or clients temporarily residing out of state.

Figure 27 Statewide Medicaid Figures (continued)

County	Total Annual Expenditures	Rank	Annual Per Capita	Rank	Monthly Per Client	Rank
LINCOLN	$16,173,613	41	$503	61	$330	60
LOGAN	$17,460,923	36	$510	59	$382	38
LOVE	$4,839,283	64	$546	55	$283	72
MCCLAIN	$11,154,769	45	$401	69	$337	57
MCCURTAIN	$32,342,528	19	$946	15	$301	70
MCINTOSH	$16,292,391	39	$835	24	$387	34
MAJOR	$3,680,155	68	$489	62	$424	16
MARSHALL	$9,173,699	53	$683	39	$357	49
MAYES	$26,309,047	25	$680	40	$354	50
MURRAY	$10,245,131	49	$805	27	$398	26
MUSKOGEE	$66,581,671	5	$953	14	$420	18
NOBLE	$9,470,058	51	$832	25	$567	5
NOWATA	$7,957,334	56	$748	34	$407	23
OKFUSKEE	$15,244,481	42	$1,294	4	$531	7
OKLAHOMA	$419,871,232	1	$634	47	$385	37
OKMULGEE	$36,831,045	12	$927	16	$389	33
OSAGE	$20,034,250	33	$445	66	$361	47
OTTAWA	$28,190,366	24	$853	23	$363	46
PAWNEE	$10,999,576	46	$653	45	$406	24
PAYNE	$30,725,231	21	$453	65	$364	44
PITTSBURG	$33,683,550	16	$769	33	$360	48
PONTOTOC	$33,105,838	17	$957	13	$474	12
POTTAWATOMIE	$43,590,729	9	$658	42	$338	55
PUSHMATAHA	$13,188,091	44	$1,127	8	$371	41
ROGER MILLS	$1,285,180	75	$386	70	$410	20
ROGERS	$31,057,149	20	$419	68	$397	27
SEMINOLE	$29,477,759	22	$1,196	6	$394	32
SEQUOYAH	$33,899,694	15	$863	22	$338	56
STEPHENS	$24,677,353	28	$574	54	$344	52
TEXAS	$4,948,196	63	$250	76	$220	76
TILLMAN	$7,329,222	59	$801	28	$367	42
TULSA	$333,470,905	2	$591	51	$440	14
WAGONER	$20,143,356	32	$341	73	$315	66
WASHINGTON	$33,976,082	14	$692	36	$536	6
WASHITA	$7,530,186	57	$656	43	$343	53
WOODS	$4,591,164	65	$520	57	$395	29
WOODWARD	$8,805,785	54	$479	63	$312	67
TOTAL*	**$2,256,187,080**		**$652**		**$394**	

* The expenditure figures are based on data extracted of claims paid through the claims payment system (MMIS). Therefore, the financial information may not be equal due to expenditures made that are not processed through the MMIS.

Figure 28 Dollars Paid to Providers and Clients by County in SFY2002

County	Total Dollars Paid by Provider County	Total Dollars Paid by Client County	% of Dollars Staying in County
ADAIR	$9,041,092	$19,122,990	47%
ALFALFA	$1,202,574	$2,023,843	59%
ATOKA	$5,473,883	$9,622,521	57%
BEAVER	$906,706	$1,283,466	71%
BECKHAM	$13,555,833	$16,236,415	83%
BLAINE	$5,009,398	$7,406,853	68%
BRYAN	$36,163,600	$28,928,822	125%
CADDO	$14,639,786	$20,751,475	71%
CANADIAN	$12,383,326	$32,585,120	38%
CARTER	$31,586,732	$36,433,388	87%
CHEROKEE	$30,495,223	$38,817,033	79%
CHOCTAW	$10,385,432	$16,914,966	61%
CIMARRON	$581,495	$792,936	73%
CLEVELAND	$50,684,848	$75,377,435	67%
COAL	$3,563,027	$6,619,541	54%
COMANCHE	$49,408,886	$51,373,900	96%
COTTON	$2,019,745	$4,251,028	48%
CRAIG	$18,104,075	$21,270,949	85%
CREEK	$48,967,292	$44,797,526	109%
CUSTER	$13,801,118	$15,097,452	91%
DELAWARE	$15,852,638	$26,034,340	61%
DEWEY	$2,666,236	$2,737,799	97%
ELLIS	$1,733,715	$2,018,929	86%
GARFIELD	$65,268,495	$74,310,282	88%
GARVIN	$45,152,911	$52,807,212	86%
GRADY	$11,993,696	$23,376,802	51%
GRANT	$2,207,685	$3,363,770	66%
GREER	$2,980,146	$4,589,991	65%
HARMON	$2,903,515	$3,588,273	81%
HARPER	$1,651,811	$2,039,504	81%
HASKELL	$14,428,145	$10,701,217	135%
HUGHES	$8,963,964	$17,744,803	51%
JACKSON	$8,978,963	$17,092,381	53%
JEFFERSON	$4,885,177	$7,131,500	69%
JOHNSTON	$5,897,249	$9,241,843	64%
KAY	$19,424,122	$24,746,618	78%
KINGFISHER	$7,810,741	$6,023,719	130%
KIOWA	$9,707,693	$10,740,965	90%
LATIMER	$4,247,604	$8,188,614	52%
LEFLORE	$28,411,518	$41,663,831	68%

Figure 28 Dollars Paid to Providers and Clients by County in SFY2002 (continued)

County	Total Dollars Paid by Provider County	Total Dollars Paid by Client County	% of Dollars Staying in County
LINCOLN	$7,958,498	$16,173,613	49%
LOGAN	$9,018,777	$17,460,923	52%
LOVE	$2,500,320	$4,839,283	52%
MCCLAIN	$6,098,513	$11,154,769	55%
MCCURTAIN	$23,969,051	$32,342,528	74%
MCINTOSH	$13,401,362	$16,292,391	82%
MAJOR	$2,597,750	$3,680,155	71%
MARSHALL	$5,998,739	$9,173,699	65%
MAYES	$12,318,143	$26,309,047	47%
MURRAY	$6,385,081	$10,245,131	62%
MUSKOGEE	$65,774,345	$66,581,671	99%
NOBLE	$7,221,138	$9,470,058	76%
NOWATA	$5,708,157	$7,957,334	72%
OKFUSKEE	$10,216,448	$15,244,481	67%
OKLAHOMA	$617,656,936	$419,871,232	147%
OKMULGEE	$24,746,240	$36,831,045	67%
OSAGE	$6,502,498	$20,034,250	32%
OTTAWA	$25,912,905	$28,190,366	92%
PAWNEE	$7,272,991	$10,999,576	66%
PAYNE	$26,192,405	$30,725,231	85%
PITTSBURG	$28,955,799	$33,683,550	86%
PONTOTOC	$39,065,100	$33,105,838	118%
POTTAWATOMIE	$20,417,243	$43,590,729	47%
PUSHMATAHA	$11,487,143	$13,188,091	87%
ROGER MILLS	$679,078	$1,285,180	53%
ROGERS	$19,678,927	$31,057,149	63%
SEMINOLE	$20,089,264	$29,477,759	68%
SEQUOYAH	$28,067,777	$33,899,694	83%
STEPHENS	$19,566,149	$24,677,353	79%
TEXAS	$4,578,067	$4,948,196	93%
TILLMAN	$3,218,374	$7,329,222	44%
TULSA	$391,815,471	$333,470,905	117%
WAGONER	$7,108,268	$20,143,356	35%
WASHINGTON	$23,311,059	$33,976,082	69%
WASHITA	$3,827,998	$7,530,186	51%
WOODS	$3,560,974	$4,591,164	78%
WOODWARD	$8,550,154	$8,805,785	97%
TOTAL*	**$2,144,567,234**	**$2,256,187,080**	**95%**

* Totals will not match due to custody children and out-of-state provider and client dollars not being included in the figures.

Provider Contracts

Each provider wishing to provide Medicaid compensable services must have an approved provider contract with the OHCA. The volume and changes in the number of provider contracts, by type of provider, is monitored in order to ensure appropriate access to medical services.

Figure 29 Contracted Medicaid Providers by Type, SFY1999 though SFY2002

Provider Type	June 1999	June 2000	June 2001	June 2002
HMOs	8	10	10	10
Physicians				
Physician	10,809	12,211	8,509	10,452
Group Practice	1,218	1,468	1,630	1,109
Pharmacy	1,007	1,029	1,090	1,138
Vision Care Providers				
Optometrist	391	390	390	401
Optician	50	39	43	38
Dentist	301	292	296	335
LTC Facilities	428	422	419	422
Inpatient Providers				
Hospitals	425	529	265	374
Inpatient Psychiatric Service Centers	79	86	40	54
Mental Health Providers				
Psychologist	343	323	311	304
Licensed Counselor	89	82	72	100
Outpatient Mental Health Centers	420	359	311	278
Family Counseling	30	38	48	61
Lab Providers				
Independent Lab	46	50	69	77
Portable X-Ray/Radiologist	3	2	5	10
Medical Supplies/Durable Goods Dealer	837	1,096	1,292	783
Clinics				
Rural Health Clinic	76	73	60	49
Clinic	15	16	14	16
Free Standing Ambulatory Surg. Centers	33	31	48	49
Federally Qualified Health Centers	4	4	4	6
Early Intervention	1	1	1	1
Speech/Hearing Clinic	-0-	3	3	3
Free Standing Dialysis Facilities	40	58	61	65
Family Planning Centers	6	6	6	6
DDSD/HCBW Providers*				
Architect Modification	67	60	65	78
Transportation/HCBW	249	265	247	303
Homemaker Services	269	276	227	251
Employment Specialist	80	91	97	108
Adaptive Equipment	136	136	144	182
Non-Fed Med DDSD	1,228	1,353	1,330	1,266
DDSD	41	40	41	44
Room/Board	7	4	4	5
Transportation	177	162	178	163

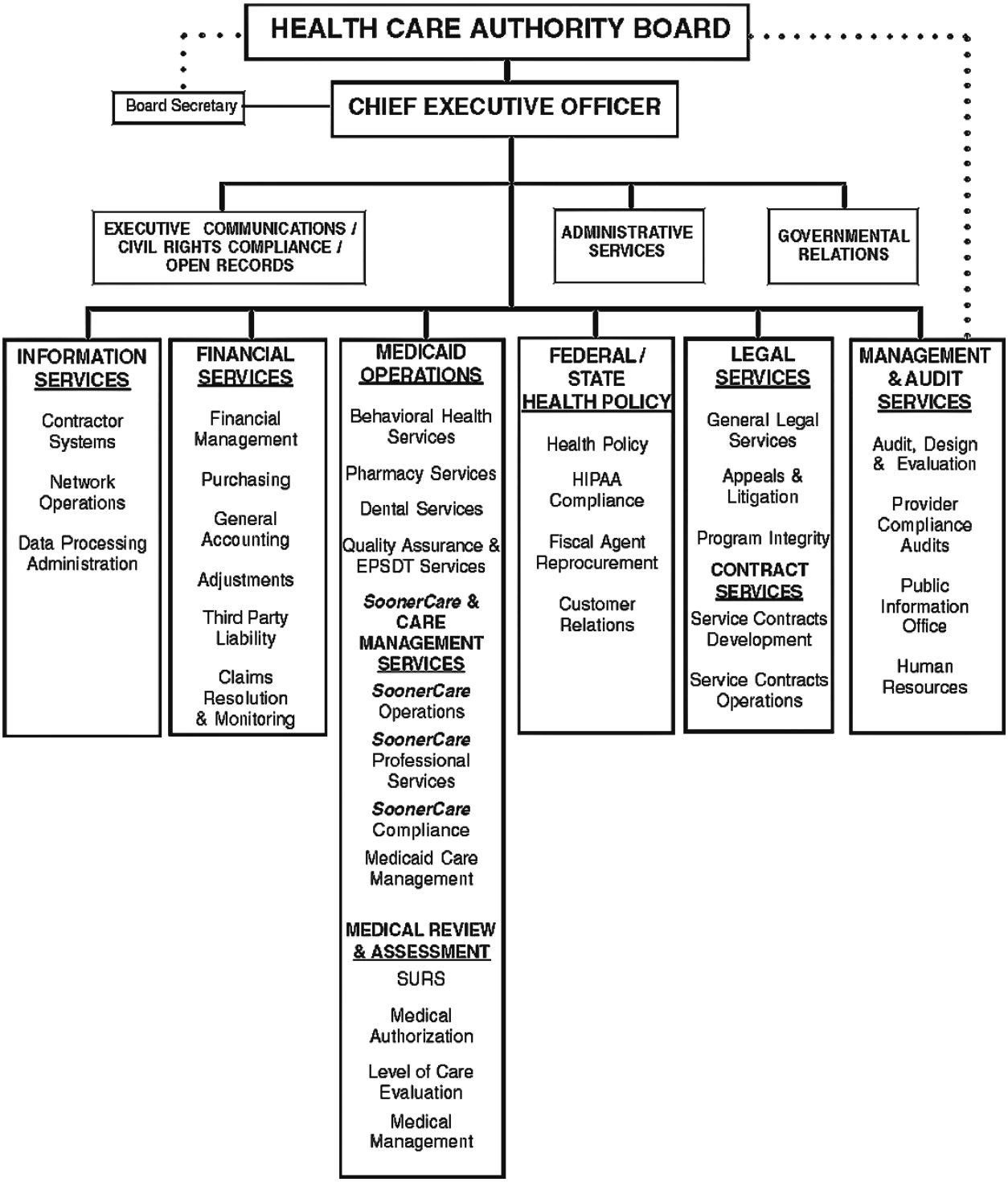
* DDSD is an acronym for Developmentally Disabled Services Division. HCBW is the acronym for the Home and Community-Based Waiver.

Provider Contracts (continued)

Figure 29 Contracted Medicaid Providers by Type, SFY1999 though SFY2002 (continued)

Provider Type	June 1999	June 2000	June 2001	June 2002
ADvantage Waiver Providers				
ADV Skill Home	52	45	41	44
ADV Health Care	10	9	9	9
ADV Nursing Facility Respite	40	53	60	71
ADV Home Delivery Meals	18	18	20	20
ADV Case Managers	21	21	21	23
Home Health Providers				
Personal Care Providers	475	127	110	111
Home Health Agencies	-0-	136	142	159
Agency Personal Care	54	46	41	45
Other Practitioners				
Chiropractor	53	46	43	28
Audiologist	59	59	54	62
Nutritionist	51	53	81	114
Physical Therapist	259	303	297	330
Certified Nurse Practitioner	83	112	211	254
Certified Nurse Midwife	12	8	9	11
Respite Care	255	248	185	210
Home Nurse	14	10	10	16
Direct Support Service	167	174	232	251
Specialized Foster Care/MR	211	226	216	228
Case Managers	148	91	86	91
Certified Registered Nurse Anesthetist	293	326	361	422
Other Practitioners	155	146	174	178
School EPSDT	306	394	348	327
Residential Behavior	22	22	22	19
Physician Assistant	113	117	289	458
Birthing Centers	1	1	2	2
Occupational Therapist	2	167	161	203
Physical Therapy Assistant	4	5	4	4
Podiatrist	69	68	69	61
Skilled Nursing	47	39	35	48
Speech Pathologist	-0-	318	290	363

Figure 30 OHCA's Organizational Chart



Organization as of June 30, 2002.
SFY2002 authorized FTE – 285.5

Core Function Summary

Executive Office and Executive Office Support *17 Full Time Equivelants (FTE)*[*]

Executive Communication/Information and Referral/Civil Right Compliance documents, controls and distributes for informational purposes and for timely responses to requests, all federal, state and other customer correspondence which comes addressed only to OHCA or which agency personnel have authorized the unit to process. Additionally, the Civil Rights Compliance Officer reports directly to the CEO and is responsible for planning, directing and managing all phases of the Affirmative Action program involving targeted recruitment, assessment of programmatic outcomes, required state and federal statistical analysis, as well as management and employee counseling. (4 FTE) *Director and Civil Rights Compliance Officer, Donna Huckleberry (405) 522-7452.*

Administrative Services answers and directs all calls which come into the main agency telephone number through the reception desk and coordinates space requests and general maintenance issues. The Administrative Services Unit also performs the administration, maintenance and monitoring of a variety of activities, including the agency's vehicles, security and telephone systems, a continuing program for the economical and efficient management of agency records in compliance with state statute, as well as sorting and delivering all incoming and outgoing mail to appropriate designations. (9 FTE) *Administrative Chief of Staff, James Smith (405) 522-7150.*

Government Relations acts as a liaison between the agency and the legislative and executive branches of state government providing clarification and information regarding agency programs and operations. This unit also provides assistance to legislators regarding constituent concerns within the scope of the OHCA and coordinates fiscal, policy and program impacts with agency staff regarding potential and pending legislation. (2 FTE) *Director, Dana Brown (405) 522-2704.*

Medicaid Operations *93 Full Time Equivelants (FTE)*[*]

Lynn Mitchell, M.D., M.P.H., Director of Medicaid/Medicaid Operations

Behavioral Health Services interfaces with other state agencies, consumer groups, providers and internal OHCA units regarding mental health and substance abuse treatment services purchased by the Oklahoma Medicaid program in the ***SoonerCare*** and fee-for-service programs. This unit develops recommendations for improving purchasing methodologies and quality improvement mechanisms to increase the effectiveness and efficiency of behavioral health care purchased through OHCA. The Behavioral Health Unit provides contract oversight for the Oklahoma Foundation for Medical Quality (OFMQ) prior authorization and quality of care services, Department of Mental Health and Substance Abuse Services and Office of Juvenile Affairs behavioral health Medicaid Services. (5 FTE)
Director, Terrie Fritz, L.C.S.W. (405) 522-7377.

Pharmacy Services performs prospective, concurrent and retrospective reviews of drug claims for quality review, quantity abnormalities, drug rebates and reversals of claims that result in recoupment of Medicaid dollars and provides a service to providers regarding Federal Upper Limits (FUL) and service to providers and clients regarding compensability and eligibility. The Drug Rebate Unit within Pharmacy Services, plans, coordinates and processes activities of the Medicaid Drug Rebate Program which includes invoicing and collecting rebates and interest, adjusting erroneous pharmacy claims, resolving rebate disputes and federal reporting of receipts and receivables, oversees OU College of Pharmacy contract and interfaces with other state agencies, consumer groups, providers and internal OHCA units. (7 FTE) *Director, Nancy Nesser, D.Ph, J.D. (405) 522-7325.*

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Core Function Summary (continued)

Medicaid Operations (continued)

Dental Services coordinates preventive and restorative dental services for eligible children, which will enable them to retain their teeth for a lifetime with the goal being to educate clients as to the importance of oral health as an integral part of their overall physical health. Dental Services also provides ongoing consultations and guidance regarding policy changes as they pertain to Medicaid dental benefits as well as day to day reviews of dental program authorizations and utilization. Other aspects of Dental Services include training and education in all counties for dental providers and coordinating dental and pharmacy grievances. Apart from Dental Services, the manager of this unit reviews all claims for the Catastrophic Drug Program. (2 FTE) *Manager, Ella Matthews, R.N. (405) 522-7314.*

Quality Assurance coordinates the Quality Assurance evaluation, assessment and monitoring processes for all OHCA medical programs by developing, monitoring and implementing necessary processes for the State Quality Assurance Plan for Managed Care to meet federal guidelines that include those requirements for the 1115 (a) Waiver and any related renewals/expansions. This unit also coordinates the agency Quality Assurance Committee activities and provides technical support in developing, implementing, monitoring and reporting federally required quality assurance activities as well as agency-wide quality improvement activities. ***EPSDT Services***, within the Quality Assurance Unit, coordinates and monitors the Early Periodic Diagnosis and Treatment (EPSDT) program, subsequently preparing and submitting required federal reporting, as well as working with Medicaid providers, school districts, the State Department of Education and the State Department of Health in maximizing EPSDT/EI (Early Intervention) services to Medicaid eligible children through school based and Early Intervention services. (8 FTE) *Director, Darendia McCauley, Ph.D. (405) 522-7355.*

SoonerCare **and Care Management Services – Director, Becky Pasternik-Ikard, J.D., R.N.**

SoonerCare Operations consists of Member Services and Contractor Services. Member Services coordinates and facilitates resolution to issues/concerns addressed in internal reports, incident reports and telephone calls and also monitors the enrollment agent. Member Services additionally researches and resolves members' calls and issues related to dire medical needs and follows up with members on an as needed basis to ascertain care received. ***SoonerCare*** Operations also identifies and participates in member outreach activities to promote member selection of PCP/CM or health plan as county residency dictates and works in collaboration with the OKDHS county offices to resolve issues regarding member eligibility and identifies system "barriers" that promote inaccurate transmission of data from OKDHS to OHCA, advising and supporting resolution of these barriers. Another aspect of ***SoonerCare*** Operations is Contractor Services that facilitates, coordinates and participates in provider contracting relating to the ***SoonerCare*** program. This includes the identification and resolution of provider contractual issues, provider training, complaints and review of network deficiencies or access/quality issues, related to program standards. Other responsibilities of Contractor Services include oversight of the complete PCCM and Native American contracting processes including also recruitment of ***SoonerCare*** providers to maintain and monitor network capacity and access to care. Additionally, Contractor Services also researches and advises provider requested member disenrollment and actively participates in recruitment efforts for ***SoonerCare*** providers to maintain and monitor network capacity and access to care. (17 FTE) *Member Services Supervisor, James Reese (405) 522-7345; Contractor Services Supervisor, Nancy Austin (405) 522-7333.*

SoonerCare Professional Services monitors and reports on ***SoonerCare*** enrollment and expenditure data, prepares related costing of financial impact for budget requests and budget reports, as well as monitors compliance of health plans with ***SoonerCare*** Plus contracts in the area of financial data reporting. This unit also monitors the ***SoonerRide*** program and acts as a ***SoonerCare*** liaison to the Department of Human Services staff. (7 FTE) *Manager, Kevin Rupe, C.P.A. (405) 522-7498.*

Core Function Summary (continued)

Medicaid Operations (continued)

SoonerCare Compliance plans, develops and implements comprehensive compliance activities through systematic approach to maximize division staff and time. ***SoonerCare*** compliance also plans, develops implements and operationalizes ***SoonerCare*** quality assurance initiatives in coordination with the Quality Assurance division, as well as coordinates and compiles data and information needed for required reports. (2 FTE) *Senior Compliance Analyst, Melinda Jones (405) 522-7125.*

Medicaid Care Management administers and facilitates care management services related to medically complex/special health care need members by coordinating access to care as it relates to specialty providers initiated by requests for PCP/CMs, incident reports, member calls, interagency referrals and legislative requests. This team also plans, develops and implements enhanced Care Management outreach to select identified Choice and fee-for-service population. OHCA Care Management is involved in the development and implementation of culturally competent population and client based disease management programs and interventions for selected disease states to promote improved "quality of life," by collaborating with other state agencies and community and provider organizations. In addition, this area coordinates with the Quality Assurance Division to perform clinical studies and targeted consumer assessments. Effective January 2003, Medicaid Care Management will begin utilizing a computer based clinical care management software system for member tracking activities and productivity measurements currently being performed on a manual basis. Care Management staff acted as agency lead in the clinical design and configuration required to implement this important clinical tool. (8 FTE) *Manager, Charlene Benson, R.N., C.P.U.R. (405) 522-7488.*

Medical Review & Assessment – Director, J. Paul Keenan, M.D.

Surveillance Utilization Review Subsystem (SURS) develops comprehensive statistical profiles and utilization patterns of health care delivery and reveals suspected instances of fraud and abuse by individual providers and clients. This unit manages the Medicaid client lock-in program which restricts the client to one pharmacy and/or physician for those clients who have demonstrated usage above the statistical norm during a 12-month period, according to 42 Code of Federal Regulations (CFR) 431.54. SURS also provides education and training to providers, through SURS review processes, regarding acceptable utilization and appropriate maintenance of file documentation and claim filings. (11 FTE) *Manager, Jana Webb, R.N. (405) 522-7112.*

Medical Authorization Unit reviews, responds and manually prices, when necessary, medical and dental requests and any services that require prior authorization for Medicaid eligible children and adults. This unit also performs prior authorization reviews and manually prices durable medical equipment, when a standard allowable cost is not in the claims payment system and answers telephone inquiries from all sources regarding Medicaid policy, scope and procedures. (8 FTE)
Manager, Peggy Davis (405) 522-7371.

Level of Care Evaluation Unit (LOCEU) coordinates the Federal PASRR (Pre-Admission Screening and Resident Review) Program statewide, providing Level I screening to all persons entering Medicaid certified nursing facilities (NFs) for possible Mental Retardation (MR) and/or Mental Illness (MI). Level II assessments are conducted when necessary to ensure that this population requires NF Level of Care and receives proper treatment for MI and/or MR within the NF. LOCEU also makes Level of Care decisions on all clients entering public and private ICF/MR facilities and on clients applying for three OKDHS, DDSD Home and Community-Based Waivers. LOCEU provides medical and categorical relationship determinations for disability and incapacity of OKDHS clients. The Unit also audits the ADvantage, Community and In-Home Supports and Home and Community-Based Services (HCBS) waiver programs. (10 FTE) *Manager, John Russell, M.Ed. (405) 522-7309.*

Core Function Summary (continued)

Medicaid Operations (continued)

Medical Management – Nurse Managers establish medical appropriateness for services referred for prior authorization from the Medical Authorization Unit and review medical data referred from other divisions within the agency, as well as supports Customer Service, Adjustments and Medical professional staff as needed in regard to the issues of medical necessity and clinical claims editing. Medical Services personnel establishes and updates administrative guidelines for medical authorizations based on State Plan provisions and medical necessity, researches clinical practice guidelines regarding new technologies and treatments and review clinical logic claims editing software, including review of input from providers, submitting recommendations to medical and policy staff. (2 FTE) *Medical Review Nurse Consultant, Gail Livengood, R.N. (405) 522-7328.*

Federal/State Health Policy *40 Full Time Equivelants (FTE)*[*]

Charles Brodt, Director of Federal/State Health Policy

Health Policy develops and presents upcoming policy issues to OHCA's Medical Advisory Committee (MAC) for the purpose of receiving direction from the members regarding additional research and/or consideration in addition to receiving requests from the members to research and subsequently report on other policy issues. Health Policy coordinates with the CMS on questions related to Medicaid policy, issues of noncompliance, expenditures and the State Plan. This unit directs the OHCA's review of administrative rules, statutes and internal policies, reporting to the Governor, the President Pro Tempore of the Senate and the Speaker of the House of Representatives those rules to be modified or repealed pursuant to the Administrative Procedures Act. Another function of Health Policy is to monitor, analyze and review financial and operational data applicable to specific waiver programs, assuring that each specific waiver program meets all associated federal requirements and is operated within its conditions and limits, in addition to assisting in the preparation and submission of waiver applications and amendments, as well as, required annual reports to the appropriate CMS offices for specific waivers. Health policy maintains the Reference File Subsystem of the Medicaid Management Information System (MMIS) providing enforcement of policy and ensuring accurate up-to-date information in support of claim processing*. (10 FTE) Director, Jim Hancock (405) 522-7268.*

HIPAA Compliance monitors and reviews development of and changes to federal rules and regulations relating to HIPAA (Health Insurance Portability and Accountability Act of 1996), as well as coordinates agency activities required for compliance with HIPAA rules and regulations. HIPAA Compliance also assists and monitors agency efforts in training, education and communication with providers and other trading partners, in addition to developing and monitoring a Business Continuity and Contingency Plan for addressing potential problems or issues with achieving HIPAA compliance. (1 FTE) *Coordinator, Laura Dickey-Hottel (405) 522-7228.*

Fiscal Agent Reprocurement plans and implements details relating to the contract monitoring of the fiscal agent, such as coordination of the contracting entity, consultants for OHCA and OHCA staff for timely implementation. (1 FTE) *Coordinator, Richard Evans (405) 522-7101.*

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Core Function Summary (continued)

Federal/State Health Policy (continued)

Customer Relations consists of Customer Service and Provider Training and is responsible for technical assistance to all of the various participants in the Medicaid program. Customer Relations answers a large volume of incoming telephone inquiries and correspondence from providers, vendors, clients, OKDHS county offices, legislators, other state Medicaid agencies and others relating to agency and federal Medicaid policy and OHCA procedures for all Medicaid programs. Customer Relations also reviews and authorizes processing for those specialized claims requiring additional medical documentation. The Provider Training unit offers individual and group information and instruction regarding Medicaid policy and claims processing for both ***SoonerCare*** and fee-for-service, non-school-based contracted providers. (25 FTE) *Director, Susan Nicholson (405) 522-7360.*

Information Services Division *30 Full Time Equivelants (FTE)*[*]
John Calabro, Director of Information Services

Contractor Systems monitors problems identified in the MMIS and recommends appropriate specifications to correct the deficiency, analyzes test results and monitors production environment for problems, as well as coordinates all maintenance and modification system changes with ongoing enhancements. This unit is responsible for the development, testing, coordination with users and implementation of a new MMIS. This unit is accountable for the fulfillment of data processing performed by the contracted fiscal agent. Contractor Systems also establishes priorities for systems development and data processing projects according to departmental requirements, as well as develops plans for future utilization of data processing services in the overall agency program. (13 FTE) *Director, Donna Witty (405) 522-7242.*

Network Operations performs all programming analysis, design, coding, implementation and operations for all computer systems not covered by the fiscal agent contract and are responsible for maintenance and modification change requests, in addition to being accountable for the fulfillment of data processing performed on the OHCA network, systems analysis and programming to implement requested changes. This unit also designs applications to be flexible, cost effective and relevant to address the needs of OHCA, as well as coordinates agency data processing activities with other state agencies, private sector entities and all OHCA units or divisions for network operations. (10 FTE) *Director, Jeff Slotnick (405) 522-7152.*

Data Processing Administration is accountable for all data processing performed both within the division and development performed by the contracted fiscal agent, including equipment selection and purchase, systems analysis, programming, operations and data entry, in addition to recommending new uses for data processes or abandonment of inefficient present uses. *(5 FTE) Administrator of Data Processing, Judi Worsham (405) 522-7222.*

[*] Division directors and support staff are not included in the unit totals; therefore, FTE totals per division may not equal the sum of the FTE per unit. FTE counts include vacancies; however, do not include contract and temporary employees or intern students.

Core Function Summary (continued)

Finance Division *57.5 Full Time Equivelants (FTE)*[*]

Anne Garcia, C.G.F.M., Director of Financial Services

Financial Management prepares the annual agency budget request, prepares and processes federal expenditure reports, agency budget work programs and any necessary revisions, as well as maintains the Cost Allocation Plan. This unit also researches and analyzes claims history and cost report data in order to develop, implement and support reimbursement rates for institutional providers and submit state plan documentation. (9 FTE) *Director, Debbie Ogles (405) 522-7270.*

Adjustments researches and reconciles claims of erroneous provider payments as reported through various sources, researches and initiates corrective action on claims for which refunds have been received from medical providers. The Adjustments Unit also identifies problem areas with the claims and recoupment process, recommending that training be provided to individual providers or provider groups. (12 FTE) *Manager, Michelle Thomas (405) 522-7305.*

General Accounting draws administrative and Medicaid program federal matching funds in accordance with the US Treasury Cash Management Improvement Act (CMIA) Agreement and maintains the general ledger for accounting of all funds, including balancing cash to the Office of State Finance (OSF) and the State Treasurer's Office (STO) and posting of all receipts and expenditures of agency funds. This unit prepares the monthly financial statement reports, quarterly cost allocation schedules as well as makes payment of claims for general agency operations and contracted services, deposits all funds received by the agency in addition to the billing, collection and administration of the Quality of Care fund. General Accounting also tracks and reconciles adjudication reports produced by the fiscal agent before authorizing weekly payment tapes to be transmitted to the STO for production of medical warrants, in addition to preparing and processing all agency payrolls, as well as processing all Medicaid provider garnishments and tax levies and reconciling and approving annual 1099 and W2 information. (10 FTE) *Director, Carrie Evans (405) 522-7359.*

Third Party Liability investigates and ascertains the legal liability of third parties to pay for care and services furnished to Medicaid clients and seek reimbursement from the responsible third parties. This unit uses the most cost effective means of recovery which is to cost avoid the claim when there is probable existence of TPL at the time it is filed. Cost avoidance is the method used for all recoveries except for prenatal, EPSDT and pharmacy due to our current waiver status from CMS. For those claims that are not cost avoided or if a third party is discovered after Medicaid has paid, the pay and chase method of recovery is utilized. The pay and chase method of recovery requires the identification of the third party source as well as timely submission of claims to third parties or their representatives, which can include but is not limited to insurance companies, tortfeasors, judges, lawyers, trusts and Medicare. This unit is also responsible for maintaining and entering all third party resource data into the TPL database. (12 FTE) *Manager, Lisa Gifford, J.D. (405) 522-7427.*

Claims Resolution and Monitoring monitors the timely and accurate input and output of the claims processing system for Medicaid providers (MMIS) and controls the edits in the claims processing system. This unit handles claim problems and inquiries by working with other divisions/units of the OHCA, other state agencies, the MMIS contractor and medical providers. (10 FTE) *Manager, Mary Lou Schniedermeyer (405) 522-7243.*

Purchasing anticipates, initiates and processes purchase requests and encumbrance documents submitted by units within the agency, follows up on purchase orders, monitors funding amounts, approves invoices and prepares change orders to increase, decrease or cancel encumbered funds. Purchasing also monitors and ensures that agency-assigned vehicles receive required maintenance and to report/track monthly mileage on agency-assigned vehicles, as well as reserves motor pool vehicles for agency personnel when required. (2.5 FTE) *Manager, Vickie Kersey (405) 522-7482.*

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Core Function Summary (continued)

Legal Services *27 Full Time Equivelants (FTE)*[*]

Howard Pallotta, J.D., Director of Legal Services

General Legal Services renders legal opinions and advises the CEO, Board members and agency management on administrative legal issues and provides legal opinions to agency personnel on issues relating to contracts, state finance, procurement and rate matters. This unit also reviews possible legislation and advises legislators and legislative staff members regarding Medicaid law, as well as advises advocacy and public interest groups regarding changes in Medicaid law. (3 FTE) *Deputy General Counsel, Lynn Rambo-Jones, J.D. (405) 522-7403.*

Appeals & Litigation coordinates all litigation for the agency, as well as all administrative law judge appeals filed by providers and clients. This unit aids the Third Party Liability Unit in Estate Recovery, Worker's Compensation, Tort and Insurance legal matters and represents the agency before administrative, state and federal courts or tribunals. (3 FTE) *Deputy General Counsel, Andrew Tevington, J.D. (405) 522-7562.*

Program Integrity represents the agency in investigative matters and provides timely, thorough research and surveillance to/for General Counsel. This unit also works with agency staff and General Counsel to develop an effective and efficient investigative component for the legal division of the agency. Program Integrity works with appropriate state, local and federal authorities to solve problems as directed by the General Counsel and conducts information gathering field trips and/or interviews with necessary individuals and/or agency representatives in order to provide General Counsel with clear and concise information for legal purposes of OHCA. (2 FTE) *Program Integrity Specialist, Paul Bouffard (405) 522-0595.*

Contract Services consists of Service Contracts Development and Service Contracts Operations. ***Service Contracts Development*** oversees the procurement and/or development of health plan contracts for the ***SoonerCare*** Plus and Choice programs, MMIS Fiscal Agent and the agency's professional services contracts, as well as ensures that the agency is adhering to statutory laws, administrative procedures and agency regulations in the procurement of contracted services and interagency agreements and provides technical expertise to program staff in the development and writing of contractual terms and conditions. The ***Service Contracts Operations*** area develops, maintains and oversees the Professional Provider Contract Procurement System and provides assistance to program providers regarding the contract processes, renewals, payment and reporting requirements, which includes determining whether a provider needs a fee-for-service or managed care contract, contract status, provider numbers and/or effective contract dates. The area also maintains current database system for sanctioned and terminated providers. (17 FTE) *Manager, Rolando Davila, J.D. (405) 522-7234.*

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Core Function Summary (continued)

Management and Audit Services *22.5 Full Time Equivelants (FTE)*[*]

Cindy Roberts, C.P.A., C.G.F.M., Director of Management and Audit Services

Audit, Design and Evaluation plans and coordinates both audit and strategic projects of organizational, functional and program activities for the purpose of evaluating the effectiveness of controls, compliance and/or strategic feasibility, as well as performs internal and external audits. Additionally, this unit is responsible for the data collection, analysis and preparation of the agency's quarterly and annual reports, as well as the required Service Efforts and Accomplishments (SEA) reporting which accompanies the annual budget request. Another aspect of Audit, Design and Evaluation includes both waiver and Title XXI reporting. (9.5 FTE) *Director, Cindy Roberts, C.P.A., C.G.F.M. (405) 522-7253.*

Provider Compliance Audits develops and collects monthly-submitted Quality of Care Reports from Long-Term Care (LTC) facilities statewide and performs monthly desk audits and on-site audits related to verification of submitted information pertaining to resident to staffing ratios, minimum wage for specified staff and determines penalties for non-compliance. Provider Compliance Audits also coordinates related operational activities with the Finance and Legal Divisions in the determination and collection of any assessed penalties and dissemination of reported information related to the billing of assessment fees. (4 FTE) *Manager, Teri Dalton (405) 522-7209.*

Public Information develops comprehensive, public information strategies and also creates and coordinates outreach activities and goals with internal staff and external partners such as advocacy groups. Public Information researches, develops and produces all written material for the agency, including all enrollment publications or informational and/or promotional materials to clients and content management for the agency's public website. This unit serves as the agency's primary contact for the media and manages and coordinates all press inquiries, information and interviews. (4 FTE) *Public Information Officer, Nico Gomez (405) 522-7484.*

Human Resources monitor and assure agency compliance with all relevant state and federal personnel regulations in addition to the basic personnel principals and practices. This unit also maintains a human resources information system for tracking recruitment and processes personnel transactions, employee evaluation activities, compensation management and supervisory training. Human Resources subsequently generates monthly, quarterly and annual personnel related reports, as well as conducts the human resources personnel transactions in a way that maximizes the agencies use of FTE and allocated budget. Human Resources also serves as the liaison on employee benefits, retirement and ethics, as well as monitors safety and workers' compensation issues. (3 FTE) *Director, Ron Wilson (405) 522-7418.*

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Glossary of Terms

ABD	The **A**ged, **B**lind and **D**isabled Medicaid population.
Capitated Payment	A monthly payment of a predetermined amount, per person, for an individual's required health care services within managed care.
Client	A person enrolled in Oklahoma Medicaid.
CMS	**C**enters for Medicare and **M**edicaid **S**ervices, formally known as Health Care Financing Administration (HCFA), establishes and monitors Medicaid funding requirements.
Eligible	For this report, an individual who is qualified and enrolled in Medicaid, who may or may not have received services during the reporting quarter.
Fee-For-Service (FFS)	The method of payment for the Medicaid population that is not covered under managed care. Claims are generally paid on a per service occurrence basis.
FFY	**F**ederal **F**iscal **Y**ear**.** The federal fiscal year starts on October 1 and ends September 30 each year.
FMAP	**F**ederal **M**edical **A**ssistance **P**ercentage – The federal dollar match percentage.
ICF/MR	**I**ntermediate **C**are **F**acility for the **M**entally **R**etarded.
EPSDT	**E**arly **P**eriodic **S**creening**, D**iagnosis and **T**reatment.
SCHIP	**S**tate **C**hildren's **H**ealth **I**nsurance **P**rogram for children age 19 and under who have no creditable insurance and meet income requirements. (Title XXI)
SFY	**S**tate **F**iscal **Y**ear. The state fiscal year starts on July 1 and ends June 30 each year.
TANF/AFDC	**T**emporary **A**ssistance for **N**eedy **F**amilies, formerly known as **A**id to **F**amilies with **D**ependent **C**hildren.
Title XIX	Federal Medicaid statute enacted in 1965 under the Social Security Act financed by both federal and state dollars.
Title XXI	See SCHIP above.

Figure 31 Technical Notes

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

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

Common Acronyms

ABD	Aged, Blind and Disabled
AFDC	Aid for Families with Dependent Children (TANF)
CEO	Chief Executive Officer
CFR	Code of Federal Regulations
CFO	Chief Financial Officer
CGFM	Certified Government Financial Manager
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
DDSD	Developmental Disabilities Services Division (DHS)
DHHS	Department of Health & Human Services (over CMS)
DHS	Department of Human Services
DME	Durable Medical Equipment
DUR	Drug Utilization Review
EBC	Employee Benefit Council
EI	Early Intervention
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
FFS	Fee for Service
FFY	Federal Fiscal Year
FMAP	Federal Medical Assistance Percentage
FQHC	Federally Qualified Health Center
FTE	Full Time Employee
HEDIS	Health Plan Employer Data and Information Set
HIFA	Health Insurance Flexibility Act
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
ICFMR	Intermediate Care Facility for the Mentally Retarded
IEP	Individual Education Program (EPSDT Related)
IHS	Indian Health Services
IHSP	Individual Health Service Plan (EPSDT Related)
LOC	Level of Care
LTC	Long Term Care
MAC	Medical Advisory Committee
MFCU	Medicaid Fraud Control Unit (Att. General's Office)
MMIS	Medicaid Management Information System
MN	Medically Needy
NF	Nursing Facility
OFMQ	Oklahoma Foundation for Medical Quality (PRO)
OIG	Office of Inspector General (DHS)
OJA	Office of Juvenile Affairs
OSDE	Oklahoma State Department of Education
OSDH	Oklahoma State Department of Health
OSF	Office of State Finance
PA	Prior Authorization
PASRR	Pre-Admission Screening Resident Review
PIO	Public Information Officer
PPO	Primary Provider Organization
PRO	Peer Review Organization (OFMQ)
QMB	Qualified Medicare Beneficiary
REVS	Recipient Eligibility Verification System
SA&I	State Auditor and Inspector's Office
SCHIP	State Children's Health Insurance Program
SEA	Service Efforts and Accomplishments
SFY	State Fiscal Year
SLMB	Specified Low-income Medicare Beneficiaries
STO	State Treasurer's Office
SURS	Surveillance/Utilization Review Services
TANF	Temporary Aide to Needy Families
TPL	Third Party Liability

Reader Notes

Reader Notes

Important Telephone Numbers

Main Number	405-522-7300
Adjustments	405-522-7450
Customer Service	
Client	**405-522-7171 or 1-800-522-0310**
Provider	405-522-6205 or 1-800-522-0114
Information and Referral	405-522-7559
Provider Contracts	405-522-7117 or 1-800-871-9347
SoonerCare Helpline	1-800-987-7767
Third Party Liability	405-522-7451 or 1-800-268-5261

OHCA Website Resources

OHCA Website	**www.ohca.state.ok.us**
Centers for Medicare and Medicaid	**www.cms.gov**
Task Force Report	**www.okdhs.org/ioppr/TaskForce/Task Force.pdf**
Medicaid Fraud Control Unit	**www.oag.state.ok.us**
Oklahoma State Auditor and Inspector	**www.sai.state.ok.us**
Office of Inspector General of the Department of Health and Human Services	**www.oig.hhs.gov**