Oklahoma Health Care Authority

State Fiscal Year 2003 Annual Report

July 2002

June 2003

The Oklahoma Health Care Authority

Oklahoma Health Care Authority 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 Values and Behaviors, !996

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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.**

Brad Henry
Governor
State of Oklahoma

EXECUTIVE BRANCH

Mary Fallin
Lieutenant Governor

Howard Hendrick
Cabinet Secretary 2002

Thomas Adelson
Cabinet Secretary 2003

LEGISLATIVE BRANCH
49th Legislature (2003-2004)

Cal Hobson
State Senate Pro Tempore

Larry Adair
House of Representatives
Speaker

Our Board members' discussion of items shows they understand the issues, but more importantly they never forget who it is we serve. They always remember we are dealing with the lives of Oklahoma's most vulnerable citizens, elders and children.

OHCA Policy Employee, April 2003

OHCA Chief Executive Officer and Board Members

Top (left to right):
CEO Mike Fogarty, JD, MSW; Charles (Ed) McFall, DPH; *Chairman* T.J. (Jerry) Brickner Jr., MD; Wayne Hoffman; *Vice Chairman* Ronald Rounds, OD

Bottom (left to right):
Jerry Humble; George Miller; Lyle Roggow

Message from the Chief Executive Officer...

It has been said that Medicaid was effective in accomplishing its goal of providing access to health care for poor people – it has, indeed. It is not a time to curse Medicaid. It is a time to thank it, bind it in fine leather and put it on the shelf along with other programs that have made great contributions to the progress of this country and its people. It is now time to move ahead, restructuring public health care to meet needs of today and the future.

What may be surprising about the preceding paragraph is not that it was my actual testimony at a congressional hearing on reforming our nation's health care system but the fact that I said it on October 15, 1984. The more things change, the more they stay the same – so it seems.

The major issue for our time is Medicaid's structural weaknesses stemming from its roots in the welfare system. The antiquated "welfare" policies imbedded in the program make it inadequate to meet the needs of those who cannot afford access to health care and unresponsive to the priorities and expectations of the taxpayers who fund it.

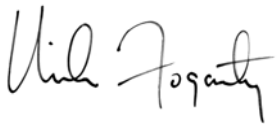
Identifying and addressing these weaknesses were steps forward taken by the OHCA Board in August 2002, and they directed the agency to explore substantive Medicaid reforms. It became a project we call "It's health care not welfare." The key objectives are to promote healthier Oklahomans, to increase patient responsibility, to purchase health care more effectively, to reimburse providers more responsibly, to develop flexible benefit packages, to redefine eligibility and to establish a more predictable budget.

It is a monumental task but a vital one. The policies and programs of four decades ago will not serve us in the new economic and social times. The nation's health care system is also undergoing tremendous change and stress. People are seeking realistic solutions at reasonable costs. This is a window of opportunity created by crisis.

Ideas are being discussed, developed and shaped. Meetings are being held with beneficiaries, providers, business leaders and advocacy groups. State and federal leaders and policy makers are showing much interest and dialogue has already begun with top federal officials with the Centers for Medicare and Medicaid Services in Washington, D.C. The climate is ripe for fundamental Medicaid reform.

If we are to be successful it will take broad support and action. The Oklahoma Health Care Authority is confident that a quality program can be created to provide health benefits for Oklahomans in need and be responsible to those who fund it.

The plea for systemic changes is virtually the same today as it was nearly 20 years ago in 1984. Ten years from now let us read in the 2013 annual report that together our willingness to tackle this enormous task and our hard work has made a healthier tomorrow for our state and its citizens.



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SFY2003 Highlights

- ✓ Overall Medicaid enrollees increased by 17,658 (or 4 percent) from June 2002 to June 2003.
- ✓ The number of children enrolled in Oklahoma Medicaid increased by 11,457 (or 2 percent) from June 2002 to June 2003.
- ✓ 68 percent of Oklahoma's Medicaid beneficiaries are children.
- ✓ Children accounted for 65 percent of the overall growth during State Fiscal Year (June through July) 2003.
- ✓ 36 percent of Medicaid beneficiaries were enrolled in ***SoonerCare* Plus**, the urban benefit package.
- ✓ Nearly 98 percent of the persons enrolled received a service or had a capitation payment made by Oklahoma Medicaid within SFY2003.
- ✓ The bulk of Medicaid expenditures were made on behalf of the elderly and disabled. Sixty one percent of expenditures are made for services provided to the elderly and disabled, who made up only 24 percent of Medicaid beneficiaries.
- ✓ OHCA received and investigated 4,048 ***SoonerCare*** beneficiary complaints. This represents just over one percent of the entire 338,716 ***SoonerCare*** enrollees.
- ✓ OHCA's Customer Relations answered over 85,000 provider calls and completed more than 25,000 written responses to inquiries received.
- ✓ There were 64 provider and 48 beneficiary formal appeals filed. This is less than one quarter of one percent of both populations.
- ✓ Health plans scored an average .95 (on a scale of .00 to 1.00) on Quality Improvement System for Managed Care (QISMC) standards.
- ✓ On average there is at least one medical provider within 2.9 miles of a ***SoonerCare* Plus** and/or **Choice** beneficiary's home. 100 percent of ***SoonerCare* Plus** or **Choice** beneficiaries live an acceptable distance to medical services. Guidelines for "acceptable distance" are five miles for urban and 25 miles for rural beneficiaries.
- ✓ The OHCA processed 28 emergency rules and 17 permanent rules.
- ✓ The OHCA also submitted 14 state plan amendments, an 8 percent decrease from the previous year.
- ✓ OHCA held 24 OKDHS county worker training sessions with an estimated attendance overall of 840 workers within SFY2003. Additionally, there were 504 provider training sessions held during SFY2003.
- ✓ Dollars recovered through post payment reviews totaled $2,162,916.
- ✓ Drug Rebate collections increased by 16 percent to $56,188,140. Collections have increased by 55 percent since SFY2000.

SFY2003 Year in Review

Electronic Data Systems (EDS) Takes Over as New Fiscal Agent

EDS has more than 30 years experience in the public health care industry and has constructed one of the most advanced Medicaid Management Information Systems (MMIS) in the nation. With the new MMIS, OHCA can now provide several new services including more efficient options to obtain eligibility and prior authorization information. Providers can submit batch claims using Electronic Data Exchange (EDI) and are able to download an electronic remittance advice. Overall, the new processes could save providers money and time.

Collaborative Project Focuses on Native American Health Issues

The Oklahoma Health Care Authority (OHCA), the Indian Health Services (IHS) and the Oklahoma City Area Inter-Tribal Health Board (IHB) recently joined together to address Medicaid issues affecting tribal and IHS interests. The IHB is providing the resources for a contract employee to be placed at OHCA to work specifically with Indian health issues. The project will help coordinate health care available to American Indians and assist Indian health care systems navigate through complex regulations. Medicaid services provided to eligible Native Americans in IHS and tribal facilities result in a 100 percent federal match.

OHCA "Medicaid on the Web" Fully Functional

On January 1, 2003, the Oklahoma Health Care Authority brought up the fully functional secure site — *Medicaid on the Web*. The secure multilevel website allows providers to receive communications directly from OHCA, to check beneficiary eligibility, submit claims and request and check the status of prior authorizations, etc. As stated by the State Medicaid Director, Dr. Lynn Mitchell, "Time is always precious in a busy medical office, and this new resource was specifically designed to minimize time and effort required to handle all the paperwork involved in claims processing. Health care is about treating the sick, not shuffling papers." The secure website can be accessed through OHCA's public website, www.ohca.state.ok.us then select *Medicaid on the Web* from the Provider drop-down menu.

Oklahoma Wins Grant Studying Payments

Payment accuracy is always at the forefront of issues facing federal and state government's Medicaid programs. To take on this challenge, the Centers for Medicare and Medicaid Services (CMS) awarded 15 Payment Accuracy Measurement (PAM) grants. The OHCA won one of these grants totaling $309,000. The goals of the grant are to identify the extent of problems in payment system, study causes and strengthen internal controls. It is also an advantage to Oklahoma to participate in this grant by influencing and preparing for future federal payment policies.

State Tax Refund Gives Option To Help

In an effort to provide another revenue source, Sen. Mike Morgan and Rep. John Carey authored state Senate Bill 549 to allow tax payers to voluntarily donate part of their state tax refund to the Oklahoma Medicaid program. Effective December 31, 2003, a check-off box for Medicaid will be added to the state tax form. People receiving a refund will have the option to donate $2 or more. These funds can also be matched with federal funds doubling the impact of the donation.

Ticket To Work Project Wins Another Trip

The Oklahoma Health Care Authority was awarded a second grant period for the Ticket To Work and Work Incentives Improvement Act of 1999 (TWIIA or Twee-ahh). The goal of this grant is to connect people with disabilities to competitive employment. Oklahoma is using this opportunity to build infrastructure and a support network by developing opportunities for employees and employers. The Centers for Medicare and Medicaid Services (CMS) has awarded OHCA $624,000 during the two grant periods.

What is Medicaid?

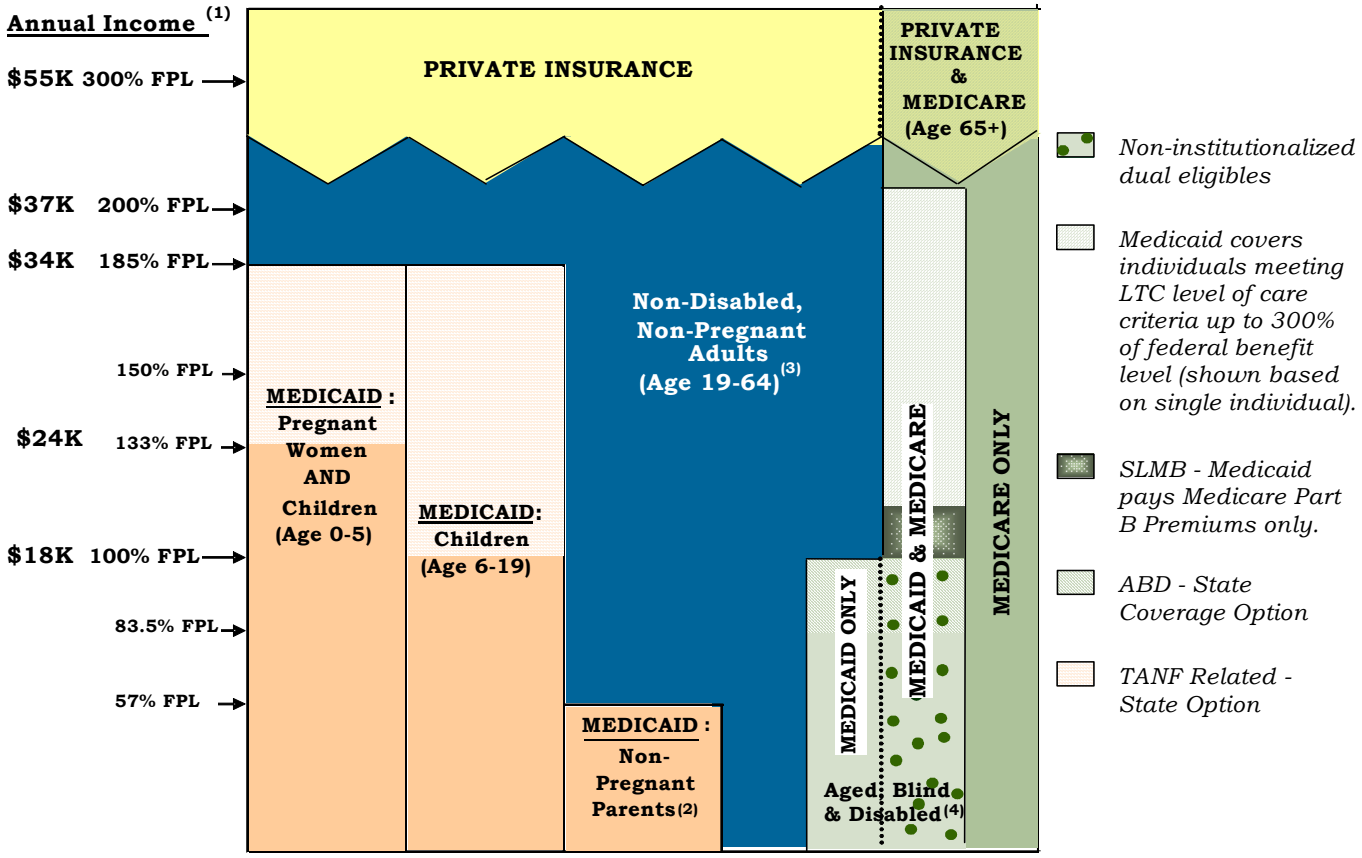
Medicaid is a federal and state entitlement program that provides medical benefits to low-income individuals who have no or inadequate health insurance coverage. Medicaid guarantees coverage for basic health and long-term care services based upon income and/or resources.

entitlement (n.)
has come to be widely used to mean "any of various governmental programs for which people qualify because of poverty, illness, age, or another condition toward which government directs financial or other assistance."

The Columbia Guide to Standard American English; 1993, Kenneth G. Wilson.

Created as Title XIX of the Social Security Act in 1965, Medicaid is administered at the federal level by the Centers of Medicare and Medicaid Services (CMS) within the Department of Health and Human Services (HHS). CMS establishes and monitors certain requirements concerning funding, eligibility standards and quality and scope of medical services. States have the flexibility to determine some aspects of their own programs, such as setting reimbursement rates and the broadening of the eligibility requirements and benefits offered.

Figure 1 **2003 Federal Poverty Levels and Coverage**



(1) 2002 Federal Poverty Guidelines, U.S. Department of Health and Human Services. Based on a family of four.
(2) 57% FPL based on single parent family of three.
(3) The U.S. Census Bureau has reported that 18.9% of Oklahomans do not have health care coverage; 75% of these are adults aged 19-64.
(4) Incomes shown on chart are for single individuals.

NOTE: Dual eligibles refer to beneficiaries that are enrolled in both Medicare and Medicaid, for additional information turn to page 33. SLMBs are Specified Low-Income Medicare Beneficiaries. LTC is the acronym for Long-Term Care. For more information on ABD (Aged, Blind and Disabled) and TANF (Temporary Assistance to Needy Families) go to page 12 and 13.

Who is Eligible for Medicaid?

Medicaid serves as the nation's primary source of health insurance coverage for the poor. During the past decade, federal and state eligibility policy changes to promote Medicaid coverage of low-income pregnant women and children, the disabled and the elderly have resulted in greater coverage of these groups within the low-income population.

The terms on which federal Medicaid matching funds are available to states include five broad requirements related to eligibility: categorical, income, resources, immigration status and residency. In order to be eligible for Medicaid, an individual must meet all of these requirements. The availability of federal matching funds for particular categories of individuals, however, does not necessarily mean that a state will cover these individuals since the state must still contribute its own matching funds toward the cost of coverage.

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

The decision by a state to cover an optional population or to provide optional benefits has important implications not just for Medicaid beneficiaries, but also for the state and health care providers that otherwise might be paying for, or providing health services to low-income residents. Federal matching payments through Medicaid often allow states to partially refinance the cost of services that states have traditionally provided at their expense or to pay for services that otherwise might be written off by providers as bad debt or charity care.

The availability of federal matching funds for particular categories of individuals, however, does not necessarily mean that a state will cover these individuals since the state must still provide their share of the costs.

Figure 2 **2003 Federal Poverty Guidelines**

Family Size	**Annual (Monthly) Income**			
	100%	133%	185%	200%
1	$8,980 ($748)	$11,943 ($995)	$16,613 ($1,384)	$17,960 ($1,497)
2	$12,120 ($1,010)	$16,120 ($1,343)	$22,422 ($1,869)	$24,240 ($2,020)
3	$15,2600 ($1,272)	$20,296 ($1,691)	$28,231 ($2,353)	$30,520 ($2,543)
4	$18,400 ($1,533)	$24,472 ($2,039)	$34,040 ($2,837)	$36,800 ($3,067)
5	$21,540 ($1,795)	$28,648 ($2,387)	$39,849 ($3,321)	$43,080 ($3,590)
6	$24,680 ($2,057)	$32,824 ($2,735)	$45,658 ($3,805)	$49,360 ($4,113)
7	$27,820 ($2,318)	$37,001 ($3,083)	$51,467 ($4,289)	$55,640 ($4,637)
8	$30,960 ($2,580)	$41,177 ($3,431)	$57,276 ($4,773)	$61,920 ($5,160)

*For family units with more than eight members, add $3,140 for each additional member. *Based on Federal Income Guidelines printed in the Federal Register, February 7, 2003*

Who is Eligible for Medicaid? (continued)

Figure 3 **Breakdown of Medicaid Eligibility by Coverage Type**

Principal Medicaid Eligibility

	Eligibility Criteria		
MANDATORY COVERAGE	**Income Test**	**Resource Test**	**Benefits**
Infants under age 1	< or = 133% FPL	Optional	Full scope of services
Children age 1 to 5	< or = 133% FPL	Optional	Full scope of services
Children age 6 to 19	< or = 100% FPL	Optional	Full scope of services
Section 1931: Children, and parents in low-income families	State AFDC level as of 7/16/96	State AFDC level as of 7/16/96 (<$1,000 in countable resources)	Full scope of services
Children and parents in welfare-to-work families (12 month Transitional Medical Assistance)	Family receives cash assistance in 3 of 6 months prior to ineligibility due to increased earnings up to 185% FPL	No resource test during coverage period	Full scope of services
Title IV-E foster care children	State AFDC level as of 7/16/96	State AFDC level as of 7/16/96	Full scope of services
Title IV-E adoption assistance children	State AFDC level as of 7/16/96, or SSI level before adoption	State AFDC level as of 7/16/96, or SSI level before adoption	Full scope of services
Pregnant women	< or = 133% FPL	Optional	Full scope of services
SSI recipients (Aged, blind and disabled)	< $531 for individual, <$796 for couple per month	< $2,000 for individual, < $3,000 for couple	Full scope of services
Qualified severely impaired individuals	But for earnings, income under SSI level; earnings may not exceed specified amount	< $2,000 for individual, < $3,000 for couple	Full scope of services
Individuals in "209(b)" states	< $512 for individual, < $769 for couple per month	< $2,000 for individual, < $3,000 for couple	Full scope of services
Qualified Medicare beneficiaries (QMBs)	< 100% FPL	< 200% of SSI limit ($4,000 for individuals, $6,000 for couples)	All Medicare premiums
Specified low-income Medicare beneficiaries (SLMBs)	Between 100% and 120% FPL	< 200% of SSI limit ($4,000 for individuals, $6,000 for couples)	Medicare Part B monthly premium

Source: The Medicaid Resource Book, The Kaiser Commission on Medicaid and the Uninsured, April 2002; http://www.kff.org/content/2003/2236/2236chapter1.pdf

Oklahoma Medicaid enrolled 648,820 people in SFY2003; that is just 147 fewer people than live in Oklahoma City, Lawton and Muskogee combined. According to the U.S. Census Bureau's July 2002 population estimates, there were 519,034 persons within Oklahoma City proper, 91,333 in Lawton and 38,600 in Muskogee.

Who is Eligible for Medicaid? (continued)

Figure 4 **General Age Breakdown of Medicaid Enrollees (for the month of June 2003)**

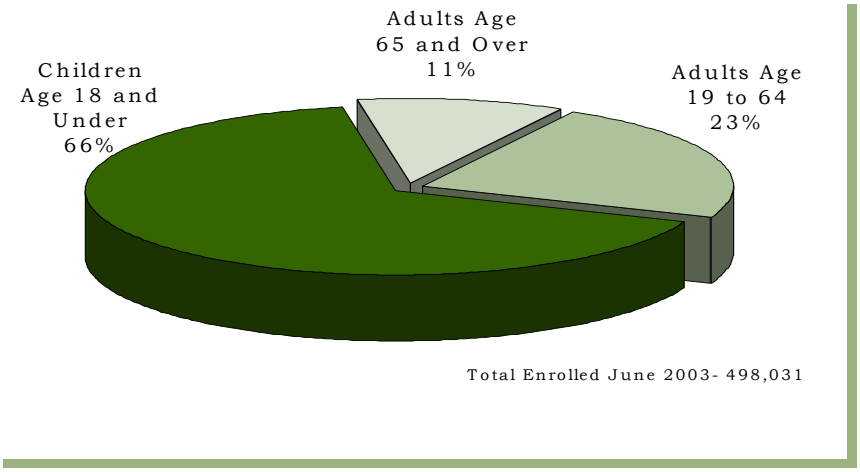
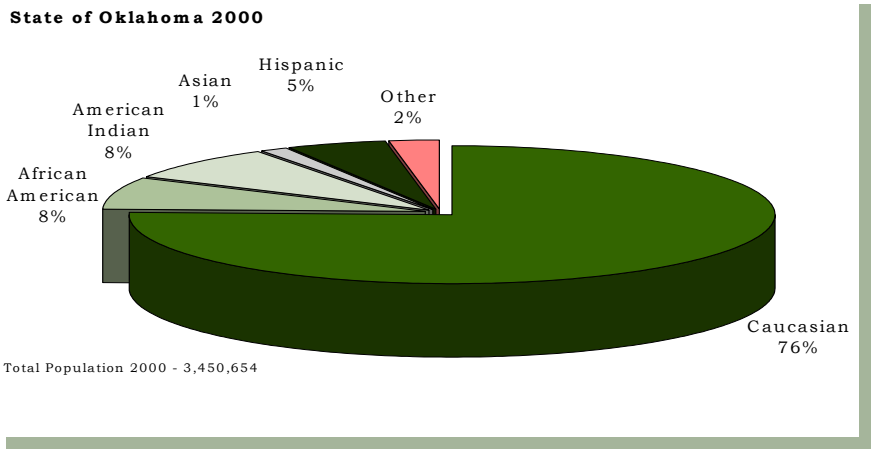
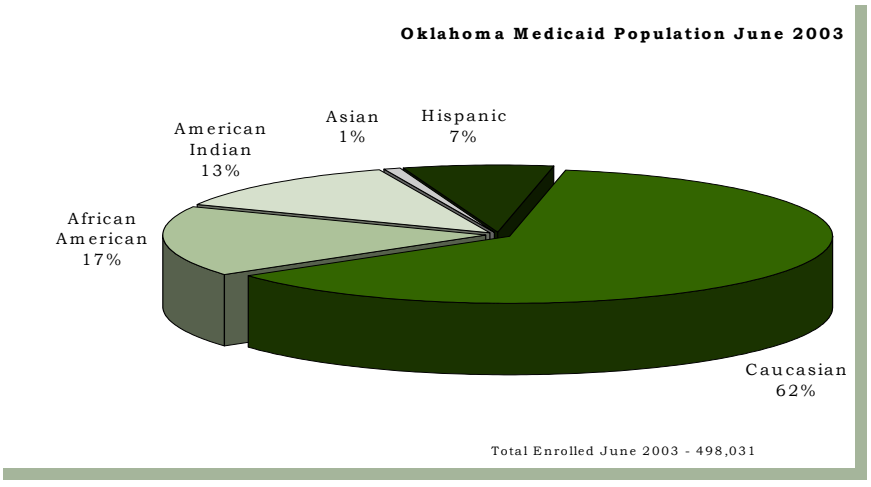


Figure 5 **State and Medicaid Population by Race**





Oklahoma state totals based upon US Bureau of the Census Oklahoma State Data Center — Oklahoma Department of Commerce http://www.odoc.state.ok.us/index.html. Oklahoma Medicaid counts based upon data extracted from beneficiary eligibility files on July 10, 2003. Race is self-reported by beneficiaries at the time of enrollment.

Medicaid Trends

National Archives: Franklin D. Roosevelt Library, 1882 - 1962

Medicaid eligibility has historically been linked to actual or potential receipt of cash assistance under the former Aid to Families with Dependent Children (AFDC) and the Supplemental Security Income (SSI) income maintenance programs. Legislation in the past decade, such as the 1996 replacement of AFDC with Temporary Assistance to Needy Families (TANF), has gradually expanded coverage to low-income pregnant women and children who have no ties to the welfare system. Additionally, partial coverage for new groups of low-income Medicare beneficiaries has been added. However, many low-income childless adults fall outside the program's eligibility categories and are precluded from coverage no matter how poor they are.

Parents and children. Most women and children qualify for Medicaid under the TANF guidelines. In SFY2003, Oklahoma Medicaid covered roughly 426,000 low-income children and 57,000 low income adults in families with children, the vast majority of whom were women. Only 58 percent of the children enrolled in Medicaid received cash assistance. Preventative and acute primary care services make up the majority of Medicaid service needs for these beneficiaries.

Elderly. More than 52,000 adults 65 and over were covered by Medicaid in SFY2003. About half were eligible because they were receiving cash assistance through the Supplemental Security Income (SSI) program. Others had too much income or assets to qualify for SSI but were able to "spend down" to Medicaid eligibility by incurring high medical or long term care expenses. In both cases, these elderly beneficiaries were covered for nursing home care and prescription drugs as well as other Medicaid services. Most of these beneficiaries are eligible within the Aged, Blind and Disabled (ABD) aid category.

Nearly 1 in 5 Oklahomans Enrolled for Services

Most of the population figures contained in this annual report represent a "point in time" reference such as June 2003. The state Medicaid program enrolled an unduplicated count of 648,820 individuals during SFY2003. On average, approximately 484,848 individuals were enrolled each month of the fiscal year.

Figure 6 **Historic Health Care Timeline**

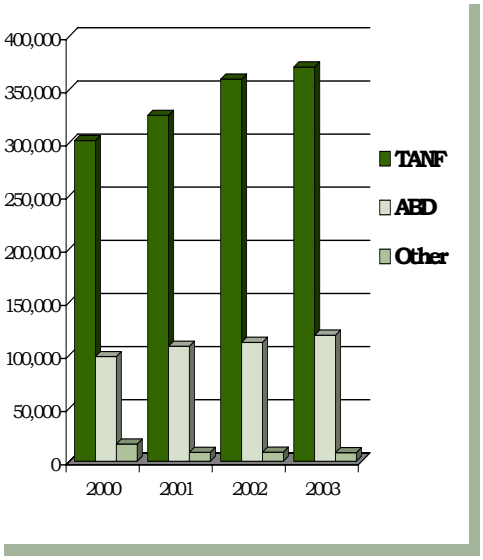
1900s	1910s	1920s	1930s	1940s	1950s
Doctors are no longer expected to provide free services to all hospital patients.	Progressive reformers argue for health insurance; seems to be gaining support.	Reformers now emphasize the cost of medical care instead of wages lost to sickness—the relatively higher cost of medical care is a new and dramatic development.	As part of the Social Security Act, the Aid to Families with Dependent Children (AFDC), a joint federal-state cash assistance program targeted primarily at low-income single parent families with dependent children, is enacted in 1935.	President Truman offers national health program plan proposing a single system that would include all of American society. Truman's plan fails.	National health care expenditures are 4.5 percent of the Gross National Product. Many legislative proposals are made for different approaches to hospital insurance, but none succeed.

For more information go to PBS's website at http://www.pbs.org/healthcarecrisis/history.htm

Medicaid Trends (continued)

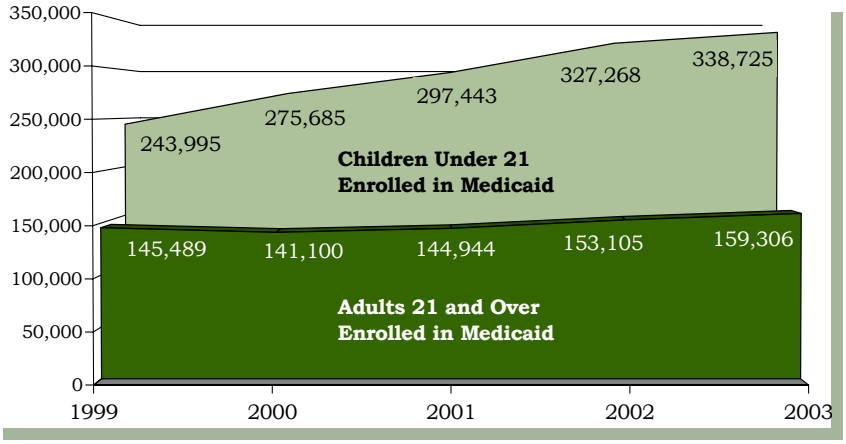
Disabled. Almost 20 percent (676,098 individuals) of the 2000 census survey respondents in Oklahoma reported some type of disability. Nearly 58,300 Oklahomans with chronic conditions and disabilities received medical services through Medicaid. Almost 18 percent were eligible because they received cash assistance through the SSI program. The remainder generally qualified by incurring large hospital, prescription drug, nursing home, or other medical or long-term care expenses to meet their "spend down" obligation. These beneficiaries are also categorized as Aged, Blind and Disabled (ABD).

Figure 7 **Historic Enrollment by Aid Category**



Source: Point in time June enrollment numbers OHCA Annual Report 2000-2003

Figure 8 **Historic Child / Adult Enrollment**



Source: Point in time June enrollment numbers OHCA Annual Report 1999-2003

Medicaid created under Title XIX of the Social Security Act in 1965.

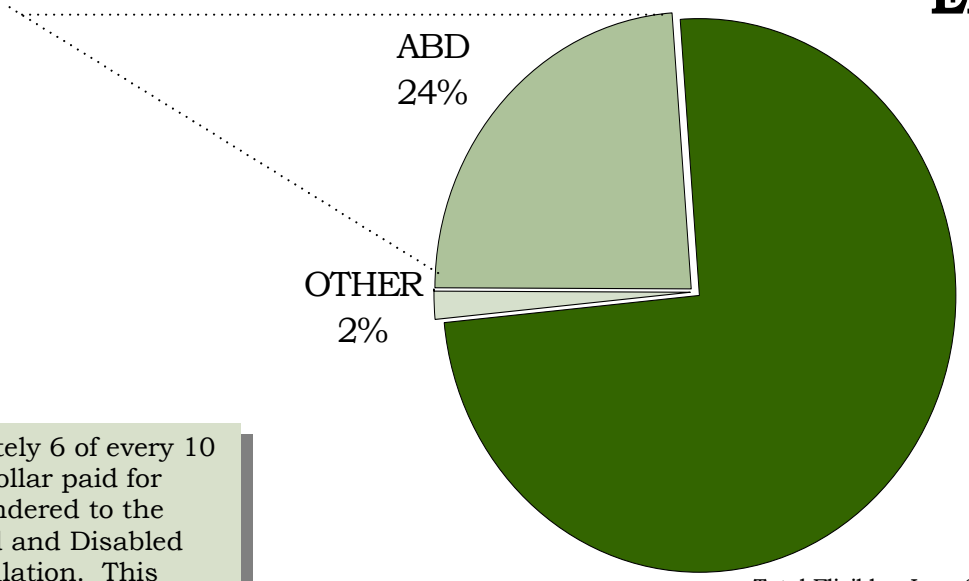
1960s	1970s	1980s	1990s	2000s
In the 1950s, the price of hospital care doubled. In the early 1960s, those outside the workplace, especially the elderly, have difficulty affording insurance.	Creation of the Supplemental Security Income (SSI) program, a federally administered, means-tested cash assistance program that provides monthly payments to eligible aged, blind, and disabled individuals who need assistance because they are minimally covered under the Social Security system.	Growing complaints by insurance companies that the traditional fee-for-service method of payment to doctors is being exploited. "Capitation" payments to doctors become more common.	Health care costs rise at double the rate of inflation. Expansion of managed care helps to moderate increases in health care costs. By the end of the decade there are 44 million Americans, 16% of the nation, with no health insurance at all.	**Health care costs are on the rise again.** Changing demographics of the workplace lead many to believe the employer-based system of insurance cannot last. New approaches to public health care are being explored.

For more information go to PBS's website at http://www.pbs.org/healthcarecrisis/history.htm

Medicaid Enrollees and Expenditures by Aid Category (as of June 2003)

61% of expenditures were paid on behalf of the Aged, Blind and Disabled

Enrollees

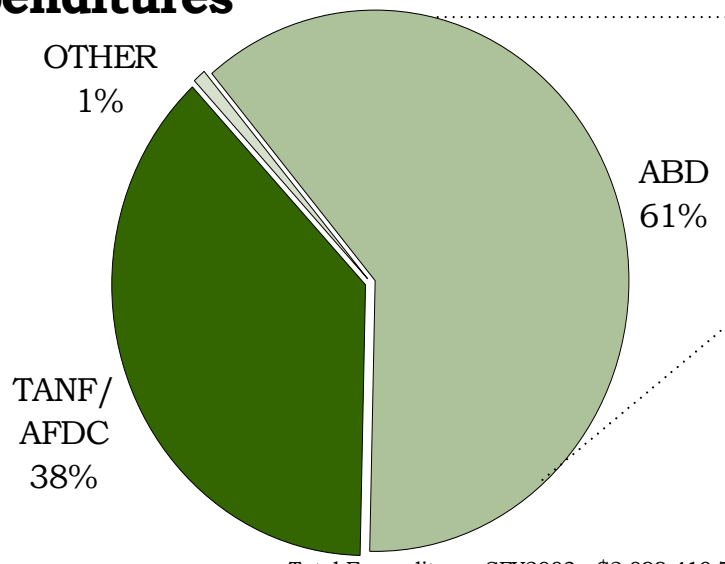


Total Eligibles June 2003 - 498,031

Approximately 6 of every 10 Medicaid dollar paid for services rendered to the Aged, Blind and Disabled (ABD) population. This group includes persons with chronic medical conditions, or in long-term care facilities and Medicare beneficiaries.

Expenditures

Only 24% of enrollees were Aged, Blind and Disabled



Total Expenditures SFY2003 - $2,099,410,781

Nearly 98% of the persons enrolled received a service or had a capitation payment made by Oklahoma Medicaid.

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.

"It is a poor government that does not realize that the prolonged life, health, and happiness of its people are its greatest asset."

Charles Horace Mayo, co-founder of the Mayo Clinic, 1919

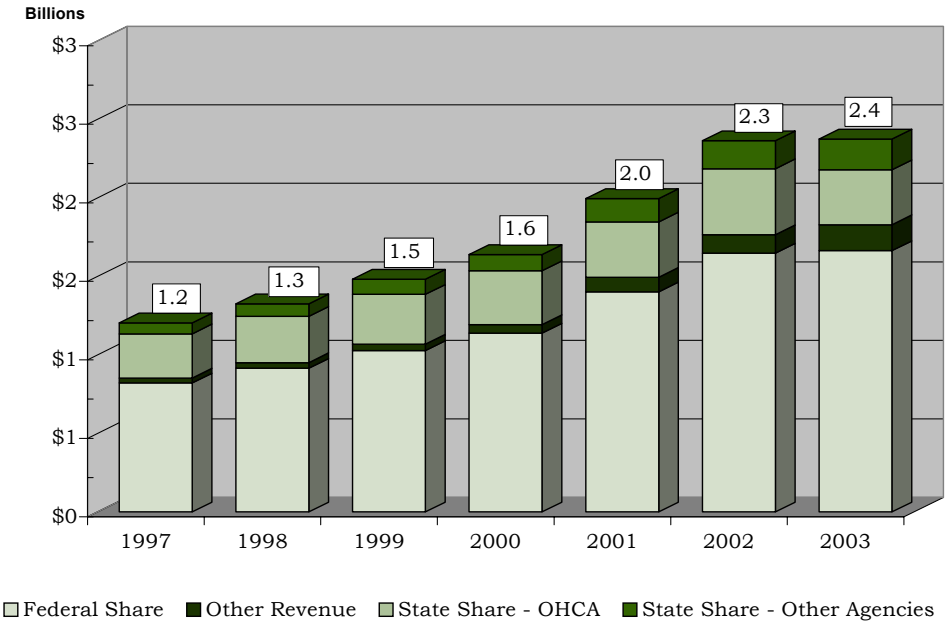
Medicaid is the largest source of federal financial assistance in Oklahoma. Medicaid accounted for an estimated 40 percent of all federal funds flowing into Oklahoma. Federal payments for Medicaid exceeded those for highways, education, housing, Temporary Assistance to Needy Families (TANF), food stamps, and child nutrition programs. Federal Medicaid dollars received for SFY2003 totaled over 1.1 billion dollars.

Figure 9 **Condensed Summary of OHCA Revenues**

As of June 30, 2003 **REVENUES**	**SFY03 Budget YTD**	**SFY03 Actual YTD**	**% Over/ (Under)**
State Appropriations	$ 420,542,170	$ 424,769,536	1.0%
Federal Funds — OHCA	1,283,847,656	1,283,243,739	0.0%
Federal Funds for Other State Agencies	442,254,175	442,254,175	0.0%
Refunds from Other State Agencies	182,467,493	182,467,493	0.0%
Other Revenue	154,896,913	155,369,786	0.3%
TOTAL REVENUES	**$ 2,484,008,407**	**$2,488,104,729**	**0.2%**

Source: OHCA Financial Services Division (August 2003).

Figure 10 **Summary of Expenditures and Revenue Sources—Oklahoma Medicaid**



Source: Annual National Association of State Budget Officers (NASBO) Survey as prepared by OHCA Financial Services Division.

How is Medicaid Financed? (continued)

Figure 11 **Historical Federal Medical Assistance Percentage (FMAP)**

Federal Fiscal Year	FMAP Rate	SCHIP‡
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	71.20%	79.87%
FFY02	70.43%	79.30%
FFY03—Qtr. 1 & 2	70.59%	79.39%
FFY03—Qtr. 3 & 4	73.54%	79.39%
FFY04—Qtr. 1-3	73.54%	79.17%
FFY04—Qtr. 4	70.24%	79.17%

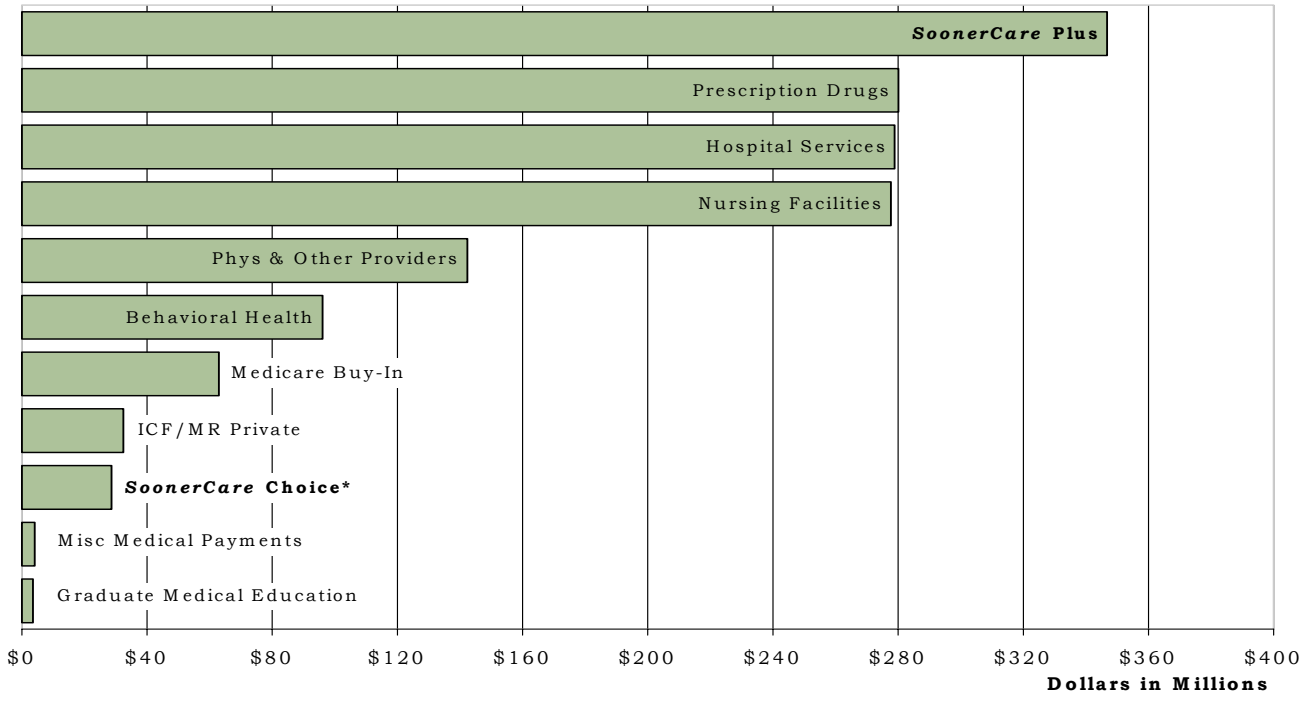
‡ SCHIP: *State Children's Health Insurance Program, see additional information on Page 28. The Federal Fiscal Year is from October through September.*

Under a new law, Oklahoma will get a temporary increase in the amount of Medicaid matching funds received from the federal government for five calendar quarters, beginning April 1, 2003, and ending June 30, 2004. The increase for all eligible expenditures will be 2.95 percentage points over the normal federal share amount. Approved by Congress and signed by President Bush, the funds are part of the Jobs and Growth Tax Relief Reconciliation Act of 2003.

On average, for every one state dollar that Oklahoma Medicaid spends, Oklahoma receives 2.4 dollars of federal money.

Where are the Medicaid Dollars Going?

Figure 12 **Oklahoma Medicaid Actual Expenditures SFY2003**



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

Where are the Medicaid Dollars Going? (continued)

Figure 13 **Condensed Summary of OHCA Expenditures SFY2003**

As of June 2003 EXPENDITURES	SFY03 Budget YTD	SFY03 Actual YTD	% (Over)/ Under
ADMINISTRATION	**$ 70,284,120**	**$ 69,205,928**	**1.5%**
OHCA MEDICAID PROGRAMS			
Managed Care:			
***SoonerCare* Plus**	359,546,766	346,760,774	3.6%
SoonerCare* Choice	30,885,670	28,613,054	7.4%
Acute Fee-for-Service Payments:			
Hospital Services	280,408,568	278,890,571	0.5%
Behavioral Health	96,521,403	96,104,129	0.4%
Physicians & Other Providers	149,785,115	142,371,794	4.9%
Prescription Drugs	275,159,242	280,094,928	(1.8)%
Miscellaneous Medical Payments	4,728,796	4,084,307	13.6%
Other Payments:			
Nursing Facilities	283,610,593	277,714,649	2.1%
ICF/MR Private	32,999,545	32,437,898	1.7%
Medicare Buy-In	62,522,579	62,963,651	(0.7)%
Graduate Medical Education	3,543,437	3,543,437	0.0%
OTHER OHCA MEDICAL PROGRAMS	**$8,648,084**	**$8,726,448**	**(0.9)%**
TOTAL OHCA	**$1,658,643,918**	**$1,631,511,567**	**1.6%**
QUALITY OF CARE PAYMENTS: State funds are from the collected Quality of Care Fee.			
ADMINISTRATION – QUALITY OF CARE	**$ 814,183**	**$ 814,183**	**0.0%**
Nursing Home Rate Adjustment	155,421,728	155,421,728	0.0%
NET – ***SoonerRide***	426,925	426,925	0.0%
Personal Allowance Increase	3,904,380	3,904,380	0.0%
Coverage for DME and supplies	2,792,009	2,792,009	0.0%
Coverage of Qualified Medicare Beneficiaries	12,995,591	12,995,591	0.0%
ICF/MR Rate Adjustment	19,103,468	19,103,468	0.0%
OSDH – 10 Inspectors	356,804	356,804	0.0%
Total Quality of Care	**$ 195,815,088**	**$ 195,815,088**	**0.0%**
OTHER STATE AGENCY PROGRAMS: State funds are reimbursed from the receiving agency or entity.			
Non-Medicaid Programs	$ 9,791,269	$ 9,791,269	0.0%
Dept. of Human Services Medicaid (OKDHS)	419,508,989	419,508,989	0.0%
Office of Juvenile Affairs Medicaid (OJA)	5,991,250	5,991,250	0.0%
Dept. of Mental Health Medicaid (DMHSAS)‡	19,139,968	19,139,968	0.0%
Oklahoma State Dept. of Health (OSDH)‡	2,058,756	2,058,756	0.0%
Department of Education Medicaid (DOE)‡	6,250,239	6,250,239	0.0%
Hospital Upper Payment Limit	18,104,484	18,104,484	0.0%
Medical Education Payments	145,657,321	145,657,321	0.0%
Total Other State Agency Programs	**$ 626,502,276**	**$ 626,502,276**	**0.0%**
TOTAL ALL EXPENDITURES	**$2,480,961,282**	**$ 2,453,828,931**	**1.1%**

Source: OHCA Financial Service Division, August 2003. 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 expenditures.*

What Services Does Medicaid Cover?

Title XIX of the Social Security Act requires that in order to receive federal matching funds, certain basic services must be offered to the categorically needy population in any state program. States may also receive federal funding if they elect to provide other optional services. Within broad federal guidelines, states determine the amount and duration of services offered under their Medicaid programs. The amount, duration, and scope of each service must be sufficient to reasonably achieve its purpose. States may place appropriate limits on a Medicaid service based on such criteria as medical necessity or utilization control. For example, Oklahoma has placed a reasonable limit on the number of covered physician visits or may require prior authorization to be obtained prior to service delivery. With certain exceptions, a state's Medicaid plan must allow beneficiaries freedom of choice among health care providers participating in Medicaid. In general, states are required to provide comparable services to all categorically needy eligible persons.

Figure 14 **Optional and Mandatory Medicaid Services**

What Services are Covered Under Medicaid?

Federally Mandated Services
Early / periodic screening diagnosis & treatment (EPSDT)(under age 21)
Family planning services & supplies
Inpatient hospital
Laboratory & x-ray
Emergency transporation
Nurse midwife
Nurse practitioner
Nursing facility / home health for age 21+
Outpatient hospital
Physician
Rural health clinic and federally qualified health center
Non-emergency transporation

Optional Covered Services
Case management
Chiropractor
Clinic
Dental
Dentures
Diagnostic services
Emergency hospital

Optional Covered Services - continued
Inpatient hospital for age 65+ (institutions for mental
Eyeglasses
Inpatient psychiatric under 21
ICF / MR
Nurse anesthetist
Nursing facility under 21
Occupational therapy
Optometrist
Personal care
Physical therapy
Podiatrist
Prescribed drugs
Preventive services
Private duty nursing
Prosthetic devices
Psychologist
Rehabilitative
Respiratory care
Screening services
Speech / hearing / language disorders
TB related

States may provide and pay for Medicaid services through various prepayment arrangements, such as a health maintenance organization (HMO). Oklahoma pays the health maintenance organizations directly under ***SoonerCare* Plus**. A prearranged fee is paid to the ***SoonerCare* Choice** Primary Care Provider and other services are paid under the fee-for-service program. The fee-for-service program operates as a vendor payment program, with payments made directly to the providers. Providers participating in Medicaid must accept the Medicaid reimbursement level as payment in full. Each state has relatively broad discretion in determining (within federally-imposed upper limits and specific restrictions) the reimbursement methodology and resulting rate for services, with exceptions, such as for institutional services, in which payment may not exceed amounts that would be paid under Medicare payment rates. For disproportionate share hospitals (DSHs), different limits apply. Oklahoma Medicaid pays for covered services provided by an Oklahoma Medicaid contracted provider to an enrolled Oklahoma Medicaid beneficiary. Services may be limited by age, duration, coverage type and/or medical necessity.

OHCA and Medicaid

From 1988 to 1992, the number of Oklahomans receiving Medicaid assistance increased by 47 percent, from 245,000 to 360,000. This escalating growth came with an associated cost increase from $580 million to a slightly more than $1 billion. At the same time, the defeat of the proposed Health Care Provider Tax effectively capped the amount of money available to the state for entitlement programs – thus placing unavoidable and serious pressures on the state's budget. These financial realities, accompanied by ever-increasing eligible populations, would have lead to the financial collapse of the state Medicaid system if left unchecked.

House Bill 1573, the Oklahoma Health Care Authority Act of 1994, created the Authority as an executive agency with the mandate to:

- ✓ Purchase Medicaid benefits and state and education employees' health care benefits.
- ✓ Study all state-purchased and state-subsidized health care systems.
- ✓ Make recommendations and changes aimed at minimizing the financial burden on the state, while allowing the state to provide the most comprehensive health care possible.
- ✓ Become the designated single state Medicaid agency effective January 1, 1995.

An immediate attempt to curb the growth in 1992 resulted in reductions in rates and specific services available to Oklahoma's Medicaid population. Physicians and other practitioners saw a 5 percent reduction in their rates and adult beneficiaries saw limits placed on office visits and hospitalization. Further, the state was also forced to completely eliminate adult dental services.

As a result of recommendations from broad-based citizens committees, the Oklahoma Health Care Authority was established by the legislature in 1993 through House Bill 1573. The Health Care Authority Act can be found in Oklahoma Statutes Title 63, Sec. 5004. In addition, their recommendations were the catalyst for Oklahoma to begin the transition of its traditional fee-for-service Medicaid program to a coordinated system of managed care – focusing on primary care, prevention and increased access. This transition was accomplished through Senate Bill 76 in 1993. Medicaid Healthcare Options Act can be found in Title 56, Sec. 1010. Under its current Section 1115(a) waiver, implemented in July 1996, Oklahoma has chosen to operate two, distinct managed care delivery systems within its Medicaid program: ***SoonerCare* Plus** and ***SoonerCare* Choice.**

Senate Bill 76 of 1993, also known as the Oklahoma Medicaid Health Care Options Act, mandated and allowed for:

- ✓ The conversion of the Oklahoma Medicaid program from fee-for-service to a statewide, comprehensive system of managed health care delivery.
- ✓ Prepaid fully-capitated health plan arrangements.
- ✓ Primary care case management systems in areas that could not support the fully-capitated approach.

Figure 15 **Breakout of *SoonerCare* and Fee-for–Service (June 2003)**

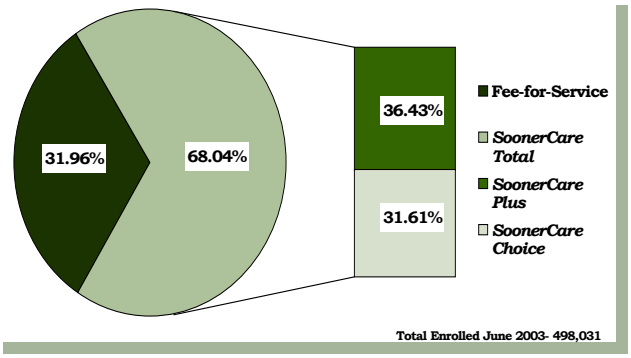


Figure 16 **Enrollees by Delivery System (Adult and Child), SFY2001 through SFY2003**

Delivery System		June-01	June-02	June-03	% Change from Prior SFY
***SoonerCare* Plus**	Adult	30,426	35,009	36,093	3%
	Child	131,957	148,494	145,358	-2%
Total		162,383	183,503	181,451	-1%
***SoonerCare* Choice**	Adult	23,271	26,135	25,185	-4%
	Child	113,618	129,181	132,223	2%
Total		136,889	155,316	157,408	1%
Fee-for-Service	Adult	91,247	91,961	98,028	7%
	Child	51,868	49,593	61,144	23%
Total		143,115	141,554	159,172	12%
Grand Total		**442,387**	**480,373**	**498,031**	**4%**

OHCA and Medicaid (continued)

As we complete our eighth year managing the now $2.4 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. One-third of the $2.4 billion pays for nursing home quality initiatives, medical education and medical-related programs administered by other state agencies.

The Oklahoma Health Care Authority has also led the effort to supplement state dollars with available and appropriate federal dollars. OHCA's revenue maximization initiatives have supported programs at the Department of Human Services, Department of Mental Health and Substance Abuse Services, Department of Health, Office of Juvenile Affairs, and the Department of Education, as well as OU and OSU medical schools and teaching hospitals.

- ✓ OHCA has increased federal revenue by more than $790 million, a 97 percent increase.
- ✓ OHCA interacts with federal and tribal governments, hundreds of contractors and providers of care in addition to beneficiaries and their families.
- ✓ OHCA employs more than 268 persons directly and provides funding for more than 750 eligibility workers employed by the Oklahoma Department of Human Services.

OHCA does not want to miss an opportunity to maximize federal revenues, however, we must be cautious. OHCA has an obligation, as a sound fiscal manager, to ensure that all plans to maximize federal revenues are compliant with applicable laws and regulations and will not put the state in jeopardy of a future disallowance.

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 cost-effective health care purchasing approaches; monitoring contractor and provider performance; promoting and preserving beneficiary rights and protections; and disseminating information to the Oklahoma Legislature, congressional delegation, beneficiaries and the general public.

As the state Medicaid agency, a board of directors meets monthly to direct the action and to oversee the operations of OHCA. Board members are appointed by the governor, president pro tempore of the Senate and the speaker of the House. OHCA also has a Drug Utilization Review (DUR) board, a Medical Advisory Committee (MAC) and a joint legislative oversight committee. These groups of health professionals, providers, advocates and elected officials all serve to ensure that decisions are made to best serve the beneficiary's needs while maintaining the fiscal integrity of the agency.

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.

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 beneficiaries, and in meeting the highest standards of administrative performance.

Strategic Planning (continued)

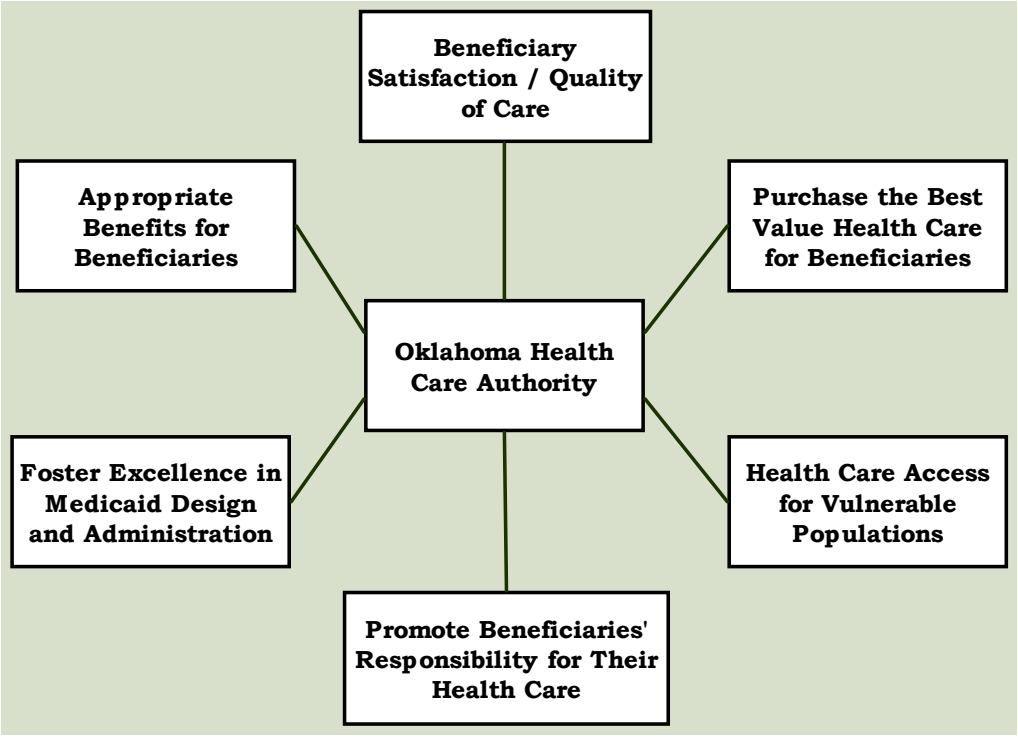
In order to be a leader, OHCA must continually plan. Changes in environmental forces are now so volatile, a proactive planning stance is necessary for advantage rather than just for survival. Societal needs and expectations, technological advances, demographic and economic change – all indicate an opportune time for OHCA to take stock, assess its current position and strengths and build for the future.

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 — a 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, which are:

- ✓ Improve health care access for the underserved and vulnerable populations of Oklahoma. (Medicaid Beneficiaries)
- ✓ Protect and improve beneficiary health and satisfaction, as well as ensure quality, with programs, services and care. (Beneficiary Satisfaction/Quality of Care)
- ✓ Promote beneficiaries' personal responsibility for their health services utilization, behaviors and outcomes.
- ✓ Ensure that programs and services respond to the needs of beneficiaries by providing necessary medical benefits to our beneficiaries. (Benefits)
- ✓ Purchase the best value health care for beneficiaries by paying appropriate rates and exploring all available valid options for program financing. (Purchasing Issues/Provider Relations)
- ✓ Foster excellence in the design and administration of the Medicaid program.

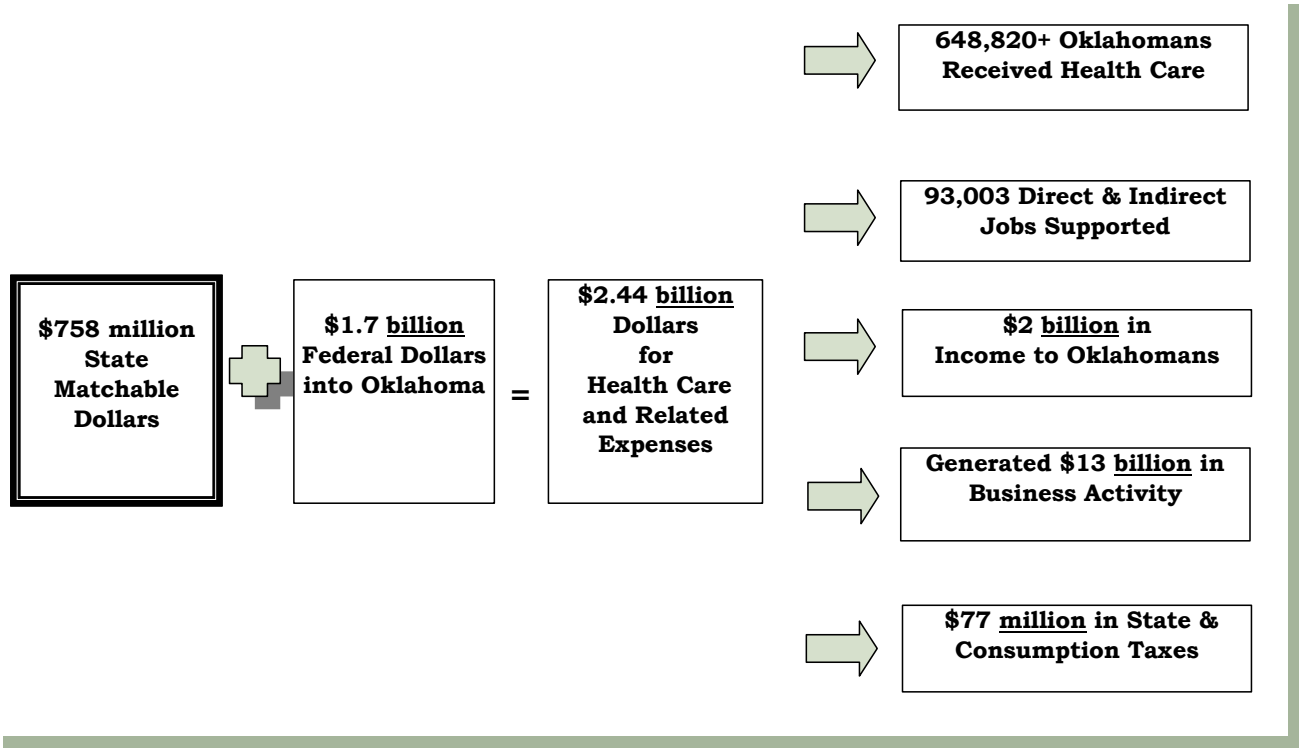


Medicaid and the Economy

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.

> "Poverty and inadequate health care take their toll on the quality of a community's health"
>
> *Los Angeles Times* December 17, 1995

Figure 17 **Estimated Direct and Indirect Impact of Oklahoma Medicaid Dollars**



State matchable dollars consisted of dollars appropriated to OHCA and other various state agencies, drug rebates, quality of care fees, other fees and refunds.

Estimated Economic Impacts based on Families USA, Medicaid: Good Medicine for State Economies, January 2003; and SFY2000 Input / Output Model developed by the Oklahoma Department of Commerce.

Oklahoma's Uninsured

Based on 2000-2001 state data, the Kaiser Family Foundation reported Oklahoma's uninsured population to be more than 630,000 or 19 percent of the state population. Of this number, more than 470,000 (75 percent) are adults between the ages of 19 and 64. Uninsured children 18 and under are reported at 155,000 (25 percent).

Uninsured children are by and large caught in an unforgiving gap. Surprisingly, many are not children of Oklahoma's poorest families. In most cases, their parents earn too much for the children to be eligible for traditional Medicaid, but too little to make the purchase of private insurance possible.

The lack of health care coverage has significant impacts on the health of children. Health insurance helps assure access to appropriate health services that can monitor a child's cognitive, physical and emotional development. However, for low-income families who cannot afford health insurance, access to care on an ongoing basis is out of reach. Frequently, the only medical attention their children receive comes from crowded emergency rooms.

Children without health care coverage have substantially less access to health care services, including preventive care that ensures childhood immunizations are up to date, vision and hearing screening, and routine dental care have been provided. Care for uninsured children is also far more likely to be delayed due to cost. Unmet health care needs reduce children's ability to learn and to grow into healthy and productive adults. Making sure that children stay healthy is an important goal for all segments of society. Healthy children are important to employers because sick children reduce employee productivity. Healthy children are important to the health care industry because they increase profitability. Healthy children are important for all of society, because they are our future.

Also, for adults, being uninsured even on a temporary basis, can have serious implications for state economies. Uninsured workers are less likely to receive adequate and timely health care and, as a result, suffer more serious illnesses that threaten their work productivity and job retention.

Economic Impact of Lack of Health Care Coverage

In spite of access problems and barriers the uninsured face in getting health care, they still do get *some* health care. Studies indicate that, on average, these individuals do not pay for over half of their health care costs. Obviously, others then are stepping in to pick up the tab.

Oklahoma needs to be concerned how health care is financed for the uninsured for two major reasons. One is that the burden is distributed very unevenly throughout the health care delivery system. Some providers serve very few uninsured persons while others face great cost pressures because they serve very large uninsured populations. The second is a concern that health care resources be spent as wisely and efficiently as possible. If people who have access problems could get proper care at a clinic or doctor's office, they would be less likely to go to the emergency room. This would free up hospitals to do what they are set up to do and reduce costs. Clearly to provide services for everyone reduces the total number of dollars in the health care system.

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. 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 Demonstration Waiver to provide Medicaid eligibility for family planning benefits to Oklahomans with incomes at-or-below 185 percent of the federal poverty level. Without this waiver, these individuals would otherwise be ineligible for Medicaid and its family planning services.

This project is a collaborative effort between OHCA, the Oklahoma State Department of Health, the Oklahoma Department of Human Services and the Oklahoma State Medical Association. OHCA has submitted the waiver application to the federal partner, Centers for Medicare and Medicaid Services (CMS), and is awaiting a decision. Pending CMS' approval, the waiver services could be offered by January 1, 2004.

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 beneficiaries 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: 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: 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: Serves the "frail elderly" (Oklahomans age 65 years and older) and adults with physical disabilities. This group comprises approximately 80 percent of this waiver's consumer population. The remaining 20 percent are adults with physical disabilities. Approximately 14,180 persons receive services through this waiver program.

Depending on each person's needs as identified in their individual Plan of Care, the waiver services could include:

- ✓ skilled nursing;
- ✓ prescription drugs;
- ✓ 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.

Services through these waiver programs are available to individuals when the beneficiary can be served safely in the community setting and the cost of providing waiver services to waiver beneficiaries is less than the cost of services in a long-term care facility (NF or ICF/MR). Waiver services are specifically defined in each waiver agreement.

Oklahoma Managed Care — *SoonerCare* Plus

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

The "Plus" in ***SoonerCare* Plus** refers to the comprehensive and integrated health care delivery system, as compared to the traditional fee-for-service program. Persons within the ***SoonerCare* Plus** program select a primary care physician (PCP). The PCP is responsible for coordinating most of the beneficiary'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.

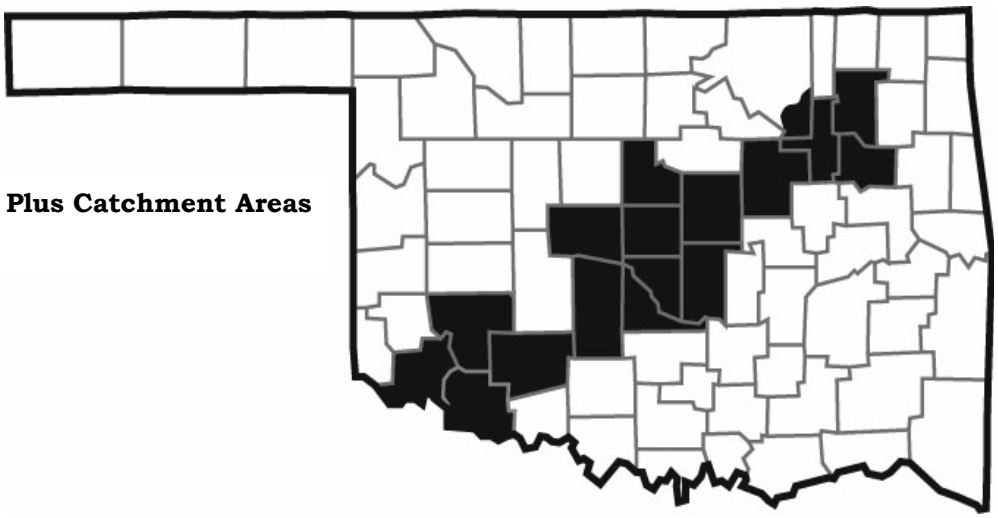


Figure 18 ***SoonerCare* Plus Catchment Areas**
(Shaded Areas)

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

Southwest 14,992 Enrolled*	Central 104,366 Enrolled*	Northeast 62,093 Enrolled*
Comanche	Canadian	Creek
Jackson	Cleveland	Rogers
Kiowa	Grady	Tulsa
Tillman	Lincoln	Wagoner
	Logan	Osage (limited)
	McClain	
	Oklahoma	
	Pottawatomie	

** Enrolled within the month of June 2003.*

SFY2003 Specific Information...

- ✓ The $346,760,774 ***SoonerCare* Plus** dollars accounted for 21 percent of the total OHCA Medicaid dollars expended in SFY2003. This amount is a 63 percent increase from the SFY2000 expenditures of $213,238,980.
- ✓ As of June 30, 2003, the ***SoonerCare* Plus** program had 181,451 persons enrolled, a 27 percent increase from the 142,527 enrolled in June 2000.

Oklahoma Managed Care — *SoonerCare* Choice

***SoonerCare* Choice** is a Primary Care Case Management (PCCM) program in which 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 beneficiary's ability to change health care providers up to four times per year. Beneficiaries enrolled in ***SoonerCare* Choice** are not "locked in" with a primary care provider/case manager (PCPCM) as their counterparts in the ***SoonerCare* Plus** delivery system. This important facet to the program 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. Providers contracting in this program include physicians, nurse practitioners, and physician assistants.

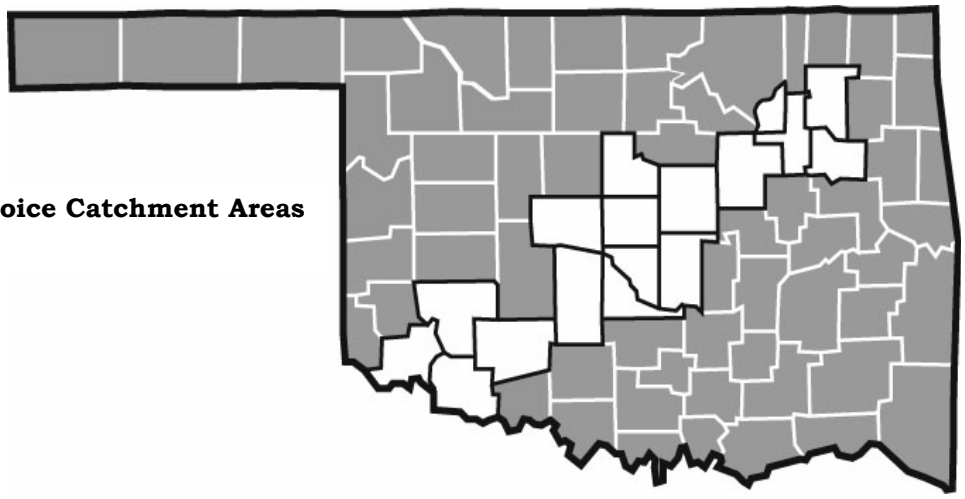


Figure 19 ***SoonerCare* Choice Catchment Areas**
(Shaded Areas)

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 other 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 in which experienced and caring individuals directly interact with both beneficiaries and providers by timely facilitating and coordinating members' care to the most appropriate facility, utilizing the most appropriate resources.

SFY2003 Specific Information

- ✓ Dollars expended in capitated payments during SFY2003 on behalf of ***SoonerCare* Choice** members totaled $28,613,054 or 1.75 percent of the total OHCA Medicaid expenditures.
- ✓ As of June 30, 2003, the ***SoonerCare* Choice** program had 157,408 persons enrolled.
- ✓ Capitation expenditures for ***SoonerCare* Choice** have increased by 39 percent and the beneficiaries have increased by 15 percent since SFY2000.

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 18 and under 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).

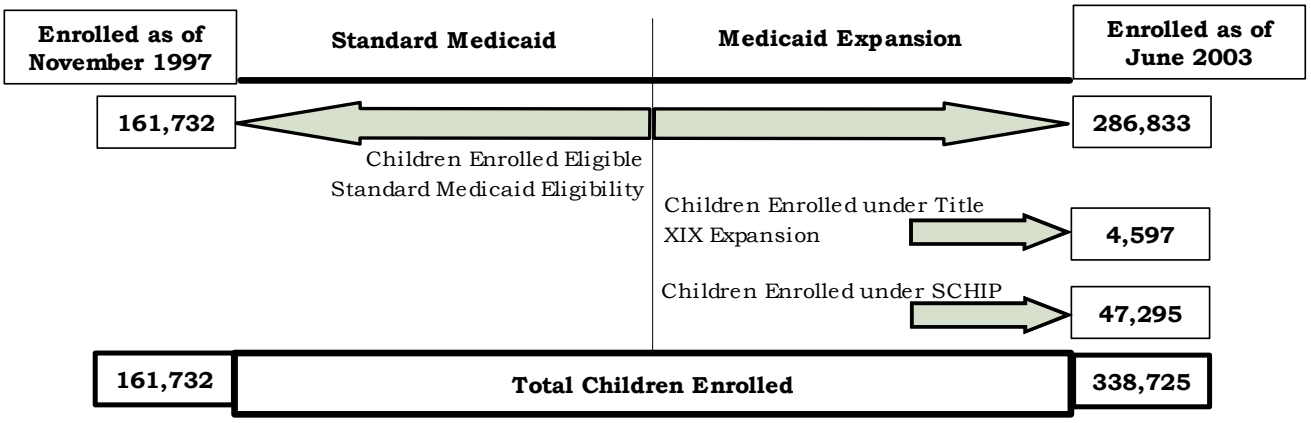
And Then Came SCHIP…
Subsequently, the Federal Budget Act of 1997 made numerous Medicaid changes and also created the State Children's Health Insurance Program (SCHIP). The optional program, referred to as SCHIP or Title XXI, is designed to help states cover additional uninsured low-income children with a higher federal match assistance percentage (See Figure 11 Historical Federal Medical Assistance Percentage, Page 16).

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

- ✓ 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 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.

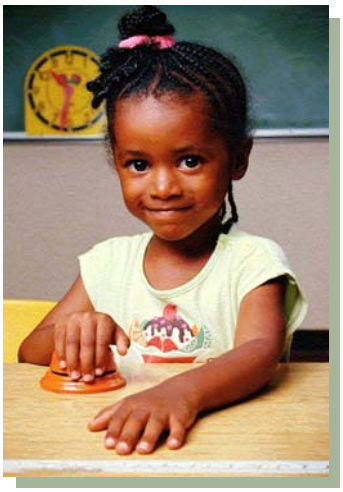
Figure 20 **Increased Enrollment of Children Since Implementing Expansion Programs**



Since the implementation of the Medicaid eligibility expansion programs, the number of children enrolled in Oklahoma Medicaid has increased 109 percent.

State Children's Health Insurance Program (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 whose eligibility falls above the federal minimum standards and 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 beneficiaries. 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.

OHCA is working hand in hand with several other state agencies (Department of Human Services, Oklahoma Juvenile Affairs, Oklahoma Commission on Children and Youth, Oklahoma State Department of Health, Department of Mental Health and Substance Abuse Services and the Department of Rehabilitative Services) to enhance services for both adults and children. A pilot program for adults that will enhance the efficient use of monetary and human resources as well as increasing consumer choice and direction is anticipated within the next fiscal year. It is also hoped that through this multi-agency effort, an improved continuum of outpatient care can be developed for children who are seriously emotionally disturbed and their families.

SFY2003 Specific Information…

- ✓ Expenditures for the behavioral health program totaled $96,104,129 for SFY2003. This represents 6 percent of the total OHCA expenditures.

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 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;
- ✓ 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.

SFY2003 Specific Information...

Estimated total payments to be made to GME qualified colleges of medicine:

University of Oklahoma – OKC	$ 20,955,565
University of Oklahoma – Tulsa	$ 18,055,243
Oklahoma State University College of Osteopathic Medicine – Tulsa	$ 8,551,258

State share monies were not available for disbursement as of August 2003.

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.

The federal disproportionate share payments are made to each state annually. The eligible hospitals are identified and the total funds are allocated on a "weighted" basis. The weighting is based on each hospital's share of Medicaid plus charity care revenues.

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.

SFY2003 Specific Information...

Payments made to IME qualified hospitals:

Oklahoma Medical Center – OKC	$ 11,309,322
Hillcrest Health Systems – Tulsa	$ 11,309,322

Hospitals (continued)

Direct Medical Education (DME)

In-state hospitals that qualify as teaching hospitals receive a supplemental payment adjustment for direct medical education (DME) expenses based on resident-months. These payments are 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.

Disproportionate Share Hospitals		SFY2003
University Hospitals	$	19,137,104
OK Youth Center	$	25,524
George Nigh Rehab	$	660
Griffin Memorial	$	3,319,550
Jim Taliaferro	$	31,503
Choctaw Memorial	$	6,104
Cimarron Memorial Hospital	$	2,348
J.D. McCarty Center for Children	$	739,814
Henryetta Medical Center	$	1,797
Hillcrest/St. Michael's	$	310,450
Logan County	$	1,424
Mission Hill	$	6,255
Parkside/Tulsa Psychiatric	$	5,787
Share Medical Center	$	4,661
Willow View	$	22,521
Arkansas Children's Hospital	$	413,580
TOTAL	$	24,029,082

DME Qualified Hospitals		SFY2003
Bone and Joint Hospital – OKC	$	2,792
Comanche County Memorial Hospital	$	53,524
Deaconess Hospital	$	115,228
Hillcrest Medical Center – Tulsa	$	9,043,520
Bass Baptist Health Care Center	$	33,609
Southwest Medical Center	$	238,920
Baptist Medical Center	$	4,353,326
Jackson County Memorial	$	272
Jane Phillips Hospital	$	29,275
Laureate Psych Hospital	$	6,397
Medical Center of Southeastern Oklahoma	$	112,364
Saint Francis – Tulsa	$	3,529,092
Shadow Mountain/Brown Schools Hospital	$	28,678
St. Anthony	$	2,304,740
St. John – Tulsa	$	2,142,442
Tulsa Regional Medical	$	6,585,414
University Health Partners	$	29,463,192
TOTAL	$	58,042,785

SFY2003 Specific Information...

- ✓ Hospital expenditures, $278,890,571 accounted for 17 percent of OHCA's total Medicaid expenditures.
- ✓ Hospital payments have increased almost 7 percent since SFY2000.
- ✓ During SFY2003, the Oklahoma Medicaid program had contracts with 433 hospitals.

Long-Term Care

We are far from the conditions in the early 1900s when there were no federal assistance programs to help pay for the care of the elderly. In those days most states sent their impoverished citizens to "poor farms" or "almshouses." These facilities were known for being dilapidated and providing inadequate care. Not until the late 1950s and early 1960s did the federal government step in to help regulate and fund what is now called a nursing home or long-term care facility.

With long-term care coverage largely unavailable through Medicare or traditional private health insurance plans, Medicaid is the nation's de facto financing system. Nationwide, Medicaid paid for over 45 percent of all long-term care in 2000. Medicaid provides coverage for poor persons and many middle-income individuals who have become nearly impoverished by "spending down" their assets to cover the high costs of their long-term care.

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 beneficiaries. 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 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 Oklahoma Department of Human Services for 10 regional ombudsmen.

Level of Care Evaluations – Long-Term Care Beneficiaries

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 beneficiary requires a long-term care facility and receives proper treatment for their MI and/or MR diagnosis.

SFY2003 Specific Information...

- ✓ Expenditures for nursing facilities (NF) serving adults were $277,714,649; expenditures for private intermediate care facilities for the mentally retarded (ICF/MR) were $32,437,898.
- ✓ Total long-term care expenditures accounted for 19 percent of the total OHCA Medicaid expenditures.
- ✓ Medicaid clients living in long-term care facilities represented an estimated 4 percent of the total Medicaid clients.
- ✓ Medicaid funded 6,383,079 long-term care facility bed days; this represents 70.75 percent of the total actual bed days for SFY2003.
- ✓ Total Quality of Care Program revenues were $56,163,443 and the state share of the total $195,815,088 Quality of Care expenditures was $57,976,493.

Medicare "Buy-In" Program

As part of the medical assistance program, Oklahoma has Medicare savings programs that may save money for anyone who has Medicare and has limited income and resources. 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".

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.

SFY2003 Specific Information...

- ✓ Medicare "Buy-In" expenditures accounted for 3.8 percent of the total Medicaid expenditures.
- ✓ "Buy-In" expenditures totaled $62,963,651 for SFY2003.
- ✓ An average of 3,351 Part A premiums and 68,994 Part B premiums were paid each month.

Medicaid and Native Americans

Oklahoma is home to 39 tribal governments and, according to the 2000 Census, more than 380,000 Native Americans live in the state. In addition to the health plans and providers who participate in Oklahoma Medicaid, Native Americans may receive health care services from three types of health care systems — Indian Health Service (IHS), Tribal health care systems, or Urban Indian Clinics (I/T/U).

The role of IHS in Oklahoma has increasingly changed and diminished as some tribes have opted to manage individual tribal health care systems. Tribal health care systems range from large health care systems to small tribal clinics. There is also one Urban Indian Clinic in Oklahoma City and one in Tulsa that are operated separately from tribal governments. 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. OHCA works with tribes by participating in quarterly meetings of the Oklahoma City Area Inter-Tribal Health Board and utilizing 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. On a national level, OHCA also participates in an informal "Indian Health Work Group" made up of representatives from 15 state Medicaid programs with large numbers of tribal members.

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 with IHS, tribal leaders and CMS to develop a new managed care model for the ***SoonerCare* Choice** program. Implemented in July 2001, the new model allows I/T/U providers to serve as primary care physicians (PCPs). 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.

SFY2003 Specific Information...

- ✓ For the month of June 2003 there were 62,259 persons categorized as Native American enrolled in Medicaid.

Pharmacy Program

Although coverage is optional under federal law, prescription drugs are currently covered by every state's Medicaid program. States cover pharmaceutical therapies not only to treat acute conditions but to prevent illness, delay complications from chronic diseases, provide an alternative to expensive surgery, or result in shorter hospital stays. However, treatment with prescription drugs can be costly. Federal law governing Medicaid prescription drug programs seeks to balance optimal use against cost-concerns.

Costs for the elderly and persons with disabilities account for 80 percent of all national Medicaid drug spending. *Urban Institute Estimates 2000*

State Medicaid programs must step in to cover the tab for low-income Medicare patients because Medicare does not cover prescription drugs. Filling the gap for these "dual-eligibles" is a particular challenge for states.

Prescription expenditures are offset by the Federal Drug Rebate Program which guarantees that states pay the lowest cost for prescription drugs. In exchange for the rebate, states must make all products of a contracted manufacturer available to Medicaid beneficiaries within the framework of the federal requirements. Pharmacy reimbursement 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 beneficiaries. The primary goal of the DUR is to enhance and improve the quality of pharmaceutical care and patient outcomes by encouraging optimal medication use as recommended in current professional literature. This goal is accomplished primarily by educating physicians and pharmacists to ensure medication therapies are appropriate, safe and effective.

SFY2003 Specific Information...

- ✓ Prescription drug program expenditures accounted for $280,094,928 or 17 percent of the total Oklahoma Medicaid expenditures.
- ✓ The average cost per prescription funded by Medicaid was $63.45.
- ✓ The average monthly prescription cost per patient funded by Medicaid was $198.56. This figure is 29 percent higher than the annual prescription costs of $153.42 reported for SFY2000.
- ✓ The total pharmacy expenditures have increased 54 percent since SFY2000.
- ✓ $56 million dollars were collected through the Drug Rebate program. For more information see page 41.

Physicians and Other Practitioners

Physicians and other practitioners are a crucial component in the delivery of health care to Oklahoma's Medicaid eligibles. The Medicaid program would not be possible without the dedication of these providers who are committed to care for all individuals who need health care but cannot afford it on their own.

SFY2003 Specific Information...

- ✓ Expenditures for physicians and other practitioners accounted for $142,371,794, or 9 percent of Oklahoma's total Medicaid expenditures.
- ✓ Physician services expenditures have increased by 33 percent since SFY2000.

This service to beneficiaries, as with all other Medicaid programs, is based on medical necessity, with physicians determining the need for medical care. Physicians provide and coordinate an individual's health care needs. Oklahoma should be proud of the health care professionals from many different and important fields participating in the state Medicaid program.

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.

"The developmental process in childhood offers a significant but time-limited opportunity for health promotion and disease prevention"

Dr. Neal Halfon, director of the UCLA Center for Healthier Children, Families and Communities; professor of pediatrics and public health.

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 known as 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. EPSDT staff conducts provider trainings and technical assistance for this program.

OHCA is also 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 as well.

SFY2003 Specific Information...

- ✓ OHCA contracted with 310 school based providers in 72 counties.
- ✓ During SFY2003, OHCA paid $1,430,518 for the Early Intervention (EI/SoonerStart) program.
- ✓ School based providers were reimbursed $8,024,144 for SFY2003.
- ✓ For more information regarding EPSDT, see page 29.

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 beneficiaries. 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 this area of Medicaid regulations, including setting reimbursement rates and transportation modes. Currently, the OHCA is responsible for reimbursement or payment of transportation for beneficiaries 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 beneficiaries enrolled in the ***SoonerCare*** **Plus** program. Nursing home residents in the Medicaid program also 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, OHCA utilizes a transportation brokerage system to provide the most cost effective form of transportation to beneficiaries 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.

SFY2003 Specific Information...

- ✓ Almost 55,000 beneficiaries utilized the ***SoonerRide*** services for just short of 400,000 transports.
- ✓ The non-emergency transportation program costs were $9,033,348; this represented less than 1 percent of the total Oklahoma Medicaid expenditures.
- ✓ Non-emergency transportation expenditures increased by 23 percent from SFY2002 to SFY2003.

Program and Payment Integrity Activities

The demand and costs for social and health care services continues to grow, while available federal and state funding continues to diminish. In addition, public demand for economy and accountability in government spending is increasing. Improper payments in government health programs, such as Medicaid, drain vital program dollars, hurting beneficiaries 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.

error (n.)

Mistake; something unintentionally done wrong.

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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. OHCA's claim processing system (MMIS) has hundreds of edits that stop many billing errors from being paid. However, no computer system can ever be programmed to prevent all potential billing errors.

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.

fraud (n.)

Crime of cheating people; the crime of obtaining money or some other benefit by deliberate deception.

Encarta® World English Dictionary [North American Edition] © & (P)2003 Microsoft Corporation.

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 Services (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).

Program and Payment Integrity Activities (continued)

Various units within the Oklahoma Health Care Authority are responsible for separate areas of potential recoveries. The Surveillance Utilization and Review Services (SURS) Unit is in place to safeguard against unnecessary utilization of care and services. The Pharmacy Unit reviews paid pharmacy claims to determine that claims are valid and in compliance with applicable federal and state rules and regulations. The Audit, Design and Evaluation Unit perform audits and reviews of external providers in regard to inappropriate billing practices and noncompliance with OHCA policy. Reviews can be initiated based on complaints from other Medicaid providers, beneficiaries, concerned citizens or 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 beneficiaries 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 beneficiaries. Medical services and/or records are reviewed for medical necessity, quality of care, appropriateness of place of service and length of stay.

Additionally, the PRO performs on-site inspection of care reviews for licensed psychiatric inpatient and day treatment facilities that provide services to Medicaid beneficiaries 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 21 **Program and Payment Integrity Recoveries, SFY2001 through SFY2003**

Provider Type	SFY2001	SFY2002	SFY2003
ADvantage Waiver	$ 45,640	$ 58,765	-
Home and Community-Based Waiver	$ 37,670	$ 81,005	$ 129,288
Behavioral Health	$ 591,070	$ 1,239,265	$ 708,350
DME Supplies	$ 25,728	$ 109,145	$ 63,198
Inpatient Hospital	$ 1,145,540	$ 337,391	$ 694,417
Long-Term Care Facilities	$ 104,191	$ 1,293,931	$ 137,952
Physician	$ 10,730	$ 8,523	$ 31,472
Pharmacy	$ 438,892	$ 146,068	$ 1,009,284
EPSDT	$ 17,560	$ 58,765	–
Other Practitioners	$ 58,186	$ 5,542	$ 48,774
Beneficiary	$ 14	–	–
HMO	$ 113,314	$ 276,359	$ 229,707
School Corporation	-	-	$ 209
Transportation Provider	-	-	$ 2,607
Total – OHCA Recoveries	**$ 2,475,221**	**$ 3,614,759**	**$ 3,055,258**
Medicaid Fraud Control Unit	$ 832,423	$ 1,003,518	$ 254,865
Total Medicaid Recoveries	**$ 3,298,644**	**$ 4,618,277**	**$ 3,310,123**

Figures are a combination of amounts recovered from SURS, Pharmacy, Audit, Design and Evaluation, contractor 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 beneficiary'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).

OHCA uses a combination of data matches, diagnosis code edits and referrals from providers, caseworkers and beneficiaries 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.

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.

Figure 22 **Third Party Liability Recoveries, SFY2001 through SFY2003**

	SFY2001	SFY2002	SFY2003
Estate Recoveries	$ 793,886	$ 3,756,885	$ 1,884,474
Credit Balance Reviews	$ 912,111	$ 437,658	$ 0
Other	$ 5,462,911	$ 4,618,887	$ 4,523,407
Total Recoveries	**$ 7,168,908**	**$ 8,813,430**	**$ 6,407,881**

Figure 23 **Third Party Liabilities Cost Avoidance, SFY2001 through SFY2003**

	SFY2001	SFY2002	SFY2003
Medicare	$ 827,824,935	$ 1,050,191,256	$ 715,618,830
Private Insurance	$ 68,163,756	$ 73,405,534	$ 45,243,945
Total Cost Avoidance	**$ 895,988,691**	**$ 1,123,596,790**	**$ 760,862,775**

USDA Historical Photos, Russell Lee;
Creek County, Oklahoma, February 1940

Program and Payment Integrity Activities (continued)

LTC Quality of Care Program Fees

In an effort to increase the quality of care received by long-term care beneficiaries, 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" prices charged by manufacturers.

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

Figure 24 **Fees, Rebates and Penalty Collection, SFY2001 through SFY2003**

	SFY2001	SFY2002	SFY2003
Quality of Care Fees	$ 33,849,967	$ 53,672,433	$ 56,163,442
Drug Rebates	$ 40,032,308	$ 48,348,254	$ 56,188,140
Penalties/Interest	$ 391,379	$ 257,447	$ 155,019
Total Collections	**$ 74,273,654**	**$ 102,278,134**	**$ 112,506,601**

USDA Historical Photos, Russell Lee;
Webber Falls, Oklahoma, June 1939

Program and Payment Integrity Activities (continued)

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.

Product Based Prior Authorization Cost Avoidance, SFY2001 through SFY2003

SFY2001 — $12,199,677
SFY2002 — $11,562,601
SFY2003 — $16,630,980

The Product Based Prior Authorization Cost Avoidance dollars to the right focus 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.

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".

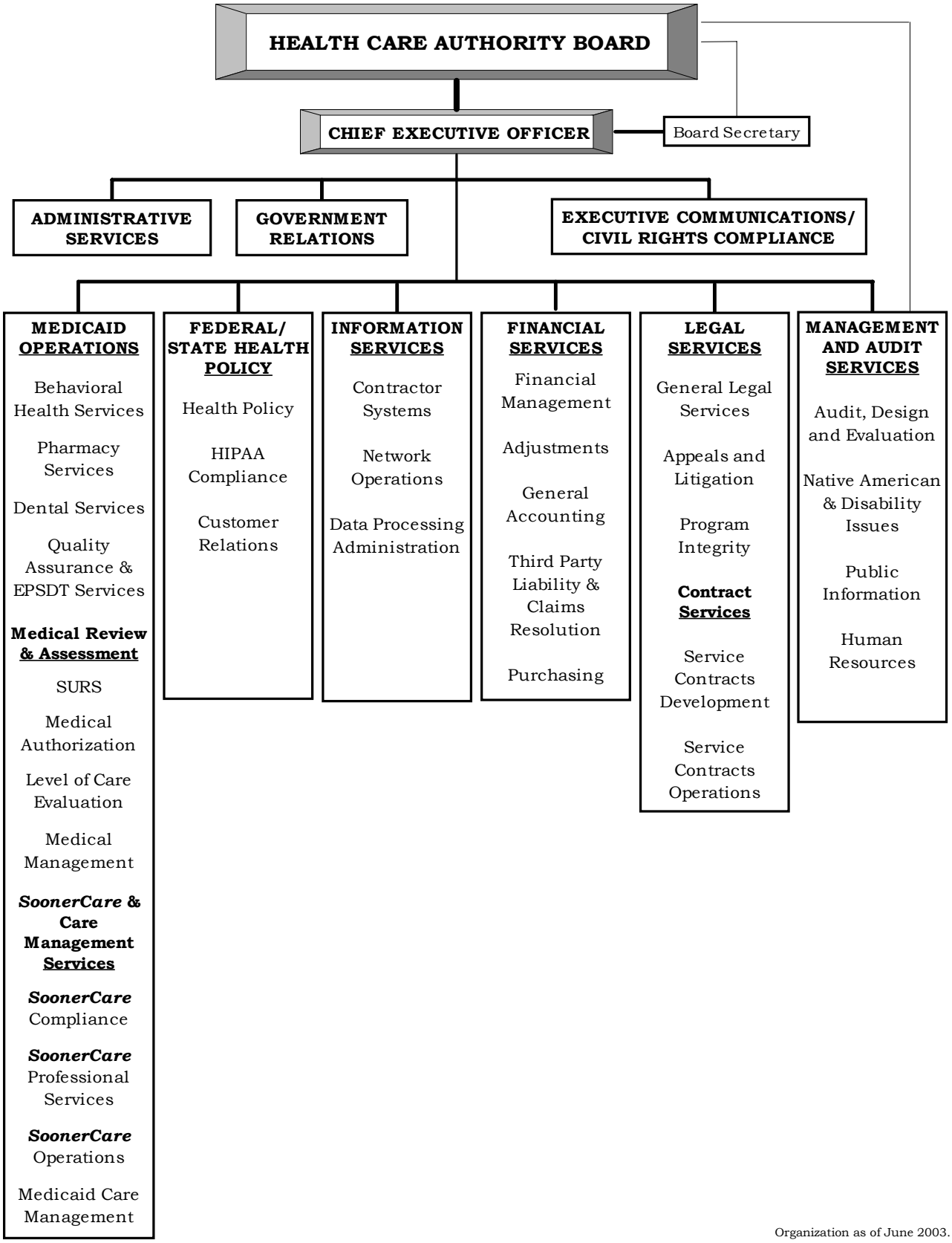
Figure 25 **Medical Case Management Cost Avoidance, SFY2001 through SFY2003**

	SFY2001	SFY2002	SFY2003
MRI Denials	$ 190,306	$ 154,822	$ 806,806
Ultrasound Denials	$ 50,001	$ 40,441*	$ 9,507
Outpatient Exception Report	$ 139,831	$ 323,384*	$ 249,915
Total	**$ 380,138**	**$ 753,796***	**$ 1,066,228**

** Amounts are restated from SFY2002.*

National Archives: Franklin D. Roosevelt Library, 1882 - 1962 Public Health nursing made possible through child welfare services.

Figure 26 **OHCA's Organizational Chart**



Organization as of June 2003.

OHCA was authorized 285.5 full time equivalents (FTE) for SFY2003.

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 Beneficiary Focus

- ✓ We will act based on the knowledge that beneficiaries are our primary customers and that OHCA's "reason for being" is to understand and respond to beneficiaries' 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 beneficiaries and encourage other purchasers of care to do the same.
- ✓ We will work toward the highest standards of service to beneficiaries, 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 beneficiaries 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.

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

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

How We Operate Within OHCA

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

Core Function Summary

In the following Core Function Summary the full time equivalent (FTE) counts per unit do not reflect the division directors and support staff. Therefore, FTE counts per unit may not equal the total filled FTE per division. FTE counts per unit and total filled FTE per division figures do not include vacant positions. During state fiscal year 2003, OHCA was authorized 285.5 FTE and the average number of regular paid FTE was 268. The Core Function Summary is a high level overview of unit responsibilities and does not necessarily reflect all of the required or performed functions of each unit.

EXECUTIVE OFFICE SUPPORT

Mike Fogarty, J.D., M.S.W., Chief Executive Officer **Total FTE Filled: 13**

"During times of reduced budgets, increased work and vacant staffing positions, your efforts are even more needed and appreciated. We are fortunate to have each and every one of you working on our behalf, and on behalf of the Oklahomans we serve. Thank you for your dedication and hard work!"

Mike Fogarty, CEO, email to OHCA staff, May 2003.

Administrative Services answers and directs all calls that come into the main agency telephone number through the receptionist desk. We coordinate space requests and general maintenance issues. Our unit sorts and delivers all incoming and outgoing mail. The Administrative Services Unit performs the maintenance and assignment of the agency's vehicles, security and telephone systems. We also account for the economical and efficient management of agency records in compliance with state statute. (8 FTE) *Administrative Chief of Staff, James Smith (405) 522-7150.*

Government Relations acts as a connection point between OHCA and the legislative and executive branches of state government. We provide 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. (1 FTE) *Former Director, Dana Brown, Currently Vacant (405) 522-7496.*

Executive Communication / Information and Referral documents, controls and distributes items requiring response and documents for informational purposes. We handle all federal, state and other customer correspondence that comes addressed only to OHCA or which agency personnel have authorized the unit to process. (2 FTE) *Director, Donna Huckleberry (405) 522-7452.*

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

Core Function Summary (continued)

MEDICAID OPERATIONS

Lynn Mitchell, M.D., M.P.H., Director of Medicaid/Medical Services ***Total FTE Filled: 89***

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

OHCA Behavioral Health Specialist receives "Champion for Children 2003" award. The Foster Care Association of Oklahoma award recognizes dedicated individuals for their work as advocates for children.

Pharmacy Services assures cost-effective pharmaceutical therapies are available to beneficiaries. We assist pharmacy providers with claim submission and reimbursement, audit pharmacy claim submissions for accuracy and integrity, and administer the federal drug rebate program for Oklahoma. The drug rebate area of Pharmacy Services is responsible for invoicing, collecting, and tracking rebate payments from the pharmaceutical companies. We monitor the telephone help desk functions provided by the Oklahoma College of Pharmacy. We also work closely with the Drug Utilization Review Board, the Medicaid Fraud Control Unit (MFCU) of the Oklahoma Attorney General's office and with the Oklahoma State Board of Pharmacy. (6 FTE) *Director, Nancy Nesser, R.Ph, J.D. (405) 522-7325.*

Dental Services coordinates preventive and restorative dental services for eligible children. Our goals are to enable them to retain their teeth for a lifetime and educate beneficiaries as to the importance of oral health as an integral part of their overall physical health. We also provide ongoing consultations and guidance regarding policy changes as they pertain to Medicaid dental benefits. Our unit provides training and education in all counties for dental providers and coordinates dental and pharmacy grievances. (1 FTE) *Manager, Ella Matthews, R.N. (405) 522-7314.*

Quality Assurance coordinates the quality assurance evaluation and monitoring processes for all OHCA medical programs. We do this by implementing and monitoring necessary processes to meet federal guidelines. This unit also coordinates the agency quality assurance committee activities and provides technical support in developing and reporting federally required quality assurance functions. We also assist with the data warehouse and ongoing activities related to data reporting and data quality. EPSDT Services, within the Quality Assurance Unit, coordinates and monitors the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program. We also work with 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. (7 FTE) *Former Director, Darendia McCauley, Ph.D. Currently Vacant (405) 522-7355.*

OHCA has a Teddy Bear tree every year at Christmas. Over 150 stuffed animals are donated and distributed to various children shelters, hospitals and needy families annually.

Core Function Summary (continued)

MEDICAID OPERATIONS (continued)

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

"Working at OHCA has given me the ability to serve people. There are many hard decisions at OHCA, but the environment is supportive and empowering and there is a genuine desire to do the very best we can, for those whose trust we are given. Our resources are limited, our problems immense, but from the top to the bottom of the hierarchy, it is evident everyday that the folks at OHCA care and do the very best we can with what we have."

OHCA Employee, April 2003

Surveillance Utilization Review Subsystem (SURS) develops comprehensive statistical profiles and utilization patterns of health care delivery of individual providers and beneficiaries. We do this to safeguard against unnecessary or inappropriate use of Medicaid services and associated payments. We also assess the quality of those services, and identify suspected instances of fraud and abuse according to the code of federal regulations. Our unit also manages the federally-outlined Medicaid beneficiary lock-in program which restricts the beneficiary to one pharmacy and/or physician during a 12 month period. (11 FTE) *Manager, Jana Webb, R.N. (405) 522-7112.*

Medical Authorization Unit reviews and responds to medical and/or dental requests and any services or durable equipment that require prior authorization for Medicaid eligible children and adults. Our unit performs manual pricing when a standard allowable cost is not in the claims payment system. We also answer 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. PASRR provides Level I screening to all persons entering Medicaid certified nursing facilities (NFs) for possible mental retardation (MR) and/or mental illness (MI) related diagnosis. Level II assessments are conducted when necessary to insure that this population requires NF level of care and receives proper treatment for MI and/or MR within the nursing facility. LOCEU also makes level of care decisions on all beneficiaries entering public and private ICF/MR, as well as on beneficiaries applying for any three Oklahoma Department of Human Services (OKDHS), Developmental Disabilities Services Division (DDSD) Home and Community-Based Waivers. Our unit also audits all of the Home and Community-Based Services waiver programs. We also provide medical and categorical relationship determinations for disability and incapacity of OKDHS beneficiaries. (10 FTE) *Manager, Kathy Smith, M.S.W. (405) 522-7309.*

Medical Management – Nurse Managers establish medical appropriateness for services referred for prior authorization from the Medical Authorization Unit. We support Customer Relations, the Adjustments Unit and medical professional staff as needed in regard to the issues of medical necessity and clinical claims editing. We also establish and update administrative guidelines for medical authorizations based on state plan provisions and medical necessity. Our team researches clinical practice guidelines regarding new technologies and treatments, in addition to reviewing clinical logic claims editing software. Medical Management also reviews input from providers, submitting recommendations to medical and policy staff. (2 FTE) *Medical Review Nurse Consultant, Gail Livengood, R.N. (405) 522-7328.*

In the last 5 years OHCA employees have contributed approximately $40,000 dollars to the United Way.

Core Function Summary (continued)

MEDICAID OPERATIONS (Continued)

SoonerCare & Care Management Services — Director, Becky Pasternick-Ikard, J.D., R.N.

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

OHCA employees have been participating in the Casual for Kids campaign for almost 10 years. The agency has raised over $7,000 dollars for the prevention of child abuse.

SoonerCare Professional Services monitors and reports on ***SoonerCare*** enrollment and expenditure data. We prepare related costing of financial impact for budget requests and budget reports, as well as monitor 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 Oklahoma Department of Human Services staff. (7 FTE) *Manager, Kevin Rupe, C.P.A. (405) 522-7498.*

SoonerCare Operations consists of Member Services and Contractor Services. Member Services facilitates resolution to issues/concerns addressed in internal reports, incident reports and telephone calls and also monitors the enrollment agent. We additionally research and resolve members' calls and issues related to dire medical needs and follow up with members on as-needed basis to ascertain care received. Our unit identifies and participates in member outreach activities to promote 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. Member Services helps identify system "barriers" that cause inaccurate transmission of data from OKDHS to OHCA. Another aspect of ***SoonerCare*** Operations is Contractor Services. Our unit facilitates and coordinates ***SoonerCare*** provider contracting. 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. We provide oversight of the complete PCCM and Native American contracting processes and the recruitment of ***SoonerCare*** providers to maintain and monitor network capacity and access to care. Additionally, Contractor Services researches and advises regarding provider requested member disenrollment. (17 FTE) *Member Services Supervisor, James Reese (405) 522-7345; Contractor Services Supervisor, Nancy Austin (405) 522-7333.*

Medicaid Care Management provides and facilitates care management services related to medically complex/special health care need members. We coordinate access to care as it relates to specialty providers initiated by requests from PCP/CMs, incident reports, member calls, interagency referrals and legislative requests. We also plan and put into operation enhanced Care Management outreach to select identified **Choice** and fee-for-service population. Our team is involved in the development and implementation of a culturally competent, beneficiary-based disease management for selected disease states. This is being accomplished by collaborating with other state agencies, community and provider organizations to promote an improved quality of life. Care Management coordinates with the Quality Assurance division to perform clinical studies and targeted consumer assessments. Our unit utilizes a computer based clinical care management software system for tracking member activities and productivity measurements. (7 FTE) *Manager, Marlene Asmussen, R.N. (405) 522-7123.*

Core Functions Summary (continued)

FEDERAL / STATE HEALTH POLICY

Charles Brodt, Director of Federal / State Health Policy ***Total FTE Filled: 35***

Health Policy develops and presents upcoming policy issues to the Medical Advisory Committee (MAC). We receive direction from the MAC members regarding additional consideration in addition to requests from the members to research and subsequently report on other policy issues. We coordinate with the Centers for Medicare and Medicaid Services (CMS) on questions related to Medicaid policy, issues of noncompliance, expenditures and the state plan. We also direct the OHCA's scheduled review of administrative rules, statutes and internal policies, reporting to the Governor, the President Pro Tempore of the Senate, and the Speaker of the House of Representatives those rules to be modified or repealed and statutes or policies which should be promulgated pursuant to the Administrative Procedures Act (APA). This unit also monitors, analyzes and reports 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. Additionally, we maintain the reference portion of the Medicaid Management Information System (MMIS) providing enforcement of policy and ensuring accurate up-to-date information in support of claim processing. (9 FTE) *Director, Jim Hancock (405) 522-7268.*

HIPAA Compliance coordinates agency activities required for compliance with Health Insurance Portability and Accountability Act (HIPAA) rules and regulations. HIPAA Compliance also assists and monitors agency efforts in education and communication with providers and other trading partners regarding safeguarding Oklahoma Medicaid's beneficiary's privacy. This unit is developing and monitoring a Business Continuity and Contingency Plan for addressing potential problems or issues with achieving HIPAA compliance. (0 FTE) *Former Coordinator, Laura Dickey-Hottel, Currently Vacant (405) 522-7228.*

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, beneficiaries, DHS county offices, legislators, other state Medicaid agencies and others relating to agency and federal Medicaid policy and OHCA procedures for all Medicaid programs. We also review and authorize 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. (23 FTE) *Director, Susan Nicholson (405) 522-7360.*

An OHCA Customer Relations employee triumphs over fatigue in a 500 mile Heartland AIDSRide.

Core Function Summary (continued)

INFORMATION SERVICES DIVISION

John Calabro, Director of Information Services ***Total FTE Filled: 28***

Contractor Systems monitors problems identified in the Medicaid Management Information System (MMIS) and recommends appropriate actions to correct the deficiency, analyzes test results, as well as coordinates all maintenance and modification system changes with ongoing enhancements. Our unit is responsible for the maintenance and coordination with users of the new MMIS. This unit is accountable for the fulfillment of data processing performed by the contracted fiscal agent, Electronic Data Systems (EDS). We also establish priorities for systems development and data processing projects according to departmental requirements, as well as develop plans for future utilization of data processing services in the overall agency program. (12 FTE) *Director, Donna Witty (405) 522-7242.*

Network Operations performs programming implementation and operations for computer systems not covered by the fiscal agent contract. We are accountable for the fulfillment of data processing performed on the OHCA network, systems analysis and programming to implement requested changes. This unit designs applications to be flexible, cost-effective and relevant to address the needs of OHCA. We also coordinate agency data processing activities with other state agencies, private sector entities and all OHCA units or divisions for network operations. (9 FTE) *Director, Jeff Slotnick (405) 522-7152.*

Carrying an average of 17 vacant positions, almost everyone at OHCA took on extra duties to help with the implementation of the new MMIS claims processing system.

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. We also perform the internal computer help desk functions. (5 FTE) *Administrator, Judi Worsham (405) 522-7222.*

FINANCIAL SERVICES

Anne Garcia, C.G.F.M., Director of Financial Services ***Total FTE Filled: 55***

Financial Management prepares and processes federal expenditure reports and the cost allocation plan, as well as manages the issuance of state Medicaid grants. This unit also researches and analyzes claims history and cost report data in order to develop and implement reimbursement rates for institutional providers and submit state plan documentation. The Budget and Analysis Section within Financial Management prepares and processes the annual agency budget request, the agency budget work programs and any necessary revisions. Our unit also analyzes data, tracks expenditures and prepares financial forecasting for the agency's program budgeting. (9 FTE) *Director, Debbie Ogles (405) 522-7270.*

"I work for OHCA because we make a difference in the lives of others in dire need of help. I enjoy helping other people. It's a place of employment of which you can be proud to be an employee. Not only do we help others outside the agency – we help each other within the agency, also."

OHCA Finance Employee, 2003

Core Function Summary (continued)

FINANCIAL SERVICES (continued)

Adjustments researches and reconciles claims of erroneous provider payments as reported through various sources. We research and initiate corrective action on claims for which refunds have been received from medical providers. Our unit also identifies problem areas with the claims and recoupment process, recommending that training be provided to individual providers or provider groups. (11 FTE) *Manager, Michelle Moulden (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 Office of State Finance (OSF) and the State Treasurer's Office (STO). We post all receipts and expenditures of agency funds. This unit prepares the monthly financial statement reports and quarterly cost allocation schedules, as well as makes payment of claims for general agency operations and contracted services. We deposit all funds received by the agency and perform 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 payments, processing all Medicaid provider garnishments and tax levies. We reconcile and process all agency payrolls, as well as approving annual 1099 and W2 information. (10 FTE) *Director, Carrie Evans (405) 522-7359.*

"OHCA makes a difference in the lives of ones that otherwise wouldn't receive health care. Having grown up in a family without health insurance, I've seen the "other side of the fence". A hospital bill can devastate a family living on minimum wage. Preventative and (sometimes routine) health care cannot even be placed on the "back burner" within the budget of lower income persons. OHCA saves many lives and *drastically* improves the quality of living for thousands within the state."

OHCA Finance Employee, April 2003

Third Party Liability (TPL) & Claims Resolution investigates the legal liability of third parties to pay for care and services furnished to Medicaid beneficiaries and seek reimbursement from the responsible third parties (TPL). We use the most cost-effective means of recovery, to cost-avoid the claim when there is probable existence of TPL at the time it is filed. For those claims that are not cost-avoided or 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 MMIS. Claims Resolution monitors the timely and accurate processing of claims for Medicaid providers and resolve suspended edits during the claims processing cycle. Our unit handles claim issues and inquiries from within the agency, as well as from Legislative staff, by working directly with other units of the OHCA, other state agencies, the MMIS contractor and contracted providers. (20 FTE) *Director, Lisa Gifford, J.D. (405) 522-7427.*

The Financial Services Division gathers toys and clothes to give to needy families at Christmas time.

Purchasing processes purchase requests and encumbrance documents submitted by units within the agency. We also follow up on purchase orders, monitor funding amounts, approve invoices and prepare change orders to increase, decrease or cancel encumbered funds. (3 FTE) *Manager, Vickie Kersey (405) 522-7482.*

Core Function Summary (continued)

LEGAL SERVICES

Howard Pallotta, J.D., Director of Legal Services ***Total FTE Filled: 27***

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. Our unit reviews possible legislation and advises legislators and legislative staff members regarding Medicaid law. We also advise advocacy and public interest groups regarding changes in Medicaid law. (3 FTE) *Deputy General Counsel, Lynn Rambo-Jones, J.D. (405) 522-7403.*

OHCA participates in the Salvation Army's Adopt-A-Child program. At Christmas, our staff buy gifts from a list provided by a "forgotten angel". In 2003, we filled requests from 85 children.

Appeals & Litigation coordinates all litigation for the agency, as well as, all administrative law judge appeals filed by providers and beneficiaries. 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.*

Thirty-four OHCA staffers and friends participated in the Race for the Cure®. Proceeds benefit breast cancer research, education, screening and treatment.

Program Integrity represents the agency in investigative matters and provides thorough research and surveillance to/for General Counsel. Our team 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 conducts information gathering field trips and/or interviews with necessary individuals and/or agency representatives. (2 FTE) *Program Integrity Specialist, Paul Bouffard (405) 522-0595.*

Contract Services consists of a Service Contracts Development Unit and a Service Contracts Operations Unit. 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. This unit insures that the agency is adhering to statutory laws, administrative procedures and agency regulations in the obtaining of professional contracted services and interagency agreements. The Service Contracts Operations Unit develops, maintains and oversees the Professional Provider Contract Procurement System and provides assistance to program providers regarding the contract processes. This unit drafts and processes new contracts and renewals for professional services, advises on payment and reporting requirements and determines if a fee-for-service or managed care contract is needed. Our unit operates and maintains a call center for inquiries on current contract status and provider numbers and/or effective contract dates and the location of specialty providers. The unit is also responsible for servicing contracts related to long-term care providers and nursing homes. We monitor survey and certification functions as well as temporary and permanent suspensions of payments and civil monetary penalties related to long-term care contract breaches. (17 FTE) *Manager, Rolando Davila, J.D. (405) 522-7234.*

Core Function Summary (continued)

MANAGEMENT AND AUDIT SERVICES

Cindy Roberts, C.P.A., C.G.F.M., Director of Management and Audit Services
Total FTE Filled: 22.5

Audit, Design and Evaluation plans and coordinates both audit and strategic projects of organizational, functional and program activities. We evaluate the effectiveness of controls, compliance and/or strategic feasibility. Our unit 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 our unit is SCHIP reporting. We also collect monthly-submitted Quality of Care Reports from long-term care facilities (LTCs) statewide and perform audits of submitted information. (12.5 FTE) *Director, Cindy Roberts, C.P.A., C.G.F.M. (405) 522-7253.*

"I have never worked at a place where people are so motivated to do their jobs conscientiously, while making a concerted effort to get along with each other and to extend kindness and encouragement to co-workers and honor the beneficiaries they serve. This wave of intentional concern and kindness starts from the top administrative level all the way down. I am proud and happy to work at such a place."

OHCA Public Information Employee, June 2003

Native American & Disability Issues performs Native American liaison services between OHCA and CMS, Indian Health Services (IHS) and the tribes of Oklahoma for state and national level issues, including Native American work groups, input from states regarding tribal consultation, services in the Office of Management and Budget rate and Federal Medical Assistance Percentages for "through a facility" services. (2 FTE) *Manager, Trevlyn Terry (405) 522-7303.*

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

"The OHCA is a great place to work because we have such dedicated, professional employees who are genuinely concerned about the health care of our beneficiaries. We are truly a mission-driven organization."

OHCA Human Resources employee, May 2003.

Human Resources monitors and assures agency compliance with all relevant state and federal personnel regulations in addition to the basic personnel principals and practices. Our unit also maintains a human resources information system for tracking recruitment; processes personnel transactions, employee evaluation activities, compensation management and supervisory training; and generates monthly, quarterly and annual personnel related reports. We also conduct 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. (2 FTE) *Director, Ron Wilson (405) 522-7418.*

A special thank you to all of the employees, providers and beneficiaries that contributed an overwhelming number of testimonials and kudos to our agency and its employees. It is important to impart to the public what a caring and generous group of people have dedicated their life to public service through their employment at the Oklahoma Health Care Authority.

Reader Notes

Appendix A Glossary of Terms

ABD	The **A**ged, **B**lind and **D**isabled Medicaid population.
Beneficiary	A person enrolled in Oklahoma Medicaid.
Capitated Payment	A monthly payment of a predetermined amount, per person, for an individual's required health care services within managed care.
CMS	**C**enters for Medicare and **M**edicaid **S**ervices, formally known as Health Care Financing Administration (HCFA), establishes and monitors Medicaid funding requirements.
EDS	**E**lectronic **D**ata **S**ystems is OHCA's fiscal agent. EDS processes claims and payments within Oklahoma's Medicaid Management Information System (MMIS).
Eligible	For this report, an individual who is qualified and enrolled in Medicaid, who may or may not have received services during the reporting period.
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 — 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.

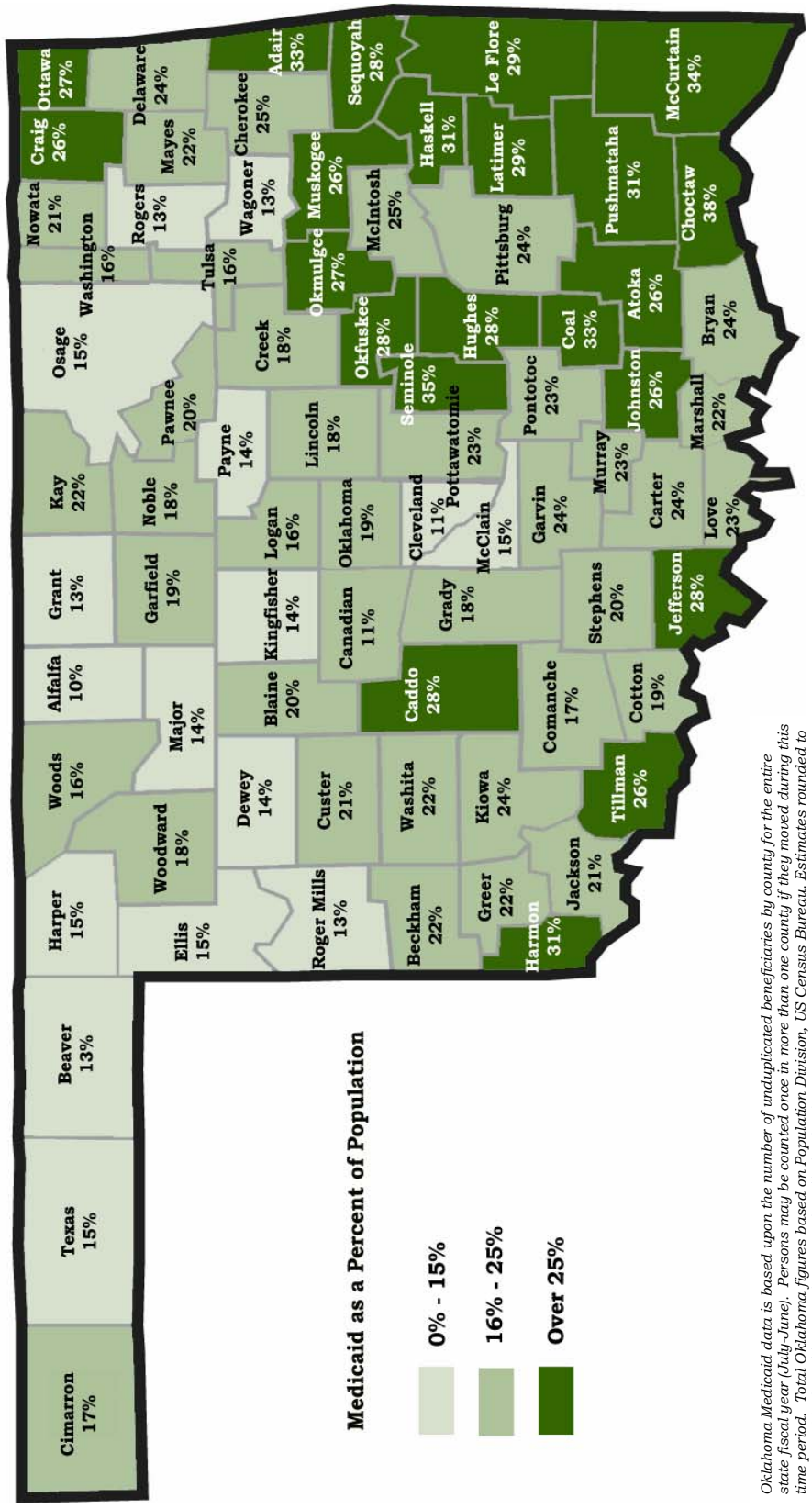
Figure i **Technical Notes**

Throughout this report a combination of data sources were used to provide the most accurate information possible. The total number of eligibles and beneficiaries are calculated on a statewide basis and various subsections. When any type of subsection is measured (i.e., aid category, county, etc.) beneficiary numbers may exceed eligible numbers. Provider billing habits can cause claim variations as well. All report claim data is extracted with the date paid by OHCA being within the report period. Provided that a beneficiary 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 beneficiary receives a Medicaid service in May and the provider submits and is paid for the claim in July, that beneficiary will be counted as a beneficiary and the dollar totals will be included in the July reporting quarter, even if the beneficiary may not be eligible within that same reporting quarter. If that beneficiary is not enrolled at some point within the reporting period, 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.

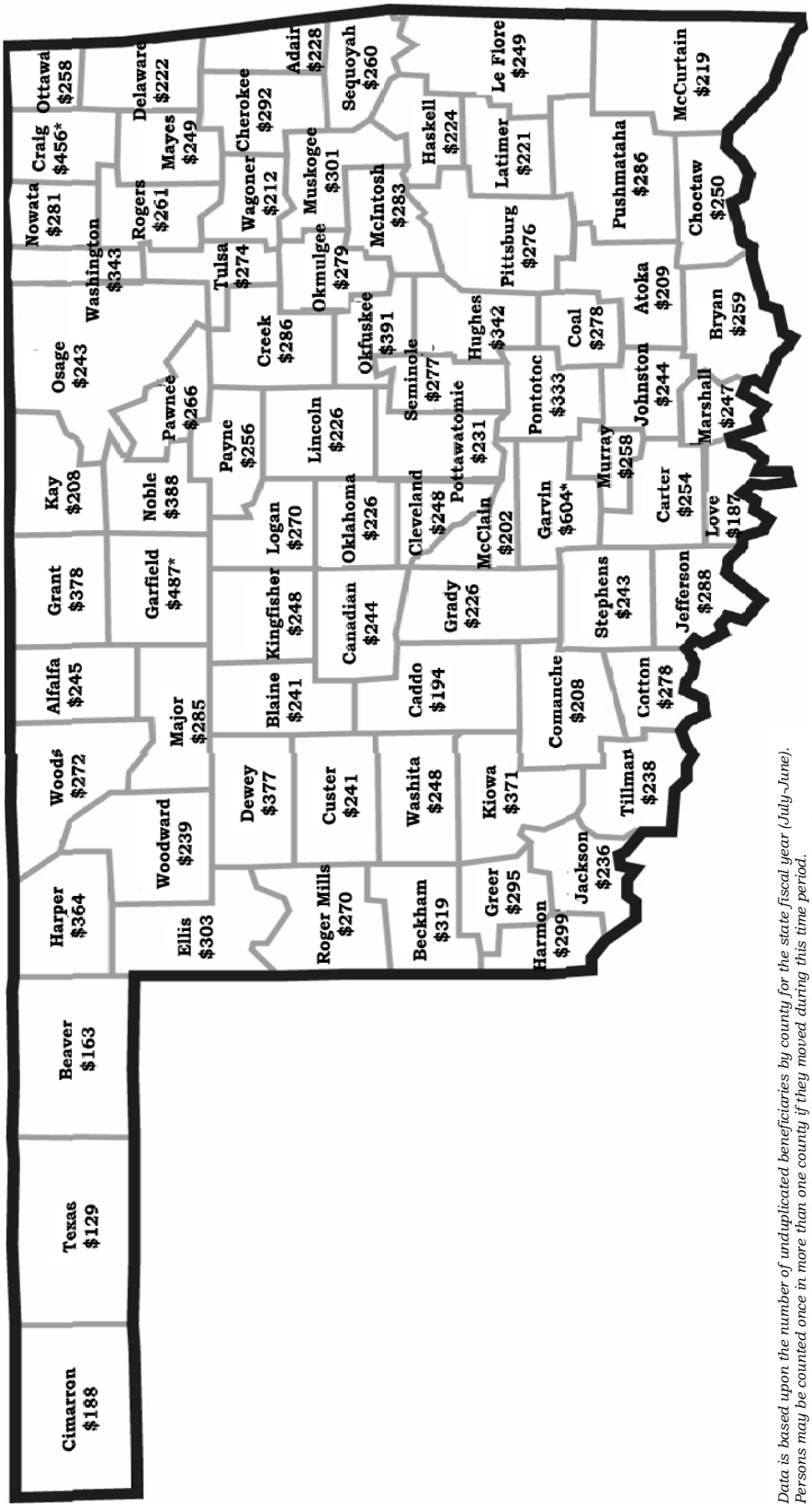
Appendix B Statewide SFY2003 Figures

Figure I **Unduplicated Persons Enrolled in Medicaid July 1, 2002 through June 30, 2003 as a Percent of the Total Oklahoma Population**



Oklahoma Medicaid data is based upon the number of unduplicated beneficiaries by county for the entire state fiscal year (July-June). Persons may be counted once in more than one county if they moved during this time period. Total Oklahoma figures based on Population Division, US Census Bureau. Estimates rounded to nearest 100. http://www.odoc.state.ok.us/index.html

Figure II **Average Dollars Spent per Medicaid Beneficiary per Month**



Data is based upon the number of unduplicated beneficiaries by county for the state fiscal year (July-June). Persons may be counted once in more than one county if they moved during this time period. Garfield and Garvin counties have public institutions and Craig county has 8 private institutions for the developmentally disabled (ICF/MRs) causing the average dollars per Medicaid beneficiary to be higher than the norm. Claim dollars were extracted from the claims history file for claims paid within the fiscal year.

Figure III **Statewide Medicaid Figures**

County	Population Proj. July 2002*	Rank	Unduplicated Eligibles**	Rank	Pop.Covered by Medicaid	Rank
ADAIR	21,400	38	7,101	31	33.18%	5
ALFALFA	5,900	67	619	73	10.49%	77
ATOKA	14,000	46	3,601	46	25.72%	21
BEAVER	5,600	70	711	70	12.70%	73
BECKHAM	19,900	40	4,477	40	22.50%	35
BLAINE	12,100	51	2,457	56	20.31%	44
BRYAN	37,000	26	8,954	21	24.20%	27
CADDO	30,000	32	8,266	27	27.55%	15
CANADIAN	91,400	5	10,258	17	11.22%	76
CARTER	46,200	17	11,221	10	24.29%	26
CHEROKEE	43,400	20	10,965	13	25.26%	23
CHOCTAW	15,200	44	5,749	35	37.82%	1
CIMARRON	3,000	77	509	75	16.97%	56
CLEVELAND	215,700	3	24,258	3	11.25%	75
COAL	5,900	67	1,958	62	33.19%	4
COMANCHE	113,400	4	19,415	4	17.12%	55
COTTON	6,500	66	1,237	67	19.03%	48
CRAIG	14,600	45	3,857	43	26.42%	18
CREEK	68,800	9	12,553	8	18.25%	51
CUSTER	25,200	36	5,256	38	20.86%	43
DELAWARE	37,800	25	9,020	20	23.86%	30
DEWEY	4,600	72	653	71	14.20%	66
ELLIS	4,000	73	598	74	14.95%	62
GARFIELD	57,200	12	11,004	12	19.24%	47
GARVIN	27,200	35	6,641	32	24.42%	25
GRADY	46,700	16	8,412	26	18.01%	54
GRANT	5,000	71	653	71	13.06%	71
GREER	5,800	69	1,300	66	22.41%	37
HARMON	3,100	76	950	69	30.65%	8
HARPER	3,500	74	509	75	14.54%	65
HASKELL	11,700	52	3,678	44	31.44%	6
HUGHES	14,000	46	3,989	42	28.49%	11
JACKSON	27,300	34	5,735	36	21.01%	41
JEFFERSON	6,600	65	1,824	64	27.64%	14
JOHNSTON	10,500	58	2,692	54	25.64%	22
KAY	47,700	15	10,333	16	21.66%	40
KINGFISHER	13,700	48	1,892	63	13.81%	69
KIOWA	9,900	60	2,374	57	23.98%	29
LATIMER	10,500	58	3,065	51	29.19%	10
LEFLORE	48,400	14	14,136	7	29.21%	9

*Source: Population Division, US Census Bureau. Estimates rounded to nearest 100. http://www.odoc.state.ok.us/index.html

**Beneficiaries listed above are the unduplicated count per county for the entire state fiscal year. A beneficiary may be counted twice if they had more than one county of residence within the fiscal year (July-June).

Figure III **Statewide Medicaid Figures (continued)**

County	Expenditures	Rank	Annual Per Capita	Rank	Monthly Per Eligible	Rank
ADAIR	$19,404,568	32	$907	16	$228	60
ALFALFA	$1,821,438	74	$309	75	$245	49
ATOKA	$9,023,767	52	$645	39	$209	69
BEAVER	$1,394,206	75	$249	76	$163	76
BECKHAM	$17,157,805	37	$862	21	$319	13
BLAINE	$7,103,554	58	$587	51	$241	55
BRYAN	$27,833,421	23	$752	29	$259	37
CADDO	$19,207,465	33	$640	42	$194	73
CANADIAN	$30,052,807	20	$329	74	$244	50
CARTER	$34,182,785	15	$740	31	$254	41
CHEROKEE	$38,478,105	11	$887	18	$292	18
CHOCTAW	$17,238,411	36	$1,134	6	$250	42
CIMARRON	$1,149,262	77	$383	70	$188	74
CLEVELAND	$72,106,089	3	$334	73	$248	47
COAL	$6,531,259	60	$1,107	8	$278	27
COMANCHE	$48,529,358	6	$428	65	$208	70
COTTON	$4,130,434	67	$635	44	$278	26
CRAIG ‡	$21,087,223	30	$1,444	2	$456	3
CREEK	$43,121,116	8	$627	47	$286	20
CUSTER	$15,202,209	43	$603	48	$241	54
DELAWARE	$24,011,717	28	$635	45	$222	65
DEWEY	$2,952,074	71	$642	40	$377	7
ELLIS	$2,172,653	73	$543	53	$303	14
GARFIELD ‡	$64,277,602	5	$1,124	7	$487	2
GARVIN ‡	$48,169,795	7	$1,771	1	$604	1
GRADY	$22,769,732	29	$488	62	$226	63
GRANT	$2,960,917	70	$592	50	$378	6
GREER	$4,604,596	65	$794	27	$295	17
HARMON	$3,405,113	69	$1,098	9	$299	16
HARPER	$2,225,921	72	$636	43	$364	9
HASKELL	$9,882,461	48	$845	23	$224	64
HUGHES	$16,366,528	39	$1,169	4	$342	11
JACKSON	$16,221,886	40	$594	49	$236	58
JEFFERSON	$6,296,495	61	$954	12	$288	19
JOHNSTON	$7,882,628	55	$751	30	$244	51
KAY	$25,771,205	26	$540	54	$208	71
KINGFISHER	$5,630,981	62	$411	67	$248	46
KIOWA	$10,578,054	46	$1,068	11	$371	8
LATIMER	$8,141,178	54	$775	28	$221	66
LEFLORE	$42,286,549	9	$874	20	$249	44

‡Garfield and Garvin counties have public institutions and Craig county has 8 private institutions for the developmentally disabled (ICF/MRs) causing the average dollars per Medicaid beneficiary to be higher than the norm. Claim dollars were extracted from the claims history file for claims paid within the fiscal year.

Figure III **Statewide Medicaid Figures (continued)**

County	Population Proj. July 2002*	Rank	Unduplicated Eligibles**	Rank	Pop.Covered by Medicaid	Rank
LINCOLN	32,300	31	5,929	34	18.36%	50
LOGAN	34,500	28	5,661	37	16.41%	57
LOVE	8,900	62	2,023	61	22.73%	33
MCCLAIN	28,200	33	4,215	41	14.95%	63
MCCURTAIN	34,200	29	11,605	9	33.93%	3
MCINTOSH	19,700	41	4,883	39	24.79%	24
MAJOR	7,500	64	1,045	68	13.93%	68
MARSHALL	13,500	49	3,010	52	22.30%	38
MAYES	38,900	24	8,735	23	22.46%	36
MURRAY	12,600	50	2,937	53	23.31%	31
MUSKOGEE	70,000	7	18,043	5	25.78%	19
NOBLE	11,300	56	2,055	60	18.19%	53
NOWATA	10,700	57	2,233	59	20.87%	42
OKFUSKEE	11,700	52	3,287	49	28.09%	13
OKLAHOMA	672,500	1	127,810	1	19.01%	49
OKMULGEE	39,800	23	10,826	14	27.20%	16
OSAGE	45,200	18	6,581	33	14.56%	64
OTTAWA	33,000	30	8,948	22	27.12%	17
PAWNEE	16,800	43	3,376	47	20.10%	46
PAYNE	69,900	8	9,748	19	13.95%	67
PITTSBURG	44,000	19	10,572	15	24.03%	28
PONTOTOC	34,900	27	8,125	28	23.28%	32
POTTAWATOMIE	66,700	10	15,064	6	22.58%	34
PUSHMATAHA	11,700	52	3,657	45	31.26%	7
ROGER MILLS	3,200	75	406	77	12.69%	74
ROGERS	75,600	6	9,827	18	13.00%	72
SEMINOLE	24,700	37	8,587	24	34.77%	2
SEQUOYAH	39,900	22	11,218	11	28.12%	12
STEPHENS	42,600	21	8,563	25	20.10%	45
TEXAS	20,200	39	3,118	50	15.44%	61
TILLMAN	9,000	61	2,316	58	25.73%	20
TULSA	571,300	2	90,487	2	15.84%	60
WAGONER	60,300	11	7,935	29	13.16%	70
WASHINGTON	49,200	13	7,817	30	15.89%	59
WASHITA	11,500	55	2,540	55	22.09%	39
WOODS	8,800	63	1,433	65	16.28%	58
WOODWARD	18,500	42	3,372	48	18.23%	52
TOTAL	**3,493,700**		**670,867**		**19.20%**	

*Source: Population Division, US Census Bureau. Estimates rounded to nearest 100. http://www.odoc.state.ok.us/index.html

**Beneficiaries listed above are the unduplicated count per county for the entire state fiscal year. A beneficiary may be counted twice if they had more than one county of residence within the fiscal year (July-June). Totals do not include custody children or beneficiaries temporarily residing out of state.

Figure III **Statewide Medicaid Figures (continued)**

County	Expenditures	Rank	Annual Per Capita	Rank	Monthly Per Eligible	Rank
LINCOLN	$16,053,206	41	$497	61	$226	62
LOGAN	$18,351,640	35	$532	55	$270	32
LOVE	$4,532,756	66	$509	60	$187	75
MCCLAIN	$10,223,867	47	$363	71	$202	72
MCCURTAIN	$30,493,619	19	$892	17	$219	67
MCINTOSH	$16,575,269	38	$841	24	$283	23
MAJOR	$3,569,405	68	$476	63	$285	22
MARSHALL	$8,932,962	53	$662	36	$247	48
MAYES	$26,142,746	25	$672	35	$249	43
MURRAY	$9,103,952	51	$723	33	$258	38
MUSKOGEE	$65,093,190	4	$930	14	$301	15
NOBLE	$9,560,795	50	$846	22	$388	5
NOWATA	$7,531,920	57	$704	34	$281	24
OKFUSKEE	$15,434,049	42	$1,319	3	$391	4
OKLAHOMA	$346,889,231	1	$516	59	$226	61
OKMULGEE	$36,192,889	12	$909	15	$279	25
OSAGE	$19,169,373	34	$424	66	$243	52
OTTAWA	$27,725,508	24	$840	25	$258	39
PAWNEE	$10,763,889	45	$641	41	$266	34
PAYNE	$29,951,368	21	$428	64	$256	40
PITTSBURG	$35,074,342	13	$797	26	$276	29
PONTOTOC	$32,511,910	16	$932	13	$333	12
POTTAWATOMIE	$41,842,840	10	$627	46	$231	59
PUSHMATAHA	$12,530,728	44	$1,071	10	$286	21
ROGER MILLS	$1,315,262	76	$411	68	$270	33
ROGERS	$30,730,321	18	$406	69	$261	35
SEMINOLE	$28,541,968	22	$1,156	5	$277	28
SEQUOYAH	$34,941,315	14	$876	19	$260	36
STEPHENS	$24,939,409	27	$585	52	$243	53
TEXAS	$4,824,704	63	$239	77	$129	77
TILLMAN	$6,625,476	59	$736	32	$238	57
TULSA	$297,558,393	2	$521	58	$274	30
WAGONER	$20,174,868	31	$335	72	$212	68
WASHINGTON	$32,218,034	17	$655	38	$343	10
WASHITA	$7,569,156	56	$658	37	$248	45
WOODS	$4,675,120	64	$531	56	$272	31
WOODWARD	$9,681,933	49	$523	57	$239	56
TOTAL†	**$2,099,410,781**		**$601**		**$261**	

† *The expenditure figures are based on 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 IV **Dollars Paid to Providers and Beneficiaries by County in SFY2003**

County	Total Dollars Paid by Provider County	Total Dollars Paid by Beneficiary County	% of Dollars Staying in County
ADAIR	$9,483,282	$19,404,568	49%
ALFALFA	$1,208,919	$1,821,438	66%
ATOKA	$5,339,235	$9,023,767	59%
BEAVER	$1,118,852	$1,394,206	80%
BECKHAM	$13,558,447	$17,157,805	79%
BLAINE	$4,161,777	$7,103,554	59%
BRYAN	$33,664,074	$27,833,421	121%
CADDO	$14,260,092	$19,207,465	74%
CANADIAN	$12,306,951	$30,052,807	41%
CARTER	$28,299,969	$34,182,785	83%
CHEROKEE	$33,694,746	$38,478,105	88%
CHOCTAW	$11,078,638	$17,238,411	64%
CIMARRON	$788,253	$1,149,262	69%
CLEVELAND	$47,903,021	$72,106,089	66%
COAL	$3,363,770	$6,531,259	52%
COMANCHE	$46,993,293	$48,529,358	97%
COTTON	$2,238,363	$4,130,434	54%
CRAIG	$17,834,926	$21,087,223	85%
CREEK	$42,669,370	$43,121,116	99%
CUSTER	$13,790,220	$15,202,209	91%
DELAWARE	$14,451,274	$24,011,717	60%
DEWEY	$3,113,286	$2,952,074	105%
ELLIS	$1,681,418	$2,172,653	77%
GARFIELD	$58,594,646	$64,277,602	91%
GARVIN	$43,148,140	$48,169,795	90%
GRADY	$11,892,314	$22,769,732	52%
GRANT	$2,109,651	$2,960,917	71%
GREER	$2,970,757	$4,604,596	65%
HARMON	$2,590,804	$3,405,113	76%
HARPER	$1,665,489	$2,225,921	75%
HASKELL	$13,116,020	$9,882,461	133%
HUGHES	$8,925,532	$16,366,528	55%
JACKSON	$9,455,546	$16,221,886	58%
JEFFERSON	$4,425,283	$6,296,495	70%
JOHNSTON	$5,220,335	$7,882,628	66%
KAY	$19,885,124	$25,771,205	77%
KINGFISHER	$7,788,123	$5,630,981	138%
KIOWA	$9,983,903	$10,578,054	94%
LATIMER	$4,112,903	$8,141,178	51%
LEFLORE	$30,978,969	$42,286,549	73%

Figure IV **Dollars Paid to Providers and Beneficiaries by County in SFY2003 (continued)**

County	Total Dollars Paid by Provider County	Total Dollars Paid by Beneficiary County	% of Dollars Staying in County
LINCOLN	$8,075,187	$16,053,206	50%
LOGAN	$9,161,904	$18,351,640	50%
LOVE	$2,351,003	$4,532,756	52%
MCCLAIN	$5,554,003	$10,223,867	54%
MCCURTAIN	$23,371,962	$30,493,619	77%
MCINTOSH	$15,046,499	$16,575,269	91%
MAJOR	$2,619,075	$3,569,405	73%
MARSHALL	$6,403,734	$8,932,962	72%
MAYES	$12,043,260	$26,142,746	46%
MURRAY	$6,162,577	$9,103,952	68%
MUSKOGEE	$65,366,140	$65,093,190	100%
NOBLE	$7,427,501	$9,560,795	78%
NOWATA	$5,217,693	$7,531,920	69%
OKFUSKEE	$10,956,361	$15,434,049	71%
OKLAHOMA	$635,116,796	$346,889,231	183%
OKMULGEE	$24,344,652	$36,192,889	67%
OSAGE	$6,290,697	$19,169,373	33%
OTTAWA	$24,806,562	$27,725,508	89%
PAWNEE	$7,120,152	$10,763,889	66%
PAYNE	$25,673,302	$29,951,368	86%
PITTSBURG	$29,512,671	$35,074,342	84%
PONTOTOC	$37,409,902	$32,511,910	115%
POTTAWATOMIE	$19,846,921	$41,842,840	47%
PUSHMATAHA	$11,572,292	$12,530,728	92%
ROGER MILLS	$632,810	$1,315,262	48%
ROGERS	$20,277,867	$30,730,321	66%
SEMINOLE	$19,668,681	$28,541,968	69%
SEQUOYAH	$29,125,976	$34,941,315	83%
STEPHENS	$19,474,754	$24,939,409	78%
TEXAS	$4,472,686	$4,824,704	93%
TILLMAN	$2,974,411	$6,625,476	45%
TULSA	$368,144,558	$297,558,393	124%
WAGONER	$6,018,114	$20,174,868	30%
WASHINGTON	$22,026,405	$32,218,034	68%
WASHITA	$4,051,033	$7,569,156	54%
WOODS	$3,680,588	$4,675,120	79%
WOODWARD	$8,983,580	$9,681,933	93%
TOTAL*	**$2,110,848,025.70**	**$2,099,410,781.05**	**101%**

**Totals will not match due to expenditures for custody children and out-of-state providers and beneficiaries not being included in the figures.*

Appendix C Contracted Medicaid Providers

Contracted Medicaid Providers SFY2003

Provider Type	Count	Provider Type	Count
Adult Day Care	22	Hospital — Psychiatric	24
Certified Registered Nurse Anesthetist (CRNA)	506	Hospital — Residential Treatment Center	31
Nurse Practitioner (Other)	361	Laboratory	72
Advantage Case Manager	35	Mental Health Provider	680
Advantage Home Delivered Meal	19	Nurse	87
Ambulatory Surgical Center (ASC)	52	Nutritionist	105
Audiologist	63	Optician	27
Capitation Provider — IHS Case Manager	18	Optometrist	417
Managed Care Organization (MCO)	4	Personal Care Services — Agency	41
Case Manager (Targeted)	35	Personal Care Services — Individual	130
Chiropractor	27	Pharmacy	904
Clinic — Family Planning	6	Physician — Allergist	20
Clinic — Federally Qualified Health Clinic (FQHC)	6	Physician — Anesthesiologist	830
Clinic — Free-standing Renal Dialysis	34	Physician — Cardiologist	560
Clinic — Medical	1,210	Physician — Family Practitioner	2,125
Clinic — Other	15	Physician — General Pediatrician	1,108
Clinic — Rural Health	46	Physician — General Practitioner	523
Clinic — Speech/Hearing	3	Physician — General Surgeon	516
DDSD — Architectural Modification	85	Physician — Internist	1,574
DDSD — Employee Training Specialist	115	Physician — Obstetrician/Gynecologist	487
DDSD — Homemaker Services	273	Physician — Other	2,223
DDSD — Non-Federal Medical	642	Physician — Radiologist	807
DDSD — Supportive Living Arrangements	43	Physician Assistant	339
DDSD — Transportation Provider Volunteer	320	Residential Behavior Management Services (RBMS)	20
Dentist	359	Respite Care	225
Direct Support Services	188	Room and Board	8
DME/Medical Supply Dealer	1,019	School-Based Providers	302
Extended Care — ICF/MR	62	Specialized Foster Care/MR	231
Extended Care — Nursing Facility	342	Therapist — Occupational	160
Extended Care — Respite Care - Facility Based	90	Therapist — Physical Therapist	294
Extended Care — Skilled Nursing Facility	175	Therapist — Physical Therapy Assistant	4
Free Standing Birthing Center	3	Therapist — Speech/Hearing Therapist	310
Home Health Agency	158	Transportation Provider—Ambulance	185
Hospital — Acute Care	433	X-Ray Clinic — Freestanding	17

The term "contracted" is defined as a provider that has signed a contract with Oklahoma Medicaid, it does not necessarily indicate participation or that a provider has provided services. Some of the above provider counts are grouped by the subcategory of provider specialty, therefore, a provider may be counted multiple times if they have multiple provider types and/or specialties.

Important Telephone Numbers

Main Number	405-522-7300
Adjustments	405-522-7450
Customer Service	
Beneficiary	*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**
Oklahoma Department of Human Services	**www.dhs.state.ok.us**
Medicaid Fraud Control Unit	**www.oag.state.ok.us**
Oklahoma State Auditor and Inspector	**www.sai.state.ok.us**
Centers for Medicare and Medicaid	**www.cms.gov**
Office of Inspector General of the Department of Health and Human Services	**www.oig.hhs.gov**