OKLAHOMA HEALTH CARE AUTHORITY

State Fiscal Year 2004 Annual Report

July 2003 through June 2004

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

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(middle left) Oklahoma Capital Dedication by Bryan Terry, 2003 The Oklahoman.
(bottom middle) Oklahoma City skyline provided by Oklahoma Tourism.

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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 at the Oklahoma Health Care Authority (OHCA) 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

Thomas Adelson
Cabinet Secretary

Terry Cline, Ph.D.
Cabinet Secretary 2004

LEGISLATIVE BRANCH
49th Legislature (2004-2005)

Cal Hobson
State Senate Pro Tempore

Larry Adair
House of Representatives
Speaker

"Increasing provider rates to appropriate and adequate levels continues to be a priority of this board and this agency. We must be able to compete in the health care market. This increase will help the state maintain our network of providers and give us the opportunity to attract new providers for our beneficiaries."

Ed McFall, OHCA Board chairman, regarding the January 2004 provider rate increase

OHCA Chief Executive Officer and Board Members

Top (left to right):
Vice Chairman Wayne Hoffman; *Chairman* Charles (Ed) McFall, DPH; Anne M. Roberts; George Miller; *CEO* Mike Fogarty, JD, MSW

Bottom (left to right):
Kim Holland; Lyle Roggow

Message from the Chief Executive Officer...

Care, it is the one word that captures the essence of the work we do. It is in the core of our name, the Oklahoma Health ***Care*** Authority; it is the center of our business. It is who we are. At its foundation, in this business of caring, are our employees who report for duty day after day working to ensure their fellow Oklahomans have the best care possible.

It is clear that the Oklahoma Legislature, Governor Brad Henry and other state leaders care about the health of the citizenry. Our state leaders continue to support health care as critical public policy and a financial priority. Access to health care has become ingrained in our state and national conscience and is universally recognized as an issue demanding attention. The health care needs of Oklahomans will only be met by the best efforts of both the public and private sectors and by our individual personal responsibility.

In the midst of this attention on health care, the Oklahoma Health Care Authority is poised to be part of the solution. A strong infrastructure is in place to support new approaches to meet the challenges ahead. A federally approved waiver program, ***SoonerCare***, provides a "medical home" for Oklahoma Medicaid beneficiaries with guaranteed access to a primary care provider. Thanks to a new claims processing system using the latest technology we now pay claims more accurately and more quickly than ever before. Our staff, seasoned by experience and expertise, delicately balances the health care needs of the beneficiaries with the limited financial resources to meet them. We measure our success by bridging the gap between our state's quality health care system and those Oklahomans who lack the financial ability to purchase health care.

You will find quality information in this annual report that truly reflects the caring and passion we have for our beneficiaries and this program.

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Figures

SFY2004 Highlights

Eligibles

- Overall Medicaid enrollees increased by 20,895 (or 4 percent) from June 2003 to June 2004.
- Children accounted for 88 percent of the overall growth during State Fiscal Year (June through July) 2004.
- The number of children enrolled in Oklahoma Medicaid increased by 18,467 (or 5.5 percent) from June 2004 to June 2004. At 69 percent the majority of Oklahoma's Medicaid beneficiaries are children.
- Medicaid covers more than 50 percent of the births in Oklahoma.

Expenditures

- The bulk of Medicaid expenditures were made on behalf of the elderly and disabled. 69 percent of expenditures are made for services provided to the elderly and disabled, who made up only 20 percent of Medicaid beneficiaries.
- Medicaid funded 76 percent of Oklahoma's total long-term care facility bed days.
- Quality of Care revenues totaled $58,324,445.
- Dollars recovered through post payment reviews totaled $1,673,335.
- Drug Rebate collections increased by 26 percent to $71,027,815.

Administration

- The OHCA processed 28 emergency rules and 17 permanent rules.
- OHCA held 17 OKDHS county worker training sessions with an estimated attendance overall of 323 workers within SFY2004. Additionally, there were 2,150 provider training sessions held during SFY2004.
- OHCA received and investigated 5,284 ***SoonerCare*** beneficiary complaints. This represents just over one percent of the entire 359,682 ***SoonerCare*** enrollees.
- OHCA's Customer Relations answered more than 69,000 provider calls and completed more than 26,000 written responses to inquiries received.
- There were 64 provider and 42 beneficiary formal appeals filed. This is less than one quarter of one percent of both populations.

SoonerCare Transition

In November 2003, OHCA began activities to transition members enrolled under the ***SoonerCare Plus*** program to ***SoonerCare Choice***. Below are some highlights of those activities. For more highlights on the ***SoonerCare*** transition go to page 27.

- ***SoonerCare*** **Choice** total enrollment as of June 1, 2004 was 359,682 members compared to January enrollment of 161,759
- The ***SoonerCare Choice*** rollout for the ***SoonerCare Plus*** areas had an average of 83 percent beneficiary selected primary care provider (PCP) or an average of 17 percent PCP autoassignment rate.
- OHCA conducted an outbound ***Plus*** member calling campaign from November 17, 2003 through March 12, 2004. OHCA staff attempted to call 156,539 TANF members and members categorized as ABD.
- OHCA held forty-seven (47) enrollment fairs from December 17, 2003 through March 13, 2004. These fairs were attended by 3,046 beneficiaries and resulted in 3,993 PCP selections.
- OHCA conducted an outbound calling campaign to 593 former ***Plus*** physicians. We held on-site meetings to 275 individual and group providers.

SFY2004 Year in Review

Health Care Delivery System Changes Smoothly

Prior to January 1, 2004 OHCA operated two separate forms of managed care — ***SoonerCare* Plus** and ***SoonerCare* Choice**. Under the ***SoonerCare* Plus** program OHCA contracted directly with Health Maintenance Organizations (HMOs) to provide medically necessary services to beneficiaries residing in Oklahoma's urban counties. In November of 2003, news of increased health care costs and a decision by a health maintenance organization (HMO) to pull out of the state Medicaid program prompted the Oklahoma Health Care Authority board to approve a proposal to end its health maintenance organization (HMO) contracts and expand the state's other managed care system, ***SoonerCare* Choice**.

Pharmacy Benefits Increased for Adults

The prescription limit for all adult Medicaid beneficiaries was increased to six per month, with a maximum of three brand name prescriptions, effective January 1, 2004. Prescriptions can now be filled for the greater of 100 units or a 34-day supply. Home and Community Based Waiver beneficiaries, including those on the ADvantage waiver, are able to receive an additional seven generic prescriptions per month without prior authorization.

Medicaid Providers Receive a Rate Increase

In January 2004, increases in the rate paid to nursing homes, hospitals, doctors and ambulance services that provide care to more than 500,000 Medicaid beneficiaries each month went into effect. $34 million in federal relief funds were used to increase nursing home rates by 7 percent and inpatient hospital rates by 5 percent. Evaluation and management services provided by physicians and other providers were increased to 90 percent of the Medicare fee schedule, up from the previous 72 percent.

Providers Receive EPSDT Bonus Payments

The OHCA mailed out almost $700,000 in Early and Periodic Screening, Diagnosis and Treatment (EPSDT) annual bonus payments in October 2003 to pediatricians, family physicians, obstetricians/gynecologists and general practitioners throughout the state. The bonus payments are made when providers reach more than 55 percent of the recommended number of screens for each Medicaid-eligible child in their care.

OHCA Awarded State Planning Grant

In partnership with Governor Brad Henry, the Oklahoma Health Care Authority applied for the State Planning grant and was awarded $874,360 in federal dollars to study ways to effectively provide private and public health care to more Oklahomans. It has been reported that 19 percent of Oklahoma's total population is uninsured, one of the highest rates in the nation.

OHCA Medicaid Payment System Receives Federal Approval

The claims processing and payment system, responsible for paying claims faster and more accurately, received certification from the Centers for Medicare and Medicaid Services (CMS), in turn saving the state more than $20 million through 2007 for system operations. After CMS determined the requirements of certification were met, the federal agency approved the MMIS in late August 2003. "It is difficult for most people to understand what the Oklahoma Health Care Authority accomplished in developing this new payment system. To put it in perspective, it is considered a greater undertaking than preparing for the Y2K conversion. I commend the OHCA staff and contractor for their commitment to this onerous project the result of which streamlines services with the medical community, reduces red tape, and saves Oklahoma millions," said Governor Brad Henry. Approval of the payment system by the federal government means they will share in 75 percent of the operational costs of the system rather than 50 percent.

SFY2004 Year in Review (continued)

OHCA Receives PACE Technical Assistance Grant

The OHCA received a technical assistance grant from the Centers for Medicare and Medicaid Services (CMS) and the National PACE Association (Program of All-Inclusive Care for the Elderly) to conduct studies of two market areas in Oklahoma for the feasibility of PACE sites. The two areas are the Oklahoma City and Ada vicinities. The PACE model is centered on the belief that it is better for the well-being of seniors with chronic care needs and their families to be served in the community whenever possible. The OHCA has been working with the Cherokee Nation of Oklahoma to develop a PACE program which will be the first operated by an Indian Tribe and the first rural PACE program in the nation. In addition to the Cherokee Nation PACE program, other providers have expressed interest in developing PACE in Oklahoma. For more information, see page 34.

OHCA Obtains Transportation Waiver

The Centers for Medicare and Medicaid Services (CMS) approved the Oklahoma Health Care Authority's request for a non-emergency transportation waiver under section 1915 (b) (4). The transportation waiver allows Oklahoma to receive an increased federal matching percentage. Prior to the waiver, transportation claims were paid at the administration federal match level of 50 percent. OHCA began receiving the just over 70 percent federal match June 2, 2004. It is anticipated this will result in an overall savings of approximately $3,462,464.

Oklahoma Selected Again for 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 Payment Accuracy Measurement (PAM) grants to selected states. Based on Oklahoma's success in last year's PAM pilot project, Oklahoma was chosen again to participate. Oklahoma was awarded a grant in the amount of $353,000. The ultimate goal of the grant is to identify and develop processes that will prevent inappropriate payments. The focus of the grant continues to be the determination and study of the appropriateness of claims payment, medical necessity of the service and beneficiary eligibility. It continues to be in the best interest of Oklahoma to participate in this grant as it affords us the opportunity to influence and prepare for future federal payment policies.

OHCA Prevails in Federal Appeal

The Oklahoma Health Care Authority won an important federal appeal after the state challenged a $1.9 million federal Medicaid audit regarding school-based services. The federal audit alleged Oklahoma schools improperly billed Medicaid reimbursements for providing school-based health services to low-income students that were provided free to other students and not exempt under the Individuals with Disabilities Education Act (IDEA). A federal Department of Health and Human Services Departmental Appeals Board (DHHS-DAB) reversed the decision of the federal government and ruled in Oklahoma's favor on June 14, 2004.

OHCA Continues Ticket to Work Efforts

Under the Ticket to Work and Work Incentives Improvement Act grant OHCA has continued efforts to connect people with disabilities to competitive employment. During SFY2004 grant staff held a transportation workshop, attended national conferences and participated in state and local events to increase awareness and identify any inadequacies and potential solutions. OHCA, in conjunction with other agencies and advocacy groups, is working towards building an infrastructure and support network by developing opportunities for employees and employers.

What is Medicaid?

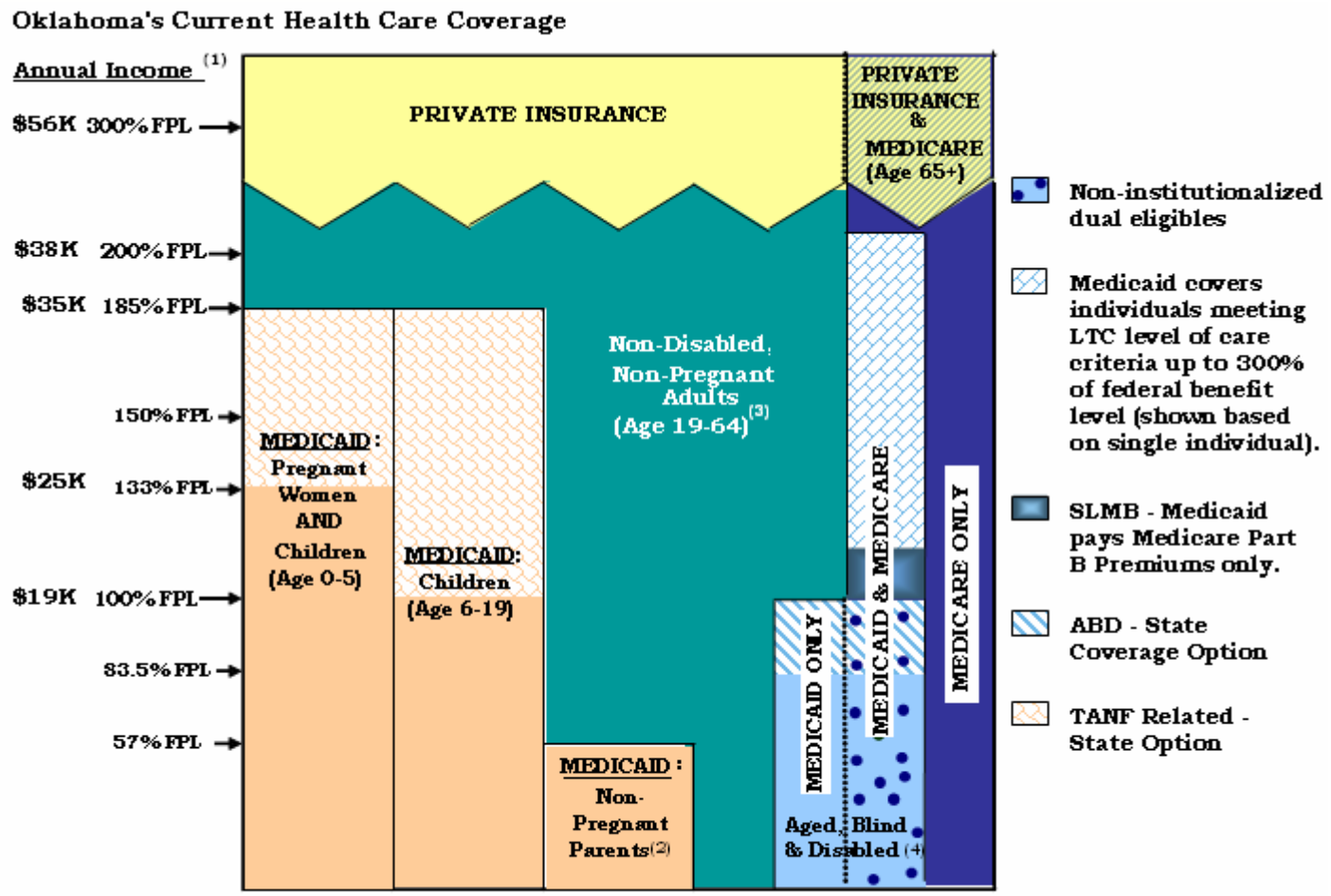
Medicaid is a federal and state entitlement program that provides medical benefits to low-income individuals who have no or inadequate health insurance coverage. Medicaid guarantees coverage for basic health and long-term care services based upon income and/or resources. Created as Title XIX of the Social 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 within certain federal parameters.

***entitlement* (*n.*)**

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.

Figure 1 **2004 Federal Poverty Levels (FPL) and Coverage**



(1) 2004 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 pages 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.

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 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 applicable 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.

Figure 2 **2004 Federal Poverty Guidelines**

Family Size	Annual (Monthly) Income			
	100%	133%	185%	200%
1	$9,310 ($776)	$12,382 ($1,032)	$17,224 ($1,435)	$18,620 ($1,552)
2	$12,490 ($1,041)	$16,612 ($1,384)	$23,107 ($1,926)	$24,980 ($2,082)
3	$15,670 ($1,306)	$20,841 ($1,737)	$28,990 ($2,416)	$31,340 ($2,612)
4	$18,850 ($1,571)	$25,071 ($2,089)	$34,873 ($2,906)	$37,700 ($3,142)
5	$22,030 ($1,836)	$29,300 ($2,442)	$40,756 ($3,396)	$44,060 ($3,672)
6	$25,210 ($2,101)	$33,529 ($2,794)	$46,639 ($3,887)	$50,420 ($4,202)
7	$28,390 ($2,366)	$37,759 ($3,147)	$52,522 ($4,377)	$56,780 ($4,732)
8	$31,570 ($2,631)	$41,988 ($3,499)	$58,405 ($4,867)	$63,140 ($5,262)

*For family units with more than eight members, add $3,180 for each additional member.
Based on Federal Income Guidelines printed in the Federal Register, February 13, 2004

Oklahoma Department of Human Services' Role in Eligibility

Each state sets an income limit within federal guidelines for Medicaid eligibility groups and determines what income counts towards that limit. Part of financial qualification for Medicaid is based upon the family size and relation of monthly income to the Federal Poverty Guidelines. According to Oklahoma State Statutes Title 63 Sec. 5009, the OHCA shall contract with the Oklahoma Department of Human Services (OKDHS) for the determination of Medicaid eligibility. This means that all applications for Oklahoma Medicaid enrollment are processed and approved or denied by OKDHS. Applications and renewals are reviewed by each county of residence OKDHS office for financial and/or medical requirements. After eligibility has been certified or extended, the records are sent to OHCA to coordinate medical services and process payments for those services.

Who is Eligible for Medicaid? (continued)

Nearly 1 in 5 Oklahomans Enrolled for Services

Some of the population figures contained in this annual report represent a "point in time" reference such as June 2004. The state Medicaid program enrolled an unduplicated count of 670,797 individuals during SFY2004. On average, approximately 513,214 individuals were enrolled each month of the fiscal year.

Figure 3 **General Age Breakdown of Medicaid Enrollees (for the month of June 2004)**

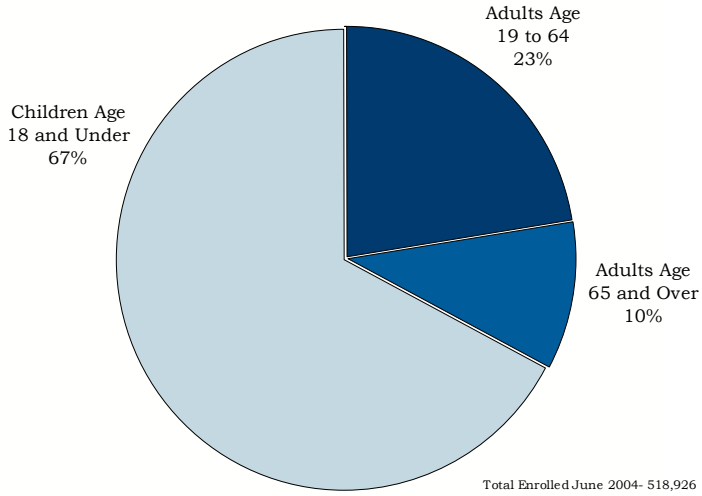
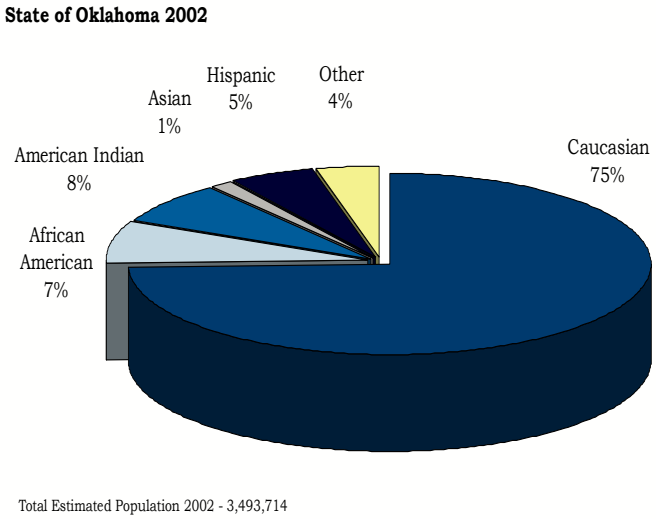
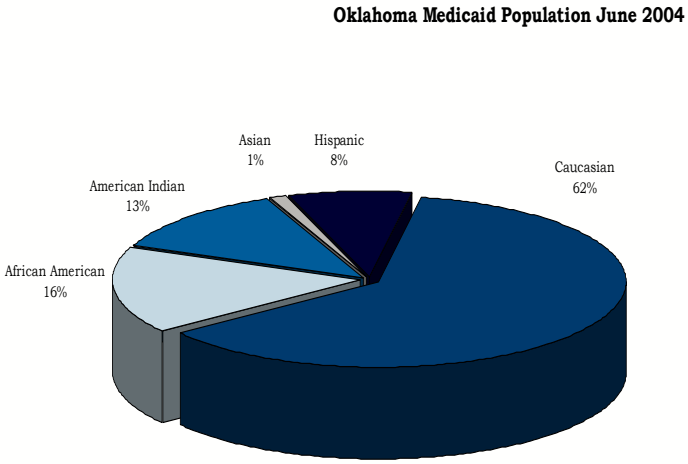


Figure 4 **State and Medicaid Population by Race**





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, 2004. Race is self-reported by beneficiaries at the time of enrollment.

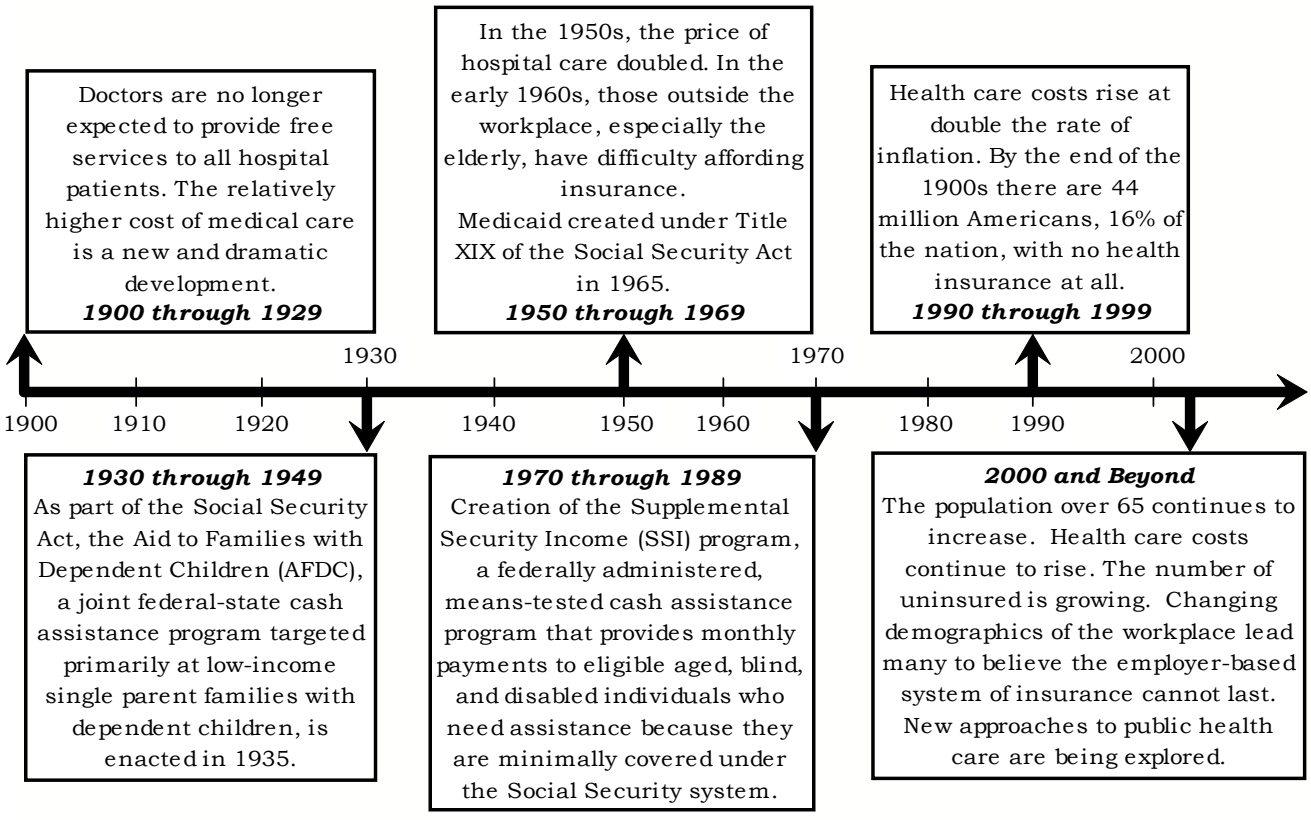
Medicaid Trends

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 low-income women and children qualify for Medicaid under the TANF guidelines. In SFY2004, Oklahoma Medicaid covered roughly 463,000 low-income children and just over 60,000 low-income adults in families with children, the vast majority of whom were women. Only 57 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.

Oklahoma Medicaid enrolled 670,797 people in SFY2004; that is 677 more people than live in Oklahoma City, Broken Arrow, Enid and Claremore combined. According to the U.S. Census Bureau's July 2003 population estimates, there were 523,300 persons within Oklahoma City proper, 83,610 in Broken Arrow, Enid 46,440 and 16,770 in Claremore.

Figure 5 **Historic Health Care Timeline**

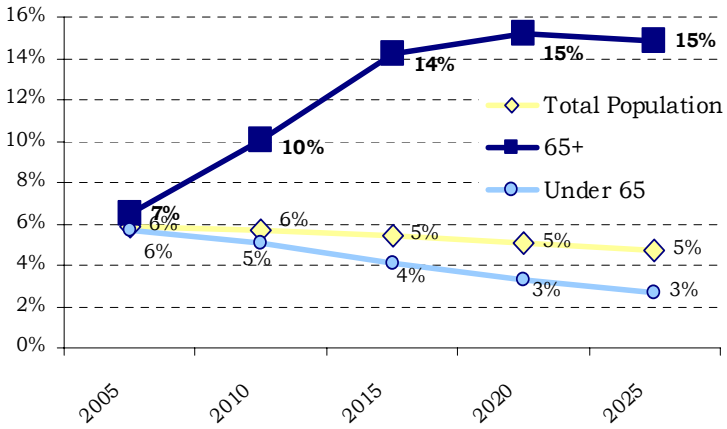


For more information go to PBS's website at http://www.pbs.org/healthcarecrisis/history.htm

Medicaid Trends (continued)

Elderly. More than 53,850 adults 65 and over were covered by Medicaid in SFY2004. More than 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.

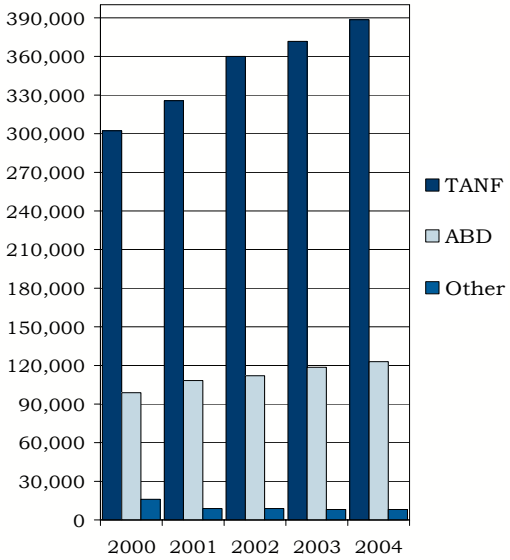
Figure 6 **Oklahoma's Estimated Population Growth, 2005 — 2025**



Source: Oklahoma Department of Commerce — Projections by Age: 2005-2025

Disabled. Almost 20 percent (676,098 individuals) of the 2000 census survey respondents in Oklahoma reported some type of disability. More than 70,000 Oklahomans with chronic conditions and disabilities received medical services through Medicaid. Almost 17 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 eligible as Aged, Blind and Disabled (ABD).

Figure 7 **Historic Enrollment by Aid Category**

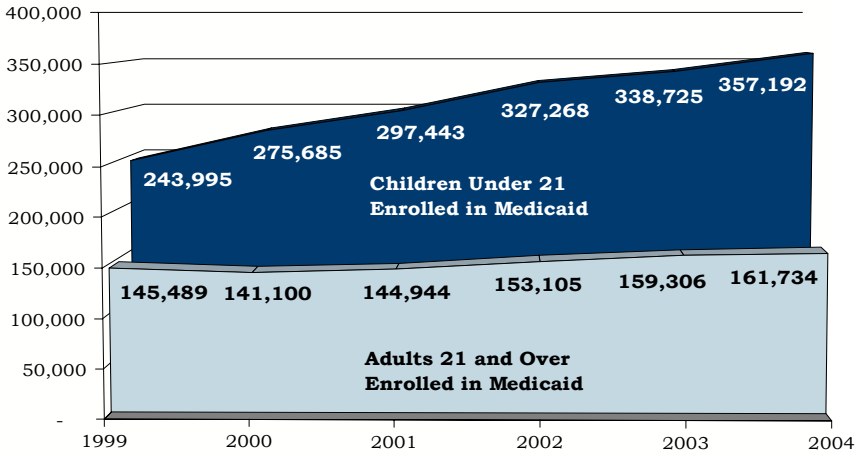


Source: Point in time June enrollment numbers OHCA Annual Report 2000-2004

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

Dual Eligibles. Some individuals are qualified for Medicaid and for Medicare. Medicare has two basic coverage components: Part A, which pays for hospitalization costs; and Part B, which pays for physician services, laboratory and x-ray services, durable medical equipment, outpatient and other services. Dual eligibles are individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit. The dual eligibles are also usually categorized as Aged, Blind and Disabled (ABD).

Figure 8 **Historic Child/Adult Enrollment**

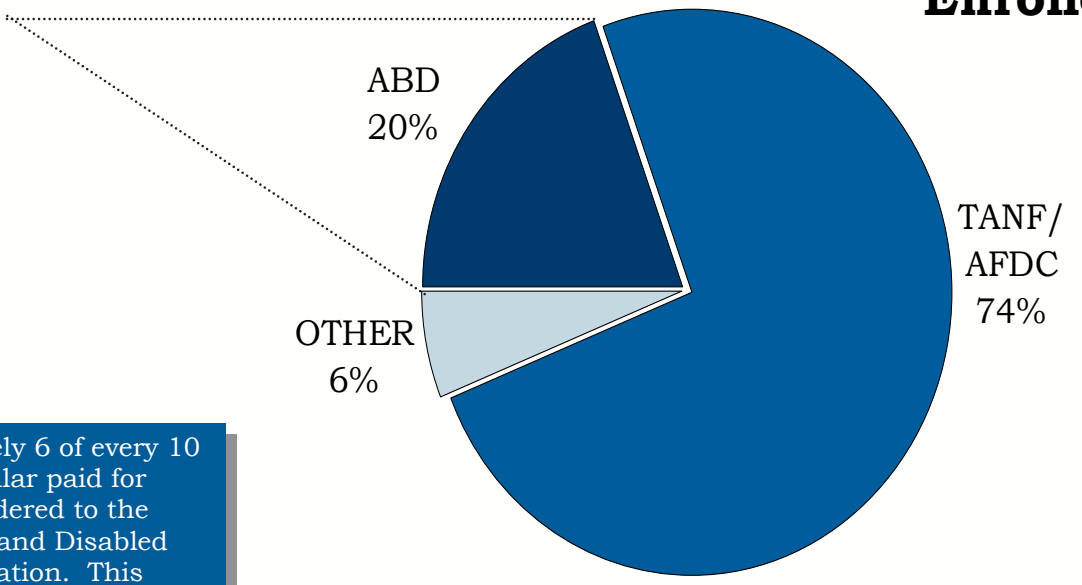


Source: Point in time June enrollment numbers OHCA Annual Report 1999-2004

Medicaid Enrollees and Expenditures by Aid Category (Unduplicated SFY2004)

69% of expenditures were paid on behalf of the Aged, Blind and Disabled

Enrollees

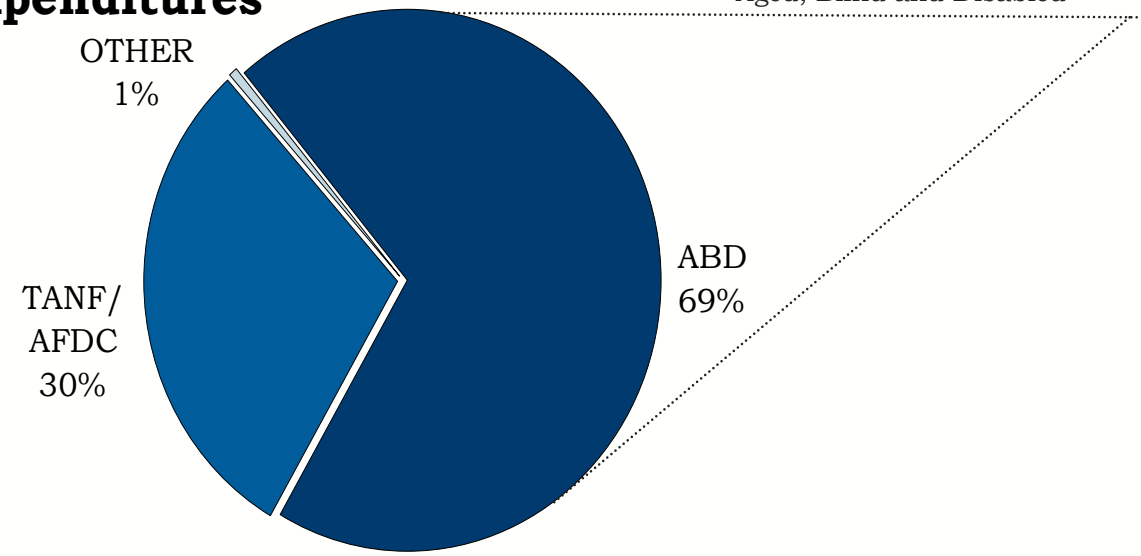


Approximately 6 of every 10 Medicaid dollar paid for services rendered to the Aged, Blind and Disabled (ABD) population. This group includes persons with chronic medical conditions, or in long-term care facilities and Medicare beneficiaries.

Unduplicated Enrollees for SFY2004 - 670,797

Only 20% of enrollees were Aged, Blind and Disabled

Expenditures



Total Expenditures* SFY2004 - $2,116,575,700

** 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 as a claim through the MMIS.*

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*

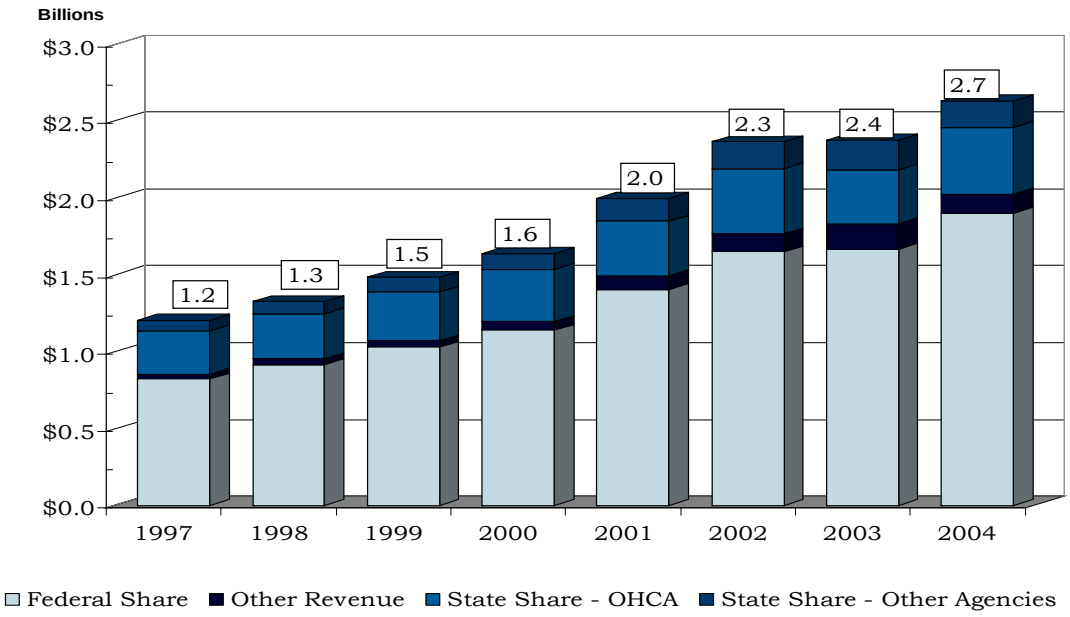
Medicaid is the largest source of federal financial assistance in Oklahoma. Medicaid accounted for an estimated 40 percent of all federal funds flowing into Oklahoma. Federal payments for Medicaid exceeded those for highways, education, housing, Temporary Assistance to Needy Families (TANF), food stamps and child nutrition programs. Federal Medicaid dollars received for SFY2004 totaled almost 1.9 billion dollars.

Figure 9 **Condensed Summary of OHCA Revenues**

As of June 30, 2004 **REVENUES**	**SFY04 Budget YTD**	**SFY04 Actual YTD**	**% Over/ (Under)**
State Appropriations	$ 439,000,000	$ 438,054,509	(0.2)%
Federal Funds — OHCA	1,420,000,619	1,455,648,999	.13%
Federal Funds for Other State Agencies	489,110,462	489,110,462	0.0%
Refunds from Other State Agencies	178,724,543	178,191,902	0.0%
Other Revenue	187,762,243	207,610,653	10.6%
TOTAL REVENUES	**$ 2,714,597,867**	**$2,768,616,526**	**2.0%**

Source: OHCA Financial Services Division (August 2004).

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	70.56%	79.39%
FFY03—Qtr. 3 & 4	73.51%	79.39%
FFY04—Qtr. 1-3	73.51%	79.17%
FFY04—Qtr. 4	70.24%	79.17%
FFY05	70.18%	79.13%

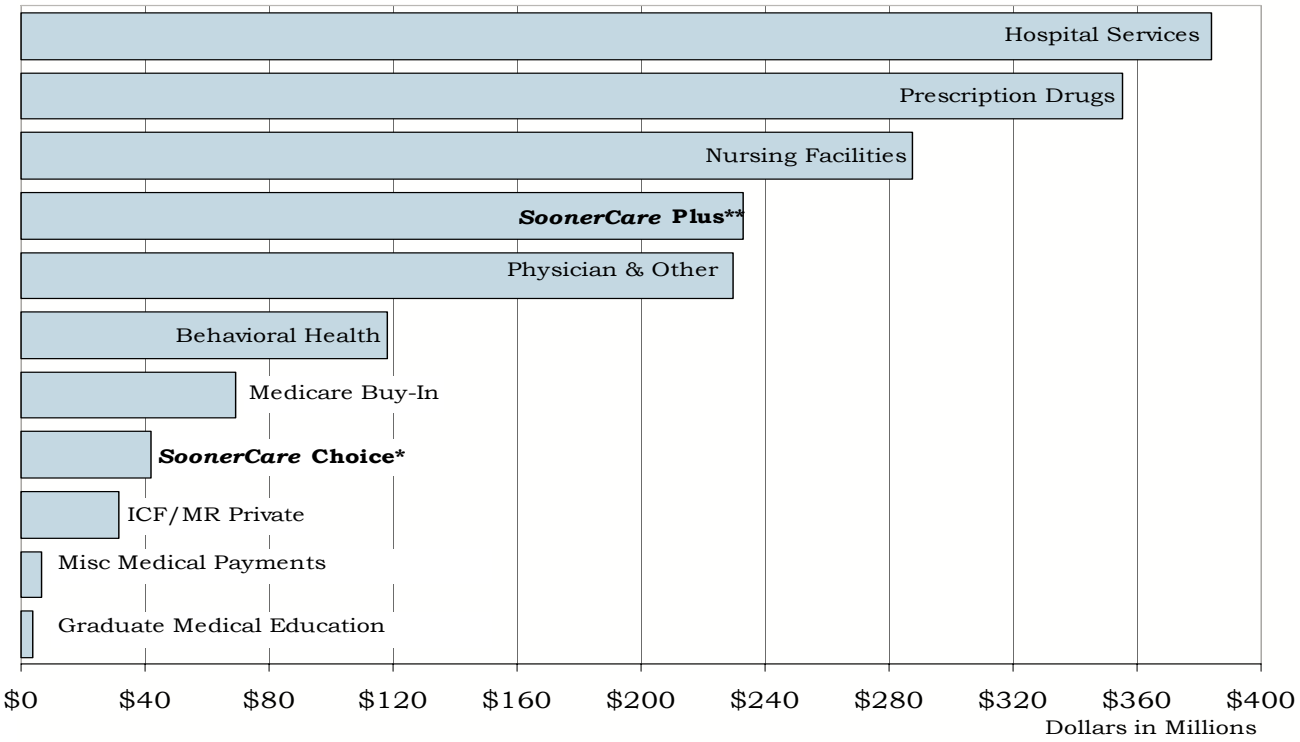
‡ *SCHIP: State Children's Health Insurance Program, see additional information on page 28. The Federal Fiscal Year is from October through September.*

Oklahoma received a temporary increase in the Medicaid matching funds received from the federal government for five calendar quarters from April 1, 2003 through June 30, 2004. The increase for all eligible expenditures was 2.95 percentage points over the normal federal share amount. The funds were 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 SFY2004**



SoonerCare Choice *expenditure figures represent capitated payments only. Noncapitated services are not included in this amount.*
** **SoonerCare Plus** *expenditures are for dates of service prior to January 1, 2004.*

Where are the Medicaid Dollars Going? (continued)

Figure 13 **Condensed Summary of OHCA Expenditures SFY2004**

As of June 2004 EXPENDITURES	SFY04 Budget YTD	SFY04 Actual YTD	% (Over)/ Under
ADMINISTRATION	**$ 64,030,651**	**$ 57,822,935**	**9.7%**
OHCA MEDICAID PROGRAMS			
Managed Care:			
***SoonerCare* Plus**	236,937,729	232,911,364	1.7%
SoonerCare* Choice	44,395,013	42,034,718	5.3%
Acute Fee-for-Service Payments:			
Hospital Services	374,779,840	384,210,619	(2.5)%
Behavioral Health	124,255,512	118,318,453	4.8%
Physicians & Other Providers	229,655,497	229,856,738	(0.1)%
Prescription Drugs	362,315,182	355,209,786	2.0%
Miscellaneous Medical Payments	6,485,356	6,731,296	(3.8)%
Other Payments:			
Nursing Facilities	286,460,702	287,584,888	(0.4)%
ICF/MR Private	33,258,964	31,751,308	4.5%
Medicare Buy-In	66,485,747	69,240,600	(4.1)%
Graduate Medical Education	3,514,861	3,938,044	(12.0)%
DMHSAS/OHCA State Share		6,123,022	0.0%
OTHER OHCA MEDICAL PROGRAMS	**$12,109,664**	**$12,164,872**	**(0.5)%**
TOTAL OHCA	**$1,844,684,718**	**$1,837,898,643**	**0.4%**
QUALITY OF CARE PAYMENTS: State funds are from the collected Quality of Care Fee.			
ADMINISTRATION – QUALITY OF CARE	**$ 664,383**	**$ 664,383**	**0.0%**
Nursing Home Rate Adjustment	160,789,516	160,789,516	0.0%
NET – ***SoonerRide***	467,520	467,520	0.0%
Personal Allowance Increase	3,893,460	3,893,460	0.0%
Coverage for DME and supplies	2,708,208	2,708,208	0.0%
Coverage of Qualified Medicare Beneficiaries	14,005,748	14,005,748	0.0%
ICF/MR Rate Adjustment	19,199,633	19,199,633	0.0%
Contract Services	14,800	14,800	0.0%
Total Quality of Care	**$ 201,743,268**	**$ 201,743,268**	**0.0%**
OTHER STATE AGENCY PROGRAMS: State funds are reimbursed from the receiving agency or entity.			
Miscellaneous and Non-Medicaid Programs	$ 20,280,885	$ 20,280,885	0.0%
Dept. of Human Services Medicaid (OKDHS)	461,290,425	461,290,425	0.0%
Office of Juvenile Affairs Medicaid (OJA)	8,514,055	8,514,055	0.0%
Dept. of Mental Health Medicaid (DMHSAS)‡	21,476,577	21,476,577	0.0%
Oklahoma State Dept. of Health (OSDH)‡	2,197,429	2,197,429	0.0%
Department of Education Medicaid (DOE)‡	5,798,048	5,798,048	0.0%
Hospital Upper Payment Limit	22,507,007	22,507,007	0.0%
Medical Education Payments	129,299,572	129,299,572	0.0%
Total Other State Agency Programs	**$ 671,363,998**	**$ 671,363,998**	**0.0%**
TOTAL ALL EXPENDITURES	**$2,717,791,984**	**$ 2,711,005,909**	**0.2%**

Source: OHCA Financial Service Division, August 2004. 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**

Federally Mandated Services

Early Periodic Screening, Diagnosis and Treatment (EPSDT) (Under age 21)
Family planning services & supplies
Inpatient Hospital
Laboratory & X-ray
Emergency transportation
Nurse midwife
Nurse practitioner
Nursing facility/home health (age 21+)
Outpatient hospital
Physician
Rural health clinic & federally qualified health center
Non-emergency transportation

Optional Covered Services

Case management
Chiropractor
Clinic
Dental
Diagnostic services
Emergency hospital

Optional Covered Services - continued

Inpatient hospital (age 65+) (institutions for mental disease)
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

A prearranged fee is paid to the ***SoonerCare*** 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 led to the financial collapse of the state Medicaid system if left unchecked.

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.

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.

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.

As we complete our ninth year managing the now $2.7 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 $2.7 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 Oklahoma Department of Human Services, Department of Mental Health and Substance Abuse Services, Oklahoma State Department of Health, Office of Juvenile Affairs, and the Department of Education, as well as Oklahoma University and Oklahoma State University medical schools and teaching hospitals.

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.

- Since its inception OHCA has increased federal revenue by more than $790 million, a 97 percent increase.
- OHCA interacts with federal and tribal governments, other state agencies, hundreds of contractors and providers of care in addition to beneficiaries and their families.
- OHCA employs more than 300 persons directly and provides funding for more than 750 eligibility workers employed by the Oklahoma Department of Human Services.

OHCA and Medicaid (continued)

As the state Medicaid agency, a board of directors meets monthly to direct and 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 beneficiaries' needs while maintaining the fiscal integrity of the agency.

Strategic Planning

It is difficult to over-estimate the importance and impact of Medicaid, because the program is so large, it serves so many people in so many different population groups and plays a role to finance virtually every state program that relates to health. By any measure, Medicaid makes a positive difference, even a critical difference, in the lives of hundreds of thousands of low-income Oklahomans.

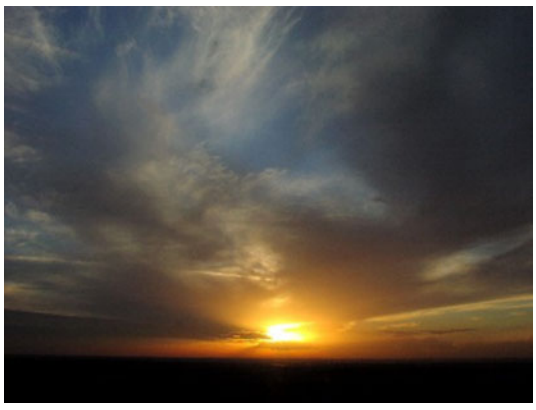
By its design, Medicaid's impact is greatest among the specific groups that are targeted for coverage, including children, pregnant women, adults and children with disabilities, persons with chronic medical and mental problems and the elderly. Medicaid is now a major economic factor in many segments of the health care market place. Most significantly, Medicaid now has an enormous impact on state budgets.

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

In carrying out its 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.

In order to be a leader, OHCA must continually plan. Changes in environmental forces are now so volatile, a proactive planning stance is necessary. 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 to come together as a state to make difficult choices regarding direction and priorities and how committed we are to work together to support those choices in our future actions will determine whether this planning process is ultimately successful.

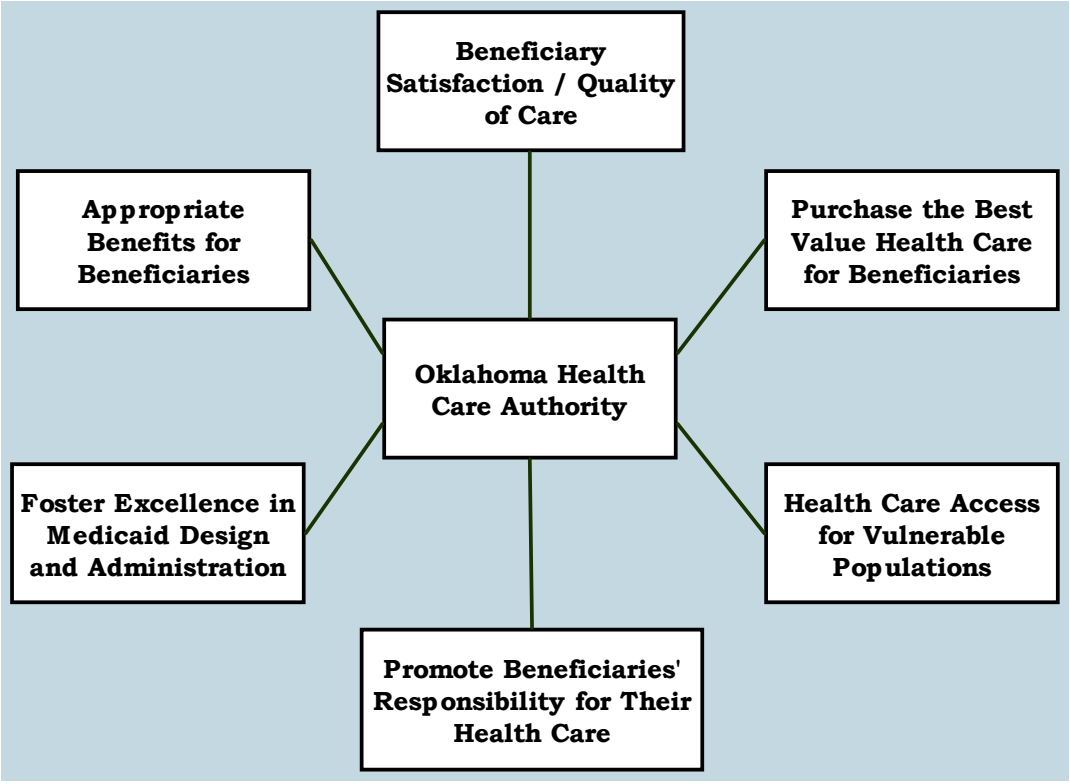


Strategic Planning (continued)

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. (Beneficiary Responsibility)
- 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.

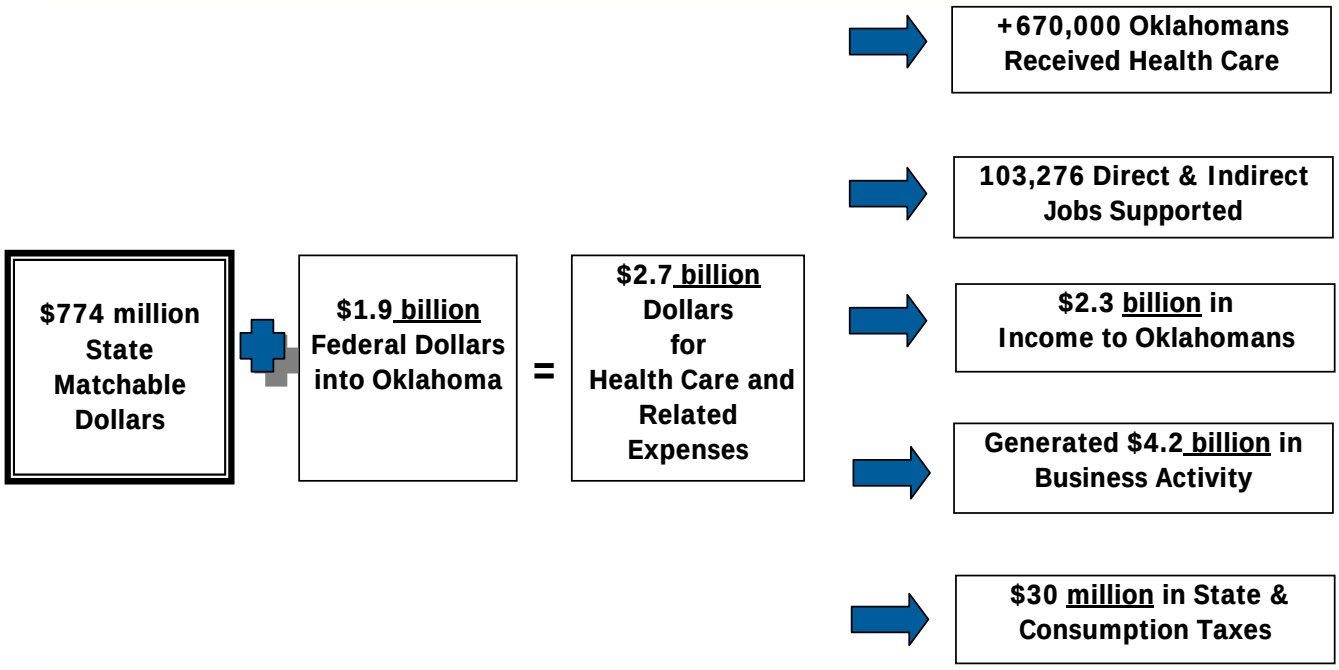


Medicaid and the Economy

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 15 **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 upon recent data from the U.S. Census Bureau, 20.4 percent of Oklahomans were uninsured during 2003; the national uninsured rate was 15.6 percent. Further broken down, 17.9 percent of children under the age of 18 and 23.8 percent of Oklahomans under the age of 65 were uninsured during 2003.

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.

Americans who lack health insurance when approaching retirement age are 43 percent more likely to die prematurely than their peers who have insurance.

Health Affairs, July 2004

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.

In a recent poll, two-thirds of insured Americans say their health insurance premiums have been going up lately; a third say they've been rising sharply. Fewer but still a sizable number, 44 percent, say their deductibles and co-pays have been rising.

ABCNEWS/Washington Post poll, October 2003

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 a portion of its Medicaid service delivery system 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. For example, 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 the Section 1115(a) waiver, Oklahoma chose to develop and implement a managed care delivery system within its Medicaid program – ***SoonerCare***.

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, 2005.

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 institutions — long-term care hospitals, nursing facilities (NF) or intermediate care facilities for persons with mental retardation (ICFs/MR). The HCBS waiver program, authorized under §1915(c) of the Social Security Act, recognizes that many individuals at risk of being institutionalized can be cared for in a community-based setting, preserving their independence and ties to family and friends at a cost no higher than that of comparable institutional care.

What is a Waiver? (continued)

Home and Community-Based Services (HCBS) Waivers (continued)

The Oklahoma Department of Human Services is responsible for and administers five Home and Community-Based Services waivers (HCBS).

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

- Community Waiver: Serves approximately 2,300 beneficiaries with mental retardation (MR) and certain persons with "related conditions" qualifyed for placement in an ICF/MR . This waiver covers children and adults, with the minimum age being 3 years old.

- ADvantage Waiver: Serves the "frail elderly" (Oklahomans age 65 years and older) and adults 21 years of age or older with physical disabilities who would otherwise qualify for placement in a nursing facility. Approximately 14,100 persons receive services through this waiver program.

- Homeward Bound Waiver: Designed to serve the needs of individuals with MR or "related conditions" who are also members of the Plaintiff Class in *Homeward Bound et al. v. The Hissom Memorial Center, et al.* who would otherwise qualify for placement in an ICF/MR. Prior to the implementation of this waiver, these beneficiaries received waiver services under the *Community* Wavier.

- 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 for waiver services. This waiver serves approximately 750 adults who would otherwise qualify for placement in an ICF/MR.

- 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 for waiver services. This waiver serves approximately 370 children who would otherwise qualify for placement in an ICF/MR.

Depending on an individual's Plan of Care or Individual Habilitation Plan and the specific waiver they are eligible under, services could include:

- case management;
- skilled nursing;
- prescription drugs;
- advanced/supportive restorative care;
- 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 qualified beneficiary can be served safely in a community-based setting, when the cost of providing waiver services is less than the cost of providing services in the comparable institutional setting and when there are waiver beneficiary slots available. Individual waiver documents specify beneficiary eligibility criteria as well as the waiver-specific services available.

Oklahoma Managed Care

Prior to January 1, 2004 OHCA operated two separate forms of managed care — ***SoonerCare* Plus** and ***SoonerCare* Choice**. Under the ***SoonerCare* Plus** program OHCA contracted 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. In November of 2003, news of increased health care costs and a decision by a health maintenance organization (HMO) to pull out of the state Medicaid program prompted the Oklahoma Health Care Authority board to approve a proposal to end its health maintenance organization (HMO) contracts and expand the state's other managed care system, ***SoonerCare* Choice**.

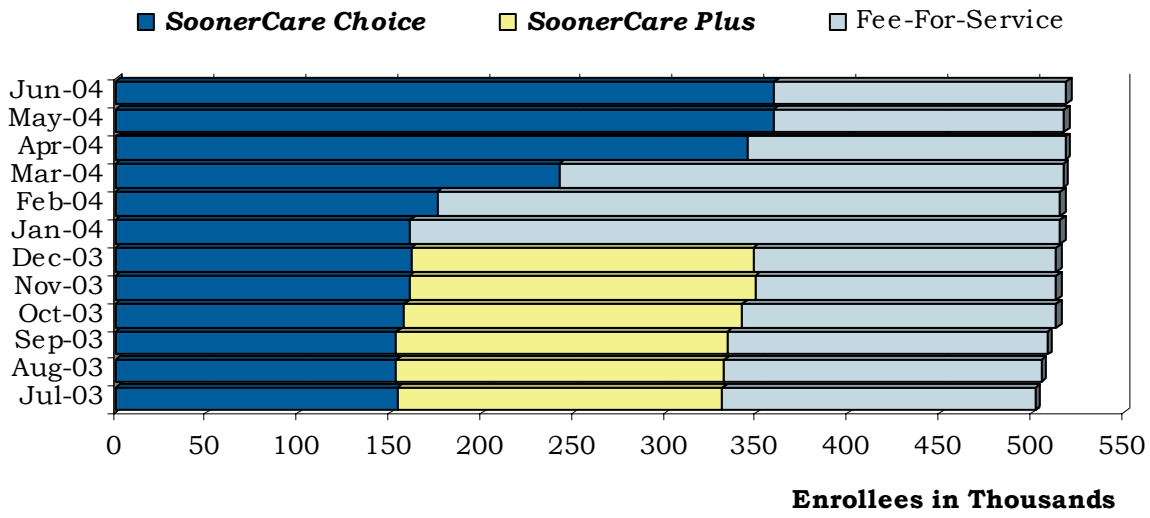
Now OHCA only has one managed care program — ***SoonerCare* Choice**. After the transition of all beneficiaries from ***SoonerCare* Plus** into ***SoonerCare* Choice** in April 2004, OHCA dropped the word "Choice" from the name of the program. We now refer to the entire managed care program as ***SoonerCare***.

SoonerCare 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*** program is partially capitated, in that providers are paid a monthly capitated rate for a fixed set of services with noncapitated services remaining compensable on a fee-for-service basis. Some beneficiary groups are not eligible to participate in the ***SoonerCare***. Persons eligible for Oklahoma Medicaid who are institutionalized, dual eligibles, in state or tribal custody or enrolled under a Home and Community-Based Waiver are not included in the ***SoonerCare*** program at this time.

Beneficiaries enrolled in ***SoonerCare*** are not "locked in" with a primary care provider/case manager (PCP/CM) and can change health care providers up to four times per year. This important facet to the program allows ***SoonerCare*** beneficiaries the opportunity to select a provider that has been added to the program. Providers contracting in this program include physicians, nurse practitioners and physician assistants.

Identifying the need to coordinate care for ***SoonerCare*** members with complex medical needs, the ***SoonerCare*** division created a Care Management department. This department contains nurse exceptional needs coordinators (ENCs) who support the Oklahoma Medicaid provider networks in both the ***SoonerCare*** program and fee-for-service areas through research, collaboration and problem resolution as related to members' care.

Figure 16 **SoonerCare Plus to SoonerCare Choice Transition Enrollment**



Oklahoma Managed Care (continued)

SoonerCare Transition Activities

In November 2003, the Oklahoma Health Care Authority began activities to transition members enrolled under the ***SoonerCare Plus*** program to ***SoonerCare Choice***. Below are some highlights of those activities.

General Information

- ***SoonerCare* Choice** total enrollment as of June 2004 was 359,682 members compared to January enrollment of 161,759.
- ***SoonerCare Choice*** rollout for the ***SoonerCare Plus*** areas had an average of 83 percent beneficiary selected primary care provider (PCP) or an average of 17 percent PCP autoassignment rate.
- 17 on-site ***SoonerCare*** training sessions for Oklahoma DHS county staff were held.
- The transition was successfully completed by April 1, 2004.

Member Activities

- OHCA conducted an outbound ***Plus*** member calling campaign from November 17, 2003 through March 12, 2004; OHCA staff attempted to call 156,539 TANF members and members categorized as ABD.
- OHCA held forty-seven (47) enrollment fairs from December 17, 2003 through March 13, 2004. These fairs were attended by 3,046 beneficiaries and resulted in 3,993 PCP selections.
- OHCA conducted a targeted post-transition calling campaign to 3,842 individuals during April.
- 103,560 open enrollment packets and 115,429 enrollment fair fliers were mailed. More than 400 enrollment fair posters were distributed.
- PCP preselections were manually or electronically entered for about 159,000 individuals.
- OHCA conducted 17 on-site visits to homeless shelters/low-income housing.

Provider Activities

- OHCA conducted an outbound calling campaign to 593 former ***Plus*** physicians.
- OHCA held on-site meetings with 275 individual and group providers.
- Contracted with 40 of 43 IHS/Tribal/Urban Indian Clinics resulting in a 20 percent increase in Native Americans enrollees with these sites.
- OHCA held large provider training sessions for the Tulsa (4) and Oklahoma City (4) areas.
- Recruitment letters were sent to 405 ***Plus*** physicians without ***Choice*** contracts.
- There was a targeted calling campaign to 480 specialty physicians.

Care Management Activities

- OHCA held multiple calling campaigns to 354 individuals with Special Behavioral Health Needs and 271 individuals identified w/special needs to educate about the transition, facilitate PCP selection and notify the members of their designated care manager.
- Initial home visits to 80 children receiving skilled nursing services were performed.
- On-site meetings were conducted with eight (8) in-state Neonatal Intensive Care Units.

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…

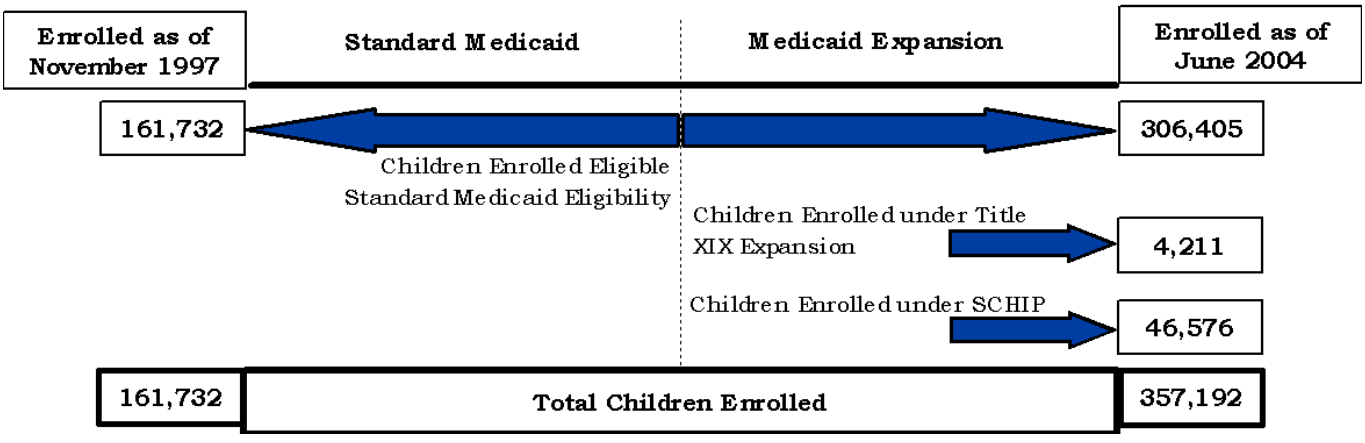
Subsequently, the Federal Budget Act of 1997 made numerous Medicaid changes and also created the State Children's Health Insurance Program (SCHIP). The optional program, referred to as SCHIP or Title XXI, is designed to help states cover additional uninsured low-income children with a higher federal 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 17 **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 121 percent.

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. Medicaid becomes the lifeline for treatment for many Oklahomans with a serious mental illness or an emotional disturbance. Many people with these conditions either lose or are unable to obtain or afford private coverage. Mental health treatment benefits for those enrolled in Oklahoma Medicaid 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.

SFY2004 Specific Information...

- Expenditures for the behavioral health services totaled $118,318,453 for SFY2004. This represents 6 percent of the total OHCA expenditures.

OHCA is working in partnership with several other state agencies as well as state advocacy organizations and consumers to improve the behavioral health system of care in Oklahoma. One effort is entitled the Partnership for Children's Behavioral Health and the OHCA is very pleased to be part of this major endeavor. Another collaborative effort is a program for adults that will enhance the efficient use of monetary and human resources as well as increasing consumer choice and is anticipated within the next fiscal year. It is hoped that through these multi-agency efforts, an improved array of evidence-based outpatient care can be developed for individuals who need treatment for severe mental illnesses or emotional disturbances.

This year, in conjunction with the transition of the ***SoonerCare* Plus** beneficiaries, the OHCA has added Behavioral Health Care Mangers who are available to assist beneficiaries who need information, assistance or care management in order to obtain necessary treatment and services. This service has been very well received and is highly utilized.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

The federally mandated Early and 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.

SFY2004 Specific Information...

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

University of Oklahoma – OKC	$ 24,571,832
University of Oklahoma – Tulsa	$ 21,594,451
Oklahoma State University College of Osteopathic Medicine – Tulsa	$ 11,607,814

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

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.

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.

SFY2004 Specific Information...

Payments made to IME qualified hospitals:

Oklahoma Medical Center – OKC	$ 11,393,839
Hillcrest Health Systems – Tulsa	$ 11,393,839

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.

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.

SFY2004 Specific Information...

- Hospital expenditures, $384,210,619 accounted for 21 percent of OHCA's total Medicaid expenditures.
- During SFY2004, the Oklahoma Medicaid program had contracts with 353 hospitals.

Disproportionate Share Hospitals		SFY2004
University Hospitals	$	21,996,524
OK Youth Center	$	80,876
George Nigh Rehab	$	55,124
Griffin Memorial	$	2,944,321
Jim Taliaferro	$	31,503
Choctaw Memorial	$	6,104
Cimarron Memorial Hospital	$	2,348
J.D. McCarty Center for Children	$	926,965
Henryetta Medical Center	$	670
Hillcrest/St. Michael's	$	255,780
Logan County	$	1,424
Mission Hill	$	6,255
Parkside/Tulsa Psychiatric	$	137,332
Share Medical Center	$	161
Willow View	$	1,975
Arkansas Children's Hospital	$	520,140
TOTAL	$	24,029,082

DME Qualified Hospitals		SFY2004
Bone and Joint Hospital – OKC	$	6,347
Comanche County Memorial Hospital	$	62,092
Deaconess Hospital	$	66,381
Hillcrest Medical Center – Tulsa	$	6,626,590
Bass Baptist Health Care Center	$	14,760
Southwest Medical Center	$	265,907
Baptist Medical Center	$	3,310,477
Jackson County Memorial	$	2,897
Jane Phillips Hospital	$	19,295
Laureate Psych Hospital	$	3,564
Medical Center of Southeastern Oklahoma	$	85,548
Saint Francis – Tulsa	$	2,442,876
Shadow Mountain/Brown Schools Hospital	$	47,504
St. Anthony	$	2,017,541
St. John – Tulsa	$	2,276,201
Tulsa Regional Medical	$	4,702,160
University Health Partners	$	29,463,192
TOTAL	$	51,413,332

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.

Nationwide, Medicaid paid for 50 percent of all nursing home care in 2002.

SOURCE: Centers for Medicare & Medicaid Services. http://www.cms.hhs.gov/statistics/nhe/historical/t7.asp

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 50 percent of all nursing home care in 2002. In Oklahoma, Medicaid funds approximately 76 percent of all nursing home care. 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.

SFY2004 Specific Information...

- Expenditures for nursing facilities (NF) serving adults were $287,584,888; expenditures for private intermediate care facilities for the mentally retarded (ICF/MR) were $31,751,308.
- Total long-term care expenditures accounted for 17 percent of the total OHCA Medicaid expenditures.
- Medicaid beneficiaries living in long-term care facilities represented an estimated 3 percent of the total Medicaid beneficiaries.
- Medicaid funded 6,668,158 long-term care facility bed days; this represents 76 percent of the total actual bed days for SFY2004.
- Total Quality of Care Program revenues were $58,324,445 and the state share of the total $201,743,268 Quality of Care expenditures was $60,270,889.

Medicare "Buy-In" Program

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):

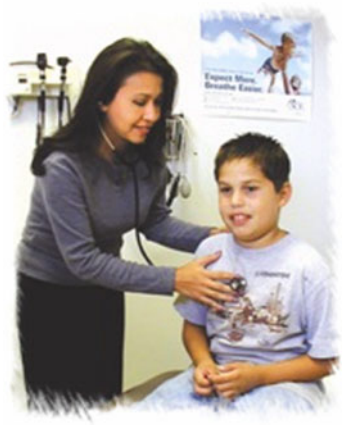
- For Medicare beneficiaries whose incomes are at least 135 percent, but less than 175 percent of the federal poverty level who have limited financial resources.
- Pays for a portion of the Medicare Part B premiums for beneficiaries who are not otherwise eligible for Medicaid.

SFY2004 Specific Information...

- Medicare "Buy-In" expenditures accounted for 3.8 percent of the total Medicaid expenditures.
- "Buy-In" expenditures totaled $69,240,600 for SFY2004.
- An average of 3,262 Part A premiums and 70,580 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. As of June 2004, there were more than 65,000 Native Americans enrolled in Oklahoma Medicaid. In addition to the 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). There are more than 40 I/T/U facilities in Oklahoma, most of which are contracted Medicaid providers.



There has been a partial shift in the operation of Indian health facilities from federal to tribal operation as some tribes have opted to manage individual tribal health care systems. Tribal health care systems range from large multi-site 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 has been participating in quarterly meetings of the Oklahoma City Area Inter-Tribal Health Board for several years and utilizes 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. In 2004, OHCA representatives were elected to head 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

Native American ***SoonerCare*** beneficiaries can select a Medicaid provider or self-refer to any I/T/U facility. Most providers in I/T/U facilities are ***SoonerCare*** providers and may serve as Primary Care Providers (PCP). As PCPs, I/T/U providers can provide culturally sensitive case management to Native American ***SoonerCare*** members, make referrals and coordinate additional services such as specialty care and hospitalization when patients access care at facilities that are not operated by tribes or IHS.

Outreach Activities

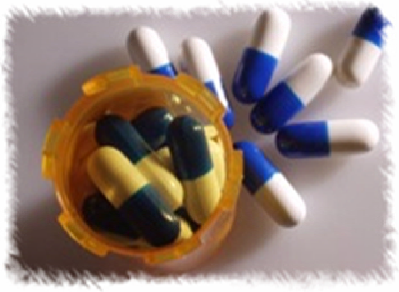
Over the past year, OHCA staff has worked with CMS to assist Oklahoma Tribal health facilities in becoming contracted providers with the Arkansas and Texas Medicaid programs. Tribal health facilities will be able to receive Medicaid reimbursement for providing services to medically eligible Native Americans who live in these states but receive services in Oklahoma. OHCA staff have also developed a brochure for Native Americans to encourage Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for children.

Program of All-Inclusive Care for the Elderly (PACE)

The Oklahoma Health Care Authority is working with the Cherokee Nation of Oklahoma to establish a Program of All-inclusive Care for the Elderly (PACE) program in the Cherokee Nation service area. PACE will serve individuals age 55 or older, certified by the state to need nursing home care, able to live safely in the community at the time of enrollment and live in a PACE service area. PACE programs will receive a capitated payment to provide the entire continuum of care and services to seniors with chronic care needs while maintaining their independence in their homes for as long as possible. A team will manage the care and services for beneficiaries.

Pharmacy Program

The value of prescription medications in modern health care is well documented. Because of its value, prescription medications are covered by every state's Medicaid program in spite of the fact that it is an optional benefit under federal law. It is almost impossible to imagine a health care benefit system in which medication therapies did not play a significant role. In response to the importance of medication therapies, the pharmacy benefit for Oklahoma Medicaid beneficiaries was significantly enriched during state fiscal year 2004.



Beginning January 1, 2004, all beneficiaries were transitioned into the Fee-for-Service Pharmacy Program. By unifying the benefit package for all beneficiaries, the prescribers are not required to juggle several formularies for their Medicaid patients. Pharmacists are able to file claims with one processor and obtain information from one source. With the transition, adult beneficiaries were provided with an enhanced drug benefit program. Beginning January 1, 2004, the adult beneficiary pharmacy benefit was increased from three prescriptions to six prescriptions per month, with a maximum of three brand name drugs.

To maintain quality of service the agency contracts with Pharmacy Management Consultants at the University of Oklahoma College of Pharmacy to process medication prior authorization requests and staff a help desk for beneficiaries and providers. OHCA is also developing chronic disease management programs that include self-monitoring and patient education as ways to increase beneficiary involvement in and responsibility for their health status. Diabetes, asthma, smoking cessation and hypertension are all disease states which can be improved through patient education.

To enhance and improve the quality of pharmaceutical care and patient outcomes by encouraging optimal medication use as recommended in current professional literature, OHCA has a Drug Utilization Review (DUR) Board. The 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.

SFY2004 Specific Information...

- Prescription drug program expenditures accounted for $355,209,786 or 19 percent of the total Oklahoma Medicaid expenditures.
- The average cost per prescription funded by Medicaid was $65.64 and the average monthly prescription cost per patient funded by Medicaid was $204.09.
- $71 million dollars were collected through the Drug Rebate program. For more Pharmacy related cost savings 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.

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.

SFY2004 Specific Information...

Expenditures for physicians and other practitioners accounted for $229,856,738, or 13 percent of Oklahoma's total Medicaid expenditures.

School Based Services

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

OHCA focuses an outreach initiative in places, such as schools, where we know we can find low-income 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. For more information regarding EPSDT, see page 29.

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.

School Based Services (continued)

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.

SFY2004 Specific Information...

- OHCA contracted with 252 school based providers in 66 counties.
- During SFY2004, OHCA paid $1,430,518 for the Early Intervention (EI/SoonerStart) program.
- School based providers were reimbursed $8,024,144 for SFY2004.

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.

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. Similar to a managed care health care delivery system, the contracted transportation broker is reimbursed on a per-member-per-month (PM/PM) basis.

SFY2004 Specific Information...

- Almost 55,000 beneficiaries utilized the ***SoonerRide*** services for more than 418,000 transports.
- The non-emergency transportation program costs were $12,039,929; this represented less than 1 percent of the total Oklahoma Medicaid expenditures.

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)2004 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 Management 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, as well as risk-based assessments.

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. Federal regulations require this function to be performed by a PRO.

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 18 **Program and Payment Integrity Recoveries, SFY2002 through SFY2004**

Provider Type	SFY2002	SFY2003	SFY2004
ADvantage Waiver	$ 58,765	-	$ 83
Home and Community-Based Waiver	$ 81,005	$ 129,288	$ 59,935
Behavioral Health	$ 1,239,265	$ 708,350	$ 357,218
DME Supplies	$ 109,145	$ 63,198	$ 130,290
Hospital	$ 337,391	$ 694,417	$ 263,187
Long-Term Care Facilities	$ 1,293,931	$ 137,952	$ 133,356
Physician	$ 8,523	$ 31,472	$ 27,974
Pharmacy	$ 146,068	$ 1,009,284	$ 301,232
EPSDT	$ 58,765	$ *93,480	$ 653
Other Practitioners	$ 5,542	$ 48,774	$ 143,997
Indian Health	–	–	$ 79,535
HMO	$ 276,359	$ 229,707	$ 60,411
School Corporation	-	$ 209	$ 102,006
Transportation Provider	-	$ 2,607	$ 13,459
Total – OHCA Recoveries	**$ 3,614,759**	**$ 3,055,258**	**$ 1,673,335**
Medicaid Fraud Control Unit	$ 1,003,518	$ 254,865	$ 71,320
Total Medicaid Recoveries	**$ 4,618,277**	**$ 3,310,123**	**$ 1,744,655**

Figures are a combination of amounts recovered from SURS, Pharmacy, Audit, Design and Evaluation, contractor and PRO reviews.
**Restated from SFY2003 Annual Report.*

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.

Figure 19 **Third Party Liabilities Cost Avoidance, SFY2002 through SFY2004**

	SFY2002	SFY2003	SFY2004
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**

Figure 20 **Third Party Liability Recoveries, SFY2002 through SFY2004**

	SFY2002	SFY2003	SFY2004
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**

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.

The Product Based Prior Authorization Cost Avoidance dollars below 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 SFY2003 (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.

Product Based Prior Authorization Cost Avoidance, SFY2002 through SFY2004

SFY2002 — $11,562,601
SFY2003 — $16,630,980
SFY2004 — $24,685,677

Supplemental Drug Rebate Program

Oklahoma Medicaid implemented a Supplemental Drug Rebate program during SFY2004. It is designed to enhance the Product Based Prior Authorization Program. Drug products within a therapeutic class are divided into two tiers based on clinical effectiveness, adverse effects and cost-effectiveness. Tier One products do not require prior authorization. Tier Two products require a previous trial of a Tier One product or a prior authorization based on a clinical situation for which a Tier One product is not appropriate. The Medicaid State Supplemental Drug Rebate Program allows pharmaceutical manufacturers to voluntarily provide a rebate on their Tier Two products. This rebate is in addition to the Federal Drug Rebate Program, which guarantees that the Medicaid program receives a “best price” for each product. If a manufacturer agrees to participate in the state supplemental program, their Tier Two drugs are treated as Tier One drugs and do not require prior authorization. The State Supplemental Drug Rebate program is advantageous to beneficiaries, prescribers, pharmacy providers and taxpayers because it provides more drugs with less restrictions and helps assure pharmaceuticals are delivered in the most cost-effective way.

Drug Rebate Program

The Federal Drug Rebate Program (established by the enactment of the Omnibus Budget Reconciliation Act of 1990) was designed to offset prescription expenditures and guarantee that states pay no more than the lowest price charged by a manufacturer 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. Drug manufacturers are invoiced on a quarterly basis. Interest is assessed by the OHCA on late payments.

Figure 21 **Drug Rebates and Interest Collections SFY2002 through SFY2004**

	SFY2002	SFY2003	SFY2004
Drug Rebates	$ 48,192,263	$ 56,154,573	$ 71,003,152
Interest	$ 155,991	$ 33,567	$ 24,663
Total Collections	**$ 48,348,254**	**$ 56,188,140**	**$ 71,027,815**

Program and Payment Integrity Activities (continued)

Long-Term Care Quality of Care Program Fees

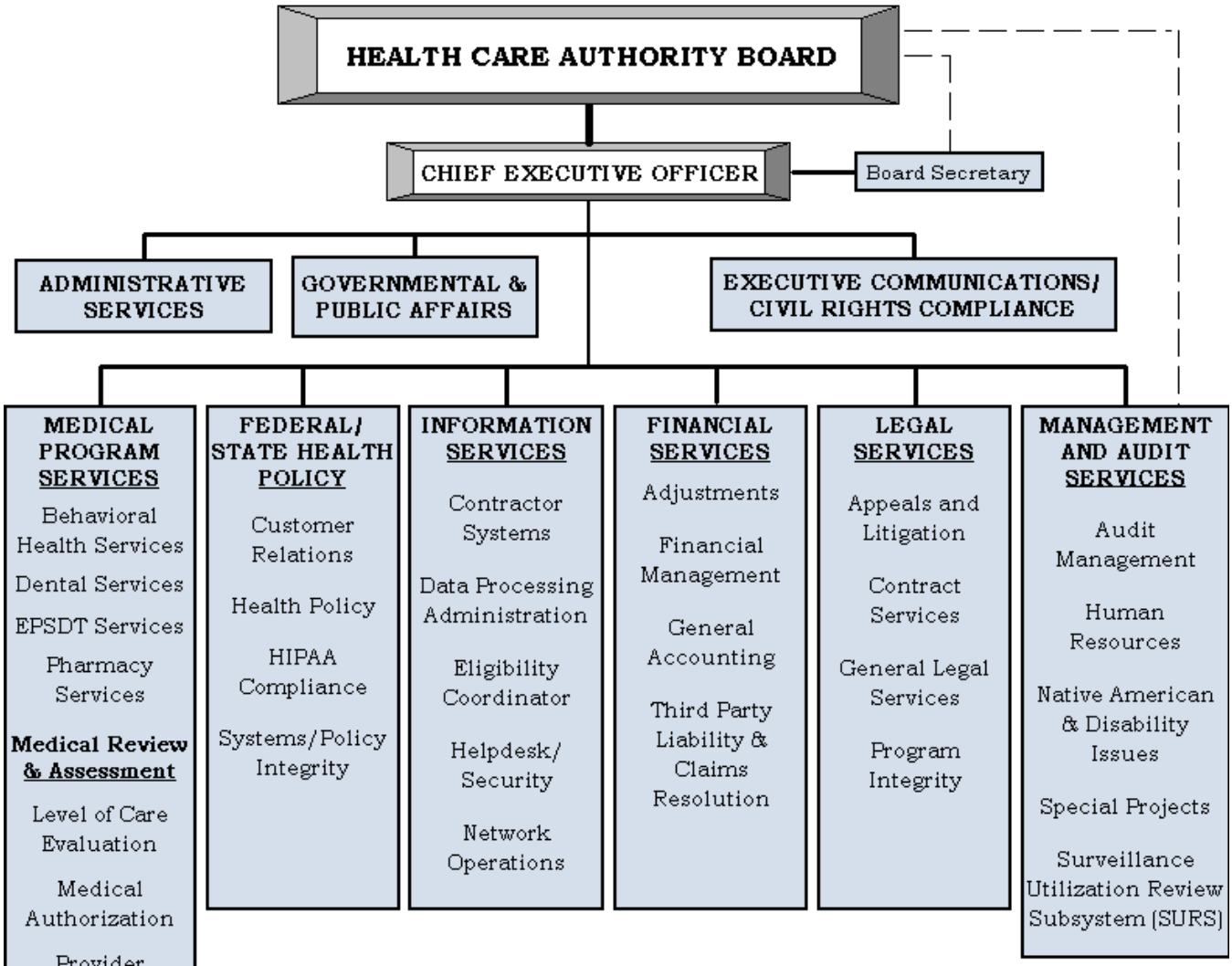
In an effort to increase the quality of care received by long-term care beneficiaries, the Quality of Care (QOC) Program was put into place. A fee per patient day is collected from long-term care facilities and placed in a revolving fund. Monies from this fund are used to pay for the higher facility reimbursement rate; increased staffing requirements; program administrative costs and other increased beneficiary 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 Oklahoma 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.

Figure 22 **Quality of Care Fee, Penalty and Interest Collection, SFY2002 through SFY2004**

	SFY2002	SFY2003	SFY2004
Quality of Care Fees	$ 53,672,433	$ 56,163,442	$ 42,296,728
Penalties/Interest	$ 257,447	$ 155,019	$ 223,375
Total Collections	**$ 53,929,880**	**$ 56,318,461**	**$ 45,520,103**

Figure 23 **OHCA's Organizational Chart**



"Employees of the State of Oklahoma serve the citizens of our state with the highest degree of professionalism, proficiency, honor; and commitment . . . our state and nation are deeply indebted to the men and women who devote themselves to public service and make incalculable contributions to the quality of life."

Except from Proclamation of Public Service Recognition Week, signed by Governor Brad Henry, April 1, 2004

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 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.

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

How We Operate Within OHCA

- OHCA staff 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 2004, OHCA was authorized 290.5 FTE for July through November 2003. The authorized FTE limit was raised to 389.5 after December 1, 2003 to handle the extra administrative duties, etc. that had been performed by the contracted ***SoonerCare* Plus** Health Maintenance Organizations (HMOs). 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: 21**

"In the midst of many challenges, we have continued to find new and improved ways to see that the beneficiaries of the program receive appropriate care and providers of care find us to be as hassle-free as possible!"

Mike Fogarty, CEO, email to OHCA staff, January 2004.

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. (11 FTE) *Administrative Chief of Staff, James Smith (405) 522-7150.*

Governmental and Public Affairs acts as a connection point between OHCA and the legislative and executive branches of state government. Governmental Affairs provides clarification and information regarding agency programs and operations. This unit coordinates fiscal, policy and program impacts with agency staff regarding potential and pending legislation. Public Affairs develops comprehensive, public information strategies, outreach activities and goals. We also produce written material for the agency, including all enrollment publications, informational and or promotional materials to beneficiaries and content management for the agency's public web site. Our unit serves as the agency's primary contact for the media. The Information and Referral area within Governmental & Public Affairs documents and distributes items requiring response as well as documents for informational purposes. We handle all federal, state and other customer correspondence. This process ensures distribution of information and timely responses to requests. (6.5 FTE) *Director, Nico Gomez, (405) 522-7484.*

Civil Rights Compliance reports directly to the CEO and is responsible for planning and managing of 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. (.5 FTE) *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: 122***

Behavioral Health Services interfaces with other state agencies, consumer groups, providers and other stakeholders to provide information about Medicaid programs and services. Our unit gathers information helpful to improving the quality and continuum of services. The Behavioral Health Services unit provides care management services to Medicaid beneficiaries in need of ongoing mental health care and treatment. We help providers and others in the community who need assistance on behalf of Medicaid beneficiaries in locating and accessing appropriate behavioral health treatment services. 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 behavioral health Medicaid services. (8 FTE) *Director, Terrie Fritz, L.C.S.W. (405) 522-7377.*

"Through your help, we were allowed the privilege of helping her (a Medicaid beneficiary) to have both a healthier dentition and much happier smile… I have been so blessed to watch her go from a very quiet, shy young lady who never smiled, to a happy, self confident young lady who never stops smiling…"

Oklahoma Medicaid Dental provider

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 important 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. (6 FTE) *Manager, Ella Matthews, R.N. (405) 522-7314.*

EPSDT Services coordinates and monitors the Early and 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. Additionally, this unit provides education for parents and providers regarding EPSDT services and performs provider outreach. (8 FTE) *Manager, Ivoria Holt (405) 522-7355.*

Pharmacy Services is divided into three sections: Pharmacy Operations, Clinical Services and Drug Rebate. The Pharmacy Operations team takes care of the daily tasks associated with processing claims, auditing payments and assisting beneficiaries and providers. The Clinical Services group includes Disease Management, provider education and beneficiary assistance projects. The Drug Rebate division processes invoices and payments under the Federal Drug Rebate Program and the new Medicaid State Supplemental Rebate Program. Our unit works closely with the Drug Utilization Review Board to formulate policy and improve the pharmacy benefit. We contract with the University of Oklahoma College of Pharmacy, to provide a telephone help desk for pharmacists, beneficiaries and prescribers. (11 FTE Filled) *Director, Nancy Nesser, D.Ph, J.D. (405) 522-7325.*

Christmas 2003, OHCA gave over $800 as well as bought gifts and food for eight families. Additionally, every year more than 150 stuffed animals are donated and distributed to various children shelters, hospitals and needy families.

Core Function Summary (continued)

MEDICAID OPERATIONS (continued)

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

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 intermediate care facilities for the mentally retarded (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, L.C.S.W. (405) 522-7309.*

> "Unless we think of others and do something for them, we miss one of the greatest sources of happiness."
>
> *Ray Lyman Wilbur*

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 regarding medical authorization. (11 FTE) *Manager, Vacant (405) 522-7371.*

Provider Relations recruits and supports specialty and subspecialty providers' active participation in Medicaid programs and responds to inquiries as well as requests for assistance from specialty providers. Provider Relations also communicates policies, procedures and program issues of particular importance to specialty providers. (2 FTE) *Manager, Kelevetta Nwajagu (405) 522-7301.*

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. (5 FTE) *Manager, Angela Shoffner (405) 522-7355.*

Dr. Lynn Mitchell, State Medicaid Director, has been re-elected to the National Association of State Medicaid Directors (NASMD) Executive Committee. The NASMD is a bipartisan, nonprofit organization of representatives of state Medicaid agencies, including the District of Columbia and the territories. The 12-member executive committee is elected by a national vote of the membership.

The Journal Record, 6/23/2004

Core Function Summary (continued)

MEDICAID OPERATIONS (Continued)

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

SoonerCare* Compliance & Program Development** 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. (3 FTE) *Director, Melinda Jones (405) 522-7125.*

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 primary care provider/case manager (PCP/CM) 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 recruit ***SoonerCare*** providers to maintain and monitor network capacity and access to care. (23 FTE) *Member Services Supervisor, James Reese (405) 522-7345.*

OHCA received the Governor's commendation for the efficient and timely transfer of ***SoonerCare* Plus** to ***SoonerCare* Choice**.

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 ***SoonerCare*** provider 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. (5 FTE) *Manager, Kevin Rupe, C.P.A. (405) 522-7498.*

Medicaid Care Management provides and facilitates care management services related to medically complex/special health care need members. Our unit includes nurse exceptional needs coordinators (ENCs). We coordinate access to care as it relates to specialty providers initiated by requests from primary care providers/case managers (PCP/CM), incident reports, member calls, interagency referrals and legislative requests. We also plan and put into operation enhanced Care Management outreach to select identified populations. Care Management coordinates with the Behavioral Health Quality Assurance units to perform clinical studies and targeted consumer assessments. ENCs provide educational intervention for beneficiaries with inappropriate emergency room visits, high service utilization, conditions in need of medical regimen and dual medical/behavioral health needs. Our unit utilizes a computer based clinical care management software system for tracking member activities and productivity measurements. (27 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***

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 non-school-based contracted providers. (28 FTE) *Director, Susan Nicholson (405) 522-7360.*

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 assist in preparing and submitting waiver applications and amendments to CMS. (9 FTE) *Director, Jim Hancock (405) 522-7268.*

Mike Fogarty, CEO, received the Distinguished Public Service Award from the OSU College of Osteopathic Medicine.

HIPAA Compliance coordinates agency activities required for compliance with Health Insurance Portability and Accountability Act (HIPAA) rules and regulations. HIPAA Compliance also monitors and reviews federal rules and regulations relating to HIPAA. This unit is developing and monitoring a Business Continuity and Contingency Plan for addressing potential problems or issues with achieving HIPAA compliance. (0 FTE) *Vacant, (405) 522-7228.*

Systems/Policy Integrity maintains the reference and diagnosis file for the MMIS. We also coordinate the integrity of the MMIS during the development of new programs. This unit coordinates the development of new material and changes to the existing OHCA billing and procedure manual to ensure all programs and materials are in accordance with existing state and federal regulations. (3 FTE) *Coordinator, Nelia Atkinson (405) 522-7361.*

Thirty-six OHCA staffers and friends participated in the 2003 Race for the Cure®. Proceeds benefit breast cancer research, education, screening and treatment.

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. (13 FTE) *Director, Donna Witty (405) 522-7242.*

"It took thousands of staff hours to design and implement a new MMIS to replace one that has been in service since the mid 80's. This two year project, completed on time and within budget, reflects the hard work of virtually all of the employees of the agency, who were directly or indirectly involved. Since no additional people were hired for this task, the staff devoted time and effort above their regular duties."

Mike Fogarty, OHCA Chief Executive Officer after the federal certification of the new MMIS.

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 make recommendations of new uses for data processes or for the abandonment of inefficient present uses. (4 FTE) *Administrator, Judi Worsham (405) 522-7222.*

Eligibility Coordination is accountable for management of all eligibility reporting from the OKDHS eligibility system. This area serves as the point of contact for all Medicaid eligibility concerns. This unit is also responsible for reporting and coordinating system and process modifications to improve the quality of eligibility data. (1 FTE) *Coordinator, Richard Evans (405) 522-7101.*

Helpdesk/Security is the central point through which computer systems problems or issues are reported and resolutions are coordinated. This unit also provides support to the agency and other entities accessing our network and MMIS. The Security aspect of this area maintains and audits the integrity of all agency systems and assures our compliance with state and federal security regulations. (2 FTE) *Systems Security Officer/ Help Desk Supervisor, DeBorah Boneta (405) 522-7424.*

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. (11 FTE) *Director, Jeff Slotnick (405) 522-7152.*

"...the way we can verify eligibility, do the billing, and see if it paid in one easy step, makes my life much easier..."

Oklahoma Medicaid provider regarding OHCA's Medicaid on the Web

Core Function Summary (continued)

FINANCIAL SERVICES

Anne Garcia, C.G.F.M., Director of Financial Services ***Total FTE Filled: 59***

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. (13 FTE) *Manager, Kelly Freeman (405) 522-7098.*

Financial Management 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 the annual agency budget request, processes 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. Purchasing anticipates and processes purchase requests and encumbrance documents submitted by units within the agency. We follows up on purchase orders, monitor funding amounts and approve invoices. The Provider Rates & Analysis unit, also within the Financial Management Division, reviews and maintains cost reports for nursing facilities and intermediate care facilities for the mentally retarded for the effective auditing of provider costs and subsequently calculating the annual "audit adjustment" and other annual costs. This information is kept for the purpose of rate setting. We also maintain copies of hospital cost reports for the determination of base year costs, establishment of other payment rates to hospitals and to make assurances to CMS that payment rates are within regulatory upper limits. (13 FTE) *Director, Debbie Ogles (405) 522-7270.*

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. (12 FTE) *Director, Carrie Evans (405) 522-7359.*

"I would like to take this opportunity to say a big THANK YOU to the people in your department (Third Party Liability). I have had to call on several occasions and always get greeted with a warm hello and how may I help you. This is no doubt the warmest greeting I have ever received in my line of business. Not only are the people courteous, but usually solve any problem I may have while on the phone."

Oklahoma Medicaid Provider

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. Claims Resolution monitors the timely and accurate processing of claims for Medicaid providers and resolve suspended edits during the claims processing cycle. (19 FTE) *Director, Lisa Gifford, J.D. (405) 522-7427.*

Core Function Summary (continued)

LEGAL SERVICES

Howard Pallotta, J.D., Director of Legal Services ***Total FTE Filled: 26***

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.*

"OHCA faces many challenges – I enjoy working for an agency that seeks to overcome those challenges with a team oriented and supporting attitude that can be found *throughout* its workforce."

OHCA Employee

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 the 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. (16 FTE) *Manager, Vacant (405) 522-7234.*

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.*

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.*

OHCA employees showed their support for the Walk this Weigh campaign by walking from our offices to the State Capital building. Walk this Weigh is designed to raise awareness of the benefits of walking and other physical activities.

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: 27

Audit Management performs audits and reviews of organizational and functional activities. Our unit evaluates the adequacy and effectiveness of the management and the extent to which organizational units are performing their control activities. We review units for compliance with management instructions, applicable policy and procedures in a manner consistent with both agency objectives and high standards of administrative practice. This unit also completes federally mandated Payment Error Rate Measurement which requires performing a comprehensive claims payment review of the Medicaid Fee-for-Service, ***SoonerCare*** and SCHIP programs. Our unit also produces the Service Efforts and Accomplishments (SEA) report. The SEA report is a budget requirement and is a publicly available report detailing resource allocation and accountability measures. (9 FTE Filled) *Manager, Kelly Shropshire, C.P.A. (405) 522-7131.*

"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 employee.

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. (3 FTE) *Director, Ron Wilson (405) 522-7418.*

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. These issues include Native American work groups, policy development and compliance, tribal consultation, payment issues and elimination of health disparities. Our unit also develops and implements service delivery models which assure adequate access to home and community based supports for persons with disabilities. This is so persons with disabilities can live and work in the community. Additionally, we coordinate with various state agencies, legislative staff, advocacy groups and CMS on the implementation, reporting and monitoring of waivers and waiver amendments by the OHCA. (2 FTE) *Manager, Trevlyn Terry (405) 522-7303.*

"The tribal members are very fortunate to have you (an OHCA employee) as their advocate, someone that is caring, and cognizant of how the system works and can relate that knowledge to IHS and tribal care providers. I also appreciate the work that you do on behalf of these citizens."

Centers for Medicare and Medicaid official

Core Function Summary (continued)

MANAGEMENT AND AUDIT SERVICES (continued)

Special Projects develops and collects monthly-submitted Quality of Care reports from long-term care facilities statewide. We perform monthly desk and on-site audits related to verification of submitted information pertaining to resident to staffing ratios, minimum wage for specified staff and determine penalties for non-compliance. This unit also coordinates and prepares the agency-wide annual report, as well as data reports such as the monthly Fast Facts. We also coordinate with various state agencies, legislative staff, advocacy groups and CMS on the development, implementation, reporting and monitoring of waivers and waiver amendments by the OHCA. Additionally, our unit is managing the State Planning Grant activities. (5.5 FTE Filled) *Managers, Matt Lucas (405) 522-7273, Connie Steffee (405) 522-7238, Teri Dalton (405) 522-7209.*

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.*

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

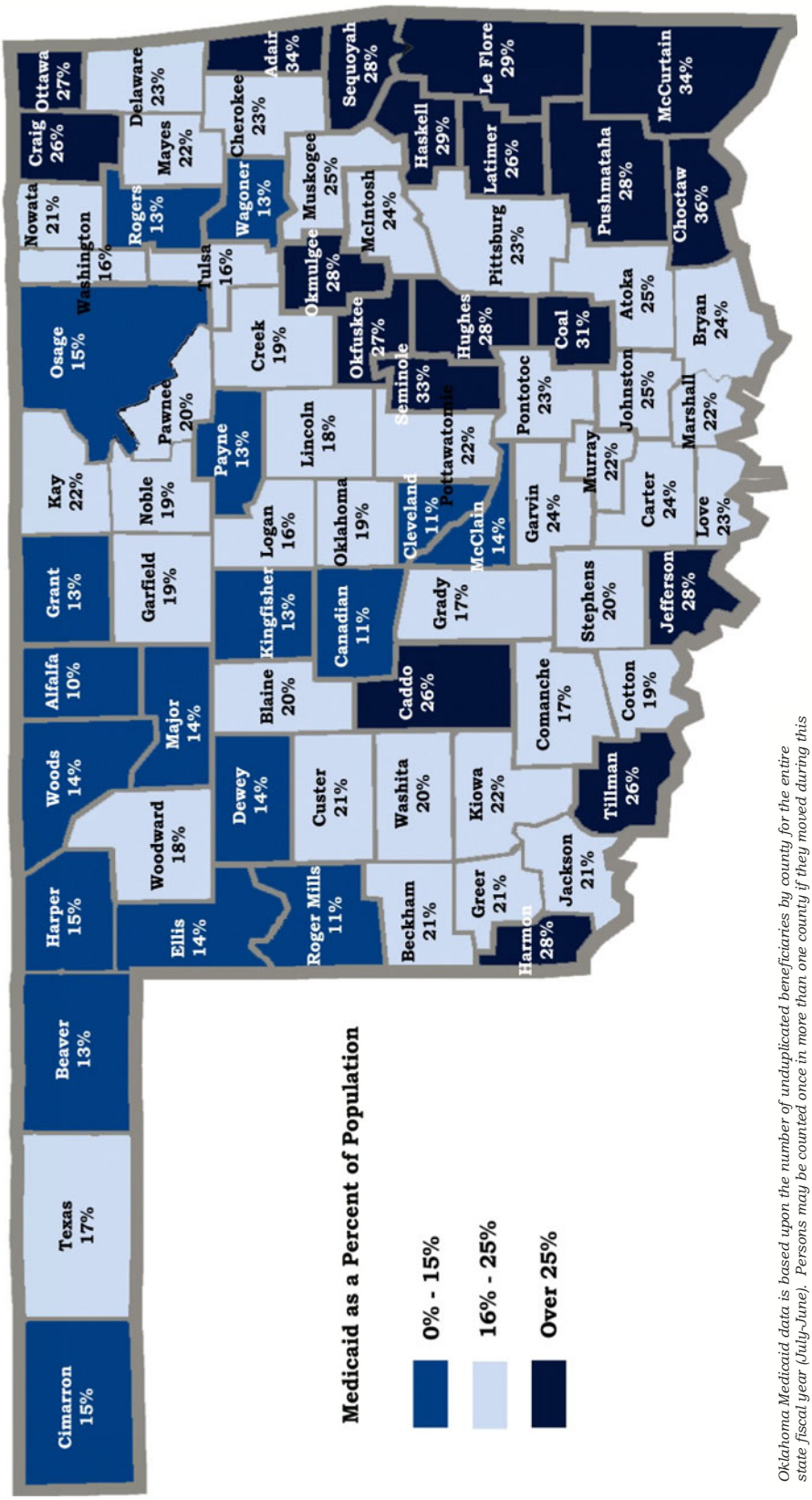
ABD	The **A**ged, **B**lind and **D**isabled Medicaid population.
Beneficiary	A person enrolled in Oklahoma Medicaid.
Capitated Payment	A monthly payment of a predetermined amount, per person, for an individual's required health care services within managed care.
CMS	**C**enters for Medicare and **M**edicaid **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	**Early and Periodic Screening, Diagnosis and Treatment**.
MMIS	**M**edical **M**anagement **I**nformation **S**ystem — the claims processing system.
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 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 vary. 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."

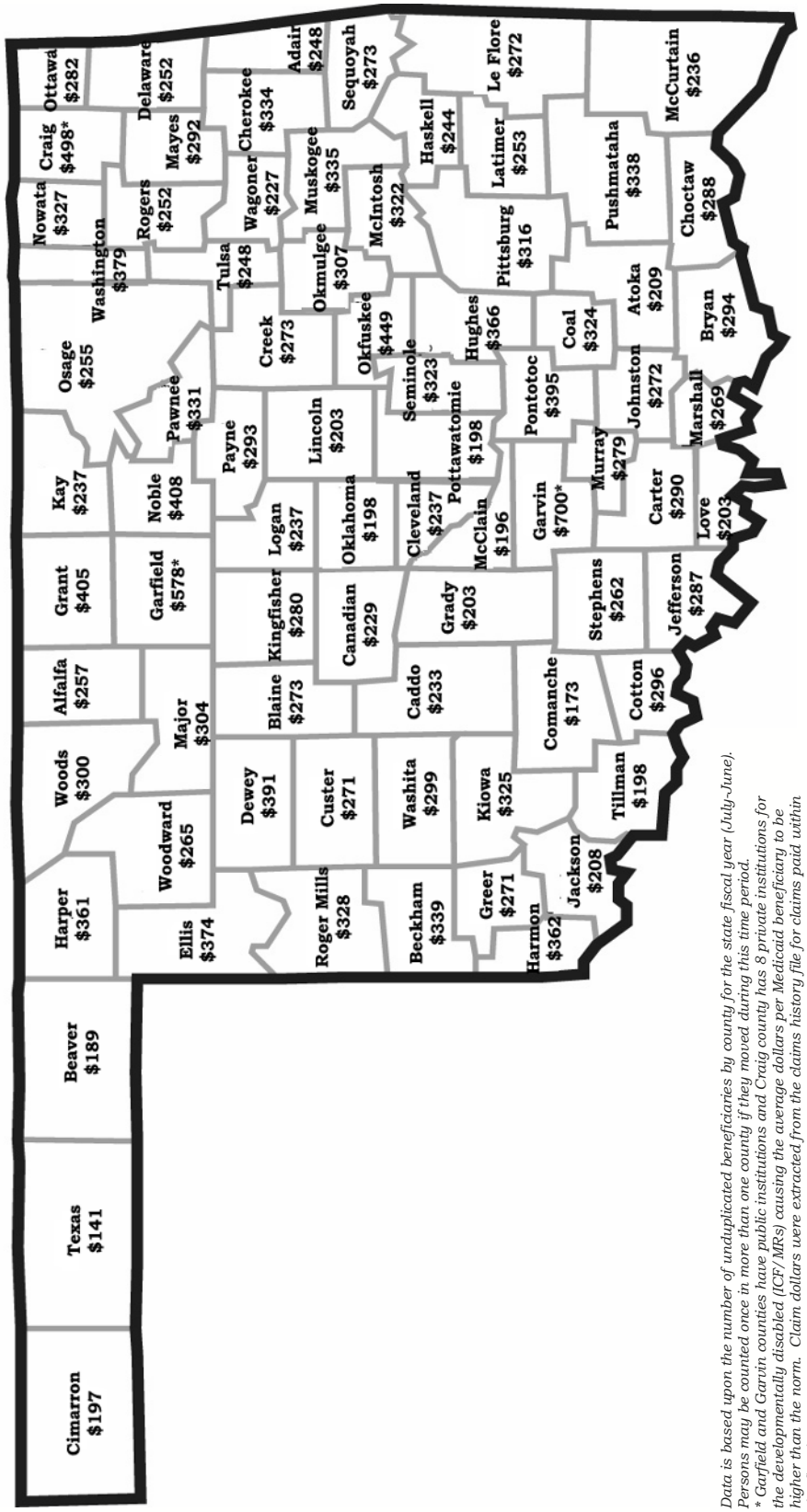
Appendix B Statewide SFY2004 Figures

Figure I **Unduplicated Persons Enrolled in Medicaid July 1, 2003 through June 30, 2004 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. 2003 Estimates rounded to nearest 100. http://www.odoc.state.ok.us/index.html

Figure II **Average Dollars Spent per Medicaid Enrollee 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 2003*	Rank	Unduplicated Enrollees**	Rank	Pop.Covered by Medicaid	Rank
ADAIR	21,600	38	7,236	31	33.50%	3
ALFALFA	5,900	67	584	73	9.90%	77
ATOKA	14,100	46	3,486	44	24.72%	21
BEAVER	5,600	70	727	70	12.98%	71
BECKHAM	19,900	39	4,272	40	21.47%	38
BLAINE	11,700	53	2,305	55	19.70%	46
BRYAN	37,300	26	8,765	21	23.50%	26
CADDO	30,100	32	7,680	30	25.51%	19
CANADIAN	92,900	5	10,320	15	11.11%	75
CARTER	46,400	17	10,982	12	23.67%	25
CHEROKEE	43,800	20	10,279	16	23.47%	27
CHOCTAW	15,400	44	5,519	37	35.84%	1
CIMARRON	3,000	77	462	76	15.40%	60
CLEVELAND	220,000	3	24,443	3	11.11%	74
COAL	5,900	67	1,818	63	30.81%	5
COMANCHE	113,900	4	19,773	4	17.36%	55
COTTON	6,600	65	1,224	67	18.55%	51
CRAIG	14,900	45	3,926	42	26.35%	16
CREEK	68,800	9	13,007	8	18.91%	49
CUSTER	25,000	36	5,144	38	20.58%	42
DELAWARE	38,700	25	8,872	20	22.93%	29
DEWEY	4,500	72	621	72	13.80%	66
ELLIS	4,000	73	542	74	13.55%	67
GARFIELD	57,100	12	11,064	11	19.38%	47
GARVIN	27,200	35	6,459	33	23.75%	24
GRADY	47,400	15	8,230	25	17.36%	54
GRANT	5,000	71	664	71	13.28%	69
GREER	5,900	67	1,254	65	21.25%	39
HARMON	3,100	76	868	69	28.00%	9
HARPER	3,400	74	505	75	14.85%	61
HASKELL	12,000	51	3,479	45	28.99%	6
HUGHES	13,900	48	3,918	43	28.19%	8
JACKSON	27,300	34	5,655	36	20.71%	41
JEFFERSON	6,500	66	1,796	64	27.63%	12
JOHNSTON	10,500	59	2,592	54	24.69%	22
KAY	47,300	16	10,344	14	21.87%	35
KINGFISHER	14,100	46	1,832	62	12.99%	70
KIOWA	10,000	60	2,215	59	22.15%	34
LATIMER	10,600	58	2,767	52	26.10%	17
LEFLORE	48,900	14	14,008	7	28.65%	7

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

**Enrollees 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 Enrollee	Rank
ADAIR	$21,500,079	31	$995	14	$248	56
ALFALFA	$1,800,208	74	$305	74	$257	50
ATOKA	$8,743,329	53	$620	49	$209	65
BEAVER	$1,652,644	75	$295	76	$189	75
BECKHAM	$17,393,782	37	$874	23	$339	14
BLAINE	$7,540,137	58	$644	45	$273	42
BRYAN	$30,893,254	21	$828	27	$294	31
CADDO	$21,461,132	32	$713	38	$233	62
CANADIAN	$28,318,923	26	$305	75	$229	63
CARTER	$38,203,985	13	$823	28	$290	34
CHEROKEE	$41,205,374	9	$941	17	$334	17
CHOCTAW	$19,058,814	35	$1,238	7	$288	35
CIMARRON	$1,090,436	77	$363	69	$197	73
CLEVELAND	$69,656,967	5	$317	73	$237	58
COAL	$7,073,017	59	$1,199	9	$324	22
COMANCHE	$41,041,076	10	$360	70	$173	76
COTTON	$4,344,171	66	$658	42	$296	30
CRAIG ‡	$23,452,119	29	$1,574	2	$498	3
CREEK	$42,566,371	8	$619	51	$273	41
CUSTER	$16,732,917	40	$669	41	$271	45
DELAWARE	$26,866,953	27	$694	39	$252	53
DEWEY	$2,914,397	71	$648	43	$391	8
ELLIS	$2,435,106	72	$609	52	$374	10
GARFIELD ‡	$76,752,103	3	$1,344	4	$578	2
GARVIN ‡	$54,239,794	6	$1,994	1	$700	1
GRADY	$20,092,254	33	$424	67	$203	67
GRANT	$3,224,923	70	$645	44	$405	6
GREER	$4,074,166	67	$691	40	$271	46
HARMON	$3,774,899	69	$1,218	8	$362	12
HARPER	$2,187,881	73	$643	46	$361	13
HASKELL	$10,170,839	48	$848	26	$244	57
HUGHES	$17,227,789	38	$1,239	6	$366	11
JACKSON	$14,124,879	42	$517	57	$208	66
JEFFERSON	$6,195,513	60	$953	15	$287	36
JOHNSTON	$8,450,942	55	$805	30	$272	44
KAY	$29,451,234	25	$623	47	$237	60
KINGFISHER	$6,158,609	61	$437	64	$280	38
KIOWA	$8,629,908	54	$863	25	$325	21
LATIMER	$8,390,543	56	$792	32	$253	52
LEFLORE	$45,692,813	7	$934	18	$272	43

‡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 enrollee 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 2003*	Rank	Unduplicated Enrollees**	Rank	Pop.Covered by Medicaid	Rank
LINCOLN	32,300	31	5,684	35	17.60%	53
LOGAN	35,400	27	5,808	34	16.41%	57
LOVE	8,900	61	2,049	61	23.02%	28
MCCLAIN	28,600	33	4,074	41	14.24%	64
MCCURTAIN	34,000	29	11,422	9	33.59%	2
MCINTOSH	19,700	41	4,738	39	24.05%	23
MAJOR	7,400	64	1,059	68	14.31%	63
MARSHALL	13,700	49	3,039	51	22.18%	33
MAYES	38,900	24	8,727	23	22.43%	32
MURRAY	12,700	50	2,759	53	21.72%	37
MUSKOGEE	70,300	8	17,437	5	24.80%	20
NOBLE	11,300	55	2,101	60	18.59%	50
NOWATA	10,800	57	2,250	58	20.83%	40
OKFUSKEE	11,700	53	3,127	50	26.73%	14
OKLAHOMA	676,100	1	130,283	1	19.27%	48
OKMULGEE	39,700	23	10,943	13	27.56%	13
OSAGE	45,200	18	6,573	32	14.54%	62
OTTAWA	32,800	30	8,744	22	26.66%	15
PAWNEE	16,800	43	3,367	46	20.04%	44
PAYNE	71,100	7	9,523	19	13.39%	68
PITTSBURG	44,200	19	10,096	17	22.84%	30
PONTOTOC	35,200	28	7,996	28	22.72%	31
POTTAWATOMIE	67,300	10	14,697	6	21.84%	36
PUSHMATAHA	11,800	52	3,303	49	27.99%	11
ROGER MILLS	3,200	75	352	77	11.00%	76
ROGERS	77,200	6	9,993	18	12.94%	73
SEMINOLE	24,500	37	8,165	26	33.33%	4
SEQUOYAH	40,000	22	11,199	10	28.00%	10
STEPHENS	42,500	21	8,394	24	19.75%	45
TEXAS	19,900	39	3,363	47	16.90%	56
TILLMAN	8,800	62	2,290	56	26.02%	18
TULSA	570,300	2	92,946	2	16.30%	58
WAGONER	61,800	11	8,009	27	12.96%	72
WASHINGTON	49,100	13	7,818	29	15.92%	59
WASHITA	11,200	56	2,273	57	20.29%	43
WOODS	8,700	63	1,239	66	14.24%	65
WOODWARD	18,500	42	3,349	48	18.10%	52
TOTAL	**3,511,800**		**668,826**		**19.05%**	

*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 Enrollee	Rank
LINCOLN	$13,855,728	43	$429	66	$203	69
LOGAN	$16,537,252	41	$467	61	$237	59
LOVE	$4,995,517	64	$561	54	$203	68
MCCLAIN	$9,571,181	50	$335	72	$196	74
MCCURTAIN	$32,380,545	19	$952	16	$236	61
MCINTOSH	$18,334,690	36	$931	19	$322	24
MAJOR	$3,867,496	68	$523	55	$304	27
MARSHALL	$9,810,181	49	$716	37	$269	47
MAYES	$30,625,010	22	$787	33	$292	33
MURRAY	$9,233,028	51	$727	35	$279	39
MUSKOGEE	$70,116,588	4	$997	13	$335	16
NOBLE	$10,294,263	47	$911	21	$408	5
NOWATA	$8,815,550	52	$816	29	$327	20
OKFUSKEE ‡	$16,843,844	39	$1,440	3	$449	4
OKLAHOMA	$309,911,252	1	$458	62	$198	72
OKMULGEE	$40,360,164	11	$1,017	12	$307	26
OSAGE	$20,085,890	34	$444	63	$255	51
OTTAWA	$29,566,152	24	$901	22	$282	37
PAWNEE	$13,373,628	45	$796	31	$331	18
PAYNE	$33,445,477	18	$470	60	$293	32
PITTSBURG	$38,330,710	12	$867	24	$316	25
PONTOTOC	$37,896,401	14	$1,077	11	$395	7
POTTAWATOMIE	$34,966,218	17	$520	56	$198	71
PUSHMATAHA	$13,389,416	44	$1,135	10	$338	15
ROGER MILLS	$1,386,627	76	$433	65	$328	19
ROGERS	$30,251,328	23	$392	68	$252	54
SEMINOLE	$31,679,704	20	$1,293	5	$323	23
SEQUOYAH	$36,681,348	15	$917	20	$273	40
STEPHENS	$26,360,283	28	$620	48	$262	49
TEXAS	$5,685,907	62	$286	77	$141	77
TILLMAN	$5,452,216	63	$620	50	$198	70
TULSA	$277,041,577	2	$486	59	$248	55
WAGONER	$21,855,213	30	$354	71	$227	64
WASHINGTON	$35,524,562	16	$724	36	$379	9
WASHITA	$8,160,894	57	$729	34	$299	29
WOODS	$4,459,928	65	$513	58	$300	28
WOODWARD	$10,645,649	46	$575	53	$265	48
TOTAL†	**$2,116,575,700**		**$603**		**$264**	

‡ *Okfuskee County has 12 private institutions for the developmentally disabled (ICF/MRs) causing the average dollars per Medicaid beneficiary to be higher than the norm.*

† *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 as a claim through the MMIS or were paid on behalf of custody children or beneficiaries temporarily residing out of state.*

Figure IV **Dollars Paid to Providers and Beneficiaries by County in SFY2004**

County	Total Dollars Paid by Provider County	Total Dollars Paid by Beneficiary County	% of Dollars Staying in County
ADAIR	$9,833,162	$21,500,079	46%
ALFALFA	$1,158,374	$1,800,208	64%
ATOKA	$4,675,946	$8,743,329	53%
BEAVER	$1,179,326	$1,652,644	71%
BECKHAM	$14,030,332	$17,393,782	81%
BLAINE	$4,134,919	$7,540,137	55%
BRYAN	$36,899,800	$30,893,254	119%
CADDO	$15,923,023	$21,461,132	74%
CANADIAN	$17,171,324	$28,318,923	61%
CARTER	$30,658,777	$38,203,985	80%
CHEROKEE	$37,265,162	$41,205,374	90%
CHOCTAW	$12,124,528	$19,058,814	64%
CIMARRON	$652,594	$1,090,436	60%
CLEVELAND	$54,258,437	$69,656,967	78%
COAL	$3,437,896	$7,073,017	49%
COMANCHE	$39,508,646	$41,041,076	96%
COTTON	$2,174,570	$4,344,171	50%
CRAIG	$18,683,021	$23,452,119	80%
CREEK	$46,179,583	$42,566,371	108%
CUSTER	$16,118,965	$16,732,917	96%
DELAWARE	$15,621,767	$26,866,953	58%
DEWEY	$2,881,592	$2,914,397	99%
ELLIS	$1,941,872	$2,435,106	80%
GARFIELD	$70,650,113	$76,752,103	92%
GARVIN	$45,479,784	$54,239,794	84%
GRADY	$14,294,006	$20,092,254	71%
GRANT	$2,082,556	$3,224,923	65%
GREER	$3,068,563	$4,074,166	75%
HARMON	$3,410,091	$3,774,899	90%
HARPER	$1,864,260	$2,187,881	85%
HASKELL	$13,128,580	$10,170,839	129%
HUGHES	$8,813,960	$17,227,789	51%
JACKSON	$11,598,205	$14,124,879	82%
JEFFERSON	$4,064,929	$6,195,513	66%
JOHNSTON	$4,999,676	$8,450,942	59%
KAY	$21,803,623	$29,451,234	74%
KINGFISHER	$8,040,683	$6,158,609	131%
KIOWA	$9,228,268	$8,629,908	107%
LATIMER	$4,145,740	$8,390,543	49%
LEFLORE	$31,766,733	$45,692,813	70%

Figure IV **Dollars Paid to Providers and Beneficiaries by County in SFY2004 (continued)**

County	Total Dollars Paid by Provider County	Total Dollars Paid by Beneficiary County	% of Dollars Staying in County
LINCOLN	$8,905,949	$13,855,728	64%
LOGAN	$10,791,809	$16,537,252	65%
LOVE	$2,652,091	$4,995,517	53%
MCCLAIN	$7,111,847	$9,571,181	74%
MCCURTAIN	$23,340,258	$32,380,545	72%
MCINTOSH	$15,206,740	$18,334,690	83%
MAJOR	$2,832,652	$3,867,496	73%
MARSHALL	$7,164,846	$9,810,181	73%
MAYES	$14,885,299	$30,625,010	49%
MURRAY	$6,255,928	$9,233,028	68%
MUSKOGEE	$67,581,797	$70,116,588	96%
NOBLE	$7,627,743	$10,294,263	74%
NOWATA	$5,701,191	$8,815,550	65%
OKFUSKEE	$12,230,567	$16,843,844	73%
OKLAHOMA	$472,715,176	$309,911,252	153%
OKMULGEE	$25,655,856	$40,360,164	64%
OSAGE	$6,653,491	$20,085,890	33%
OTTAWA	$28,538,681	$29,566,152	97%
PAWNEE	$8,049,352	$13,373,628	60%
PAYNE	$28,773,274	$33,445,477	86%
PITTSBURG	$32,480,217	$38,330,710	85%
PONTOTOC	$40,044,599	$37,896,401	106%
POTTAWATOMIE	$23,817,159	$34,966,218	68%
PUSHMATAHA	$11,361,556	$13,389,416	85%
ROGER MILLS	$531,795	$1,386,627	38%
ROGERS	$28,276,363	$30,251,328	93%
SEMINOLE	$23,410,576	$31,679,704	74%
SEQUOYAH	$32,408,975	$36,681,348	88%
STEPHENS	$20,860,878	$26,360,283	79%
TEXAS	$4,962,858	$5,685,907	87%
TILLMAN	$3,690,364	$5,452,216	68%
TULSA	$383,976,965	$277,041,577	139%
WAGONER	$7,900,720	$21,855,213	36%
WASHINGTON	$24,441,324	$35,524,562	69%
WASHITA	$3,983,663	$8,160,894	49%
WOODS	$3,484,471	$4,459,928	78%
WOODWARD	$9,827,888	$10,645,649	92%
TOTAL *	**$2,063,088,304**	**$2,116,575,700**	**97%**

**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 as of June 30, 2004

Provider Type	Count	Provider Type	Count
Adult Day Care	28	Hospital — Psychiatric	20
Certified Registered Nurse Anesthetist (CRNA)	642	Hospital — Residential Treatment Center	34
Nurse Practitioner (Other)	476	Laboratory	183
Advantage Case Manager	35	Mental Health Provider	805
Advantage Home Delivered Meal	21	Nurse	69
Ambulatory Surgical Center (ASC)	52	Nutritionist	104
Audiologist	77	Optician	44
Capitation Provider — IHS Case Manager	39	Optometrist	452
Case Manager (Targeted)	78	Personal Care Services — Agency	37
Chiropractor	23	Personal Care Services — Individual	87
Clinic — Family Planning	7	Pharmacy	1,151
Clinic — Federally Qualified Health Clinic (FQHC)	11	Physician — Allergist	35
Clinic — Free-standing Renal Dialysis	66	Physician — Anesthesiologist	698
Clinic — Medical	1,671	Physician — Cardiologist	473
Clinic — Other	13	Physician — Family Practitioner	2,013
Clinic — Rural Health	59	Physician — General Pediatrician	1,149
Clinic — Speech/Hearing	4	Physician — General Practitioner	488
DDSD — Architectural Modification	56	Physician — General Surgeon	495
DDSD — Employee Training Specialist	93	Physician — Internist	1,360
DDSD — Homemaker Services	241	Physician — Obstetrician/Gynecologist	476
DDSD — Non-Federal Medical	673	Physician — Other	2,320
DDSD — Supportive Living Arrangements	42	Physician — Radiologist	713
DDSD — Transportation Provider Volunteer	265	Physician Assistant	590
Dental Services	454	Residential Behavior Management Services (RBMS)	19
Direct Support Services	272	Respite Care	207
DME/Medical Supply Dealer	1,528	Room and Board	6
Extended Care — ICF/MR	73	School-Based Providers	79
Extended Care — Nursing Facility	328	Specialized Foster Care/MR	199
Extended Care — Respite Care - Facility Based	89	Therapist — Occupational	183
Extended Care — Skilled Nursing Facility	165	Therapist — Physical Therapist	319
Free Standing Birthing Center	2	Therapist — Speech/Hearing Therapist	344
Home Health Agency	163	Transportation Provider—Ambulance	214
Hospice	10	X-Ray Clinic — Freestanding	10
Hospital — Acute Care	353	**TOTAL**	**23,485**

The term "contracted" is defined as a provider that has signed a contract with Oklahoma Medicaid as of June 30, 2004, 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. The total contracted providers include 5,817 out of state providers.

Important Telephone Numbers

OHCA Main Number 405-522-7300

Customer Service — Beneficiary	405-522-7171 1-800-522-0310
1 — Eligibility Questions/OKDHS	4 — Enrollment Agent/First Health
2 — Claim Status	5 — Nurse Advice Line/First Health
3 — ***SoonerCare*** Member Services	6 — Spanish Assistance/EDS Call Center
9 — Repeat Options	

SoonerCare *Helpline* 1-800-987-7767

Customer Service — Provider	405-522-6205 1-800-522-0114
1 — Claim Status	6 — Claims Adjustments
2 — Check Eligibility/EVS	7 — Third Party Liability
3 — Care Management	8 — PIN Resets/EDI/Medicaid on the Web Assistance
4 — Pharmacy Help Desk	9 — Prior Authorizations
5 — Provider Contracts	* Repeat Options

OHCA Information and Referral 405-522-7559

OHCA Internet Resources

Oklahoma Health Care Authority **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**