Our Mission Statement

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

Our Vision

Our vision is for Oklahomans to enjoy optimal health status through having access to quality healthcare 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 our success.**
- **OHCA will be open to new ways of working together.**
- **OHCA will use qualitative and quantitative data to guide and evaluate our actions and improve our performance in a purposeful way over time.**

STATE OF OKLAHOMA

EXECUTIVE BRANCH

Frank Keating
Governor of Oklahoma

Mary Fallin
Lieutenant Governor

Jerry Regier
Cabinet Secretary

LEGISLATIVE BRANCH
48th Legislature (2001-2002)

Stratton Taylor
State Senate
President Pro Tempore

Larry Adair
House of Representatives
Speaker

Frank Keating
Governor
State of Oklahoma

Board Members

(Top to Bottom - Left to Right)

Charles Ed McFall
Chairman
Appointed by Governor

T.J. (Jerry) Brickner, Jr., M.D.
Vice Chairman
Appointed by the Speaker
of the House

Wayne Hoffman
Appointed by the President
Pro Tempore

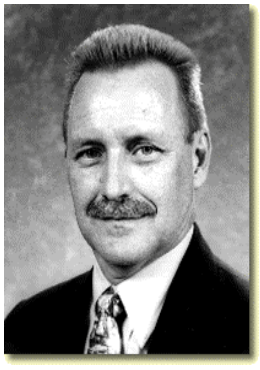
Jerry Humble
Appointed by the Governor
(Current photo unavailable)

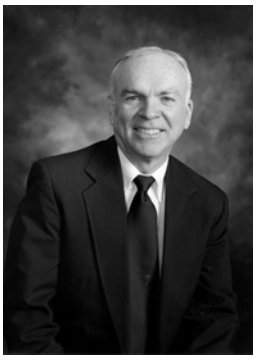
George Miller
Appointed by the Speaker
of the House

Lyle Roggow
Appointed by the Governor

Ronald Rounds, O. D.
Appointed by the President
Pro Tempore

OHCA Board Members





Message from the Oklahoma Health Care Authority…

Mike Fogarty, J.D. MSW
Chief Executive Officer
OHCA

Lynn Mitchell, M.D. MPH
State Director of Medicaid
OHCA

Providing greater benefits to more Oklahomans in need and paying better compensation to those who deliver health care were among the priorities of the Oklahoma Health Care Authority's sixth year. State fiscal year 2001 proved to be a year of successes made possible by the hard work of not only the agency's staff and board, but also the office of Governor Keating and the Oklahoma Legislature. The agency overcame extreme financial difficulties when faced with a funding shortfall. Action was taken by our elected state leadership to provide funding and avoid disruption of critical health services.

New pilot programs were initiated this past year to address specific health issues, including improved disease management for asthma patients and for those suffering from depression. The ***SoonerCare*** Plus program, with its more comprehensive benefit package, was made available in four more counties (Grady, Lincoln, McClain, Tillman) in January. Eligibility was increased so that adults with disabilities and elderly adults with income up to 100 percent of the federal poverty level may now receive Medicaid services, including much needed pharmacy benefits. Also, payment rates for most health care providers received moderate increases.

In an effort to have the necessary technology to effectively administer this program, including claims payment, a seven-year contract was awarded for the development and operation of a new Medicaid Management Information System. The telephone system was also expanded to help us be more responsive to calls from both clients and providers. A significant investment of administrative resources was made to implement the new Quality of Care program. The funds received from nursing facility fees resulted in improved quality of care requirements for direct care staffing in nursing homes along with additional benefits for all adult clients.

The agency has taken strong steps toward meeting the short and long-term goals of our strategic plan. OHCA employees have been working hard to meet key objectives in areas such as customer service, quality of care and program administration. We have also been measuring our progress and performance with the results reflected in the data found in this report and annual reports to come.

The highlights of this past year signal areas of challenge for the future. While ***SoonerCare*** Plus now serves 16 counties, there are 61 counties in which benefits are still limited (three prescriptions and two physician visits per month, 24 hospital days per year, etc.). There is a growing concern about the inequity of these benefits between Plus and Choice counties. In addition, there are many Oklahomans who are not eligible for Medicaid and cannot afford private insurance and are therefore restricted in their access to health care. Finally, since we are in the health care "market place" purchasing services, we must offer sufficient compensation to make it possible for health care professionals to serve Medicaid clients. That reality continues to make provider payment rates a very high priority.

All of these highlights and more are featured in the following pages. We hope you will find them informative and encouraging.

Contents

Contents (continued)

Figures

OHCA's State Fiscal Year 2001 Accomplishments

Asthma Disease Management Pilot Program Launched

Oklahoma is one of seven states that participated in the Institute for Healthcare Improvement (IHI) Asthma Collaborative, Improving the Health Care for Beneficiaries with Asthma during SFY2001. OHCA launched "Breathing Better in Oklahoma!" as a pilot program for asthma disease management. The agency obtained the participation of a group of ***SoonerCare*** Choice pediatricians and a pediatric practice from one of the ***SoonerCare*** Plus health plans, Heartland Health. The participating providers implemented the "Improving Chronic Illness Care (ICIC) Model" of evidence based, planned, integrated care as they incorporated available resources into a care plan.

Benefits Increased for State's Qualified Medicare Beneficiaries

A new Oklahoma Health Care Authority program, Qualified Medicare Beneficiary Plus (QMBP), became effective November 1, 2000. Prescription drugs were one of the new benefits for participants of Oklahoma's QMBP program, another health care initiative directed by Oklahoma 2001 Healthcare legislation. QMB Plus pays for three prescriptions per month for the participant. All managed care benefits are available under the expanded program including in-home personal care and non-emergency transportation.

Medicaid Management Information System Contract Awarded

OHCA awarded a $102 million, seven-year contract for work on the state's Medicaid Management Information System (MMIS) to EDS of Plano, Texas. Overall, the federal government will be contributing more than 85 percent of the development costs. EDS will introduce a new, innovative, MMIS with a newly developed web-based interface. Called, *i*nterChange, the system will replace OHCA's current MMIS, which is an old mainframe system. The new system is scheduled to be online by January 1, 2003.

Accomplishments (continued)

New Pharmacy Point-of-Sale System Debuts

OHCA implemented a new pharmacy claims processing system, Rx-POS/UniDUR, that uses a relational database system on a minicomputer to fully manage pharmacy claims without competing for resources on the traditional mainframe system. The UniDUR system assesses potential risks of a medication based on the clinical information available coupled with the information we have on the client and provides an alert to the pharmacist that a drug may create a health risk for the client. Risk areas that are evaluated are therapeutic duplication, drug-to-drug interactions, pregnancy precautions and more. A goal of the UniDUR portion of this system enhancement is to improve the quality of care received by our Medicaid clients.

Nursing Home Quality of Care Funding and Benefits Established

Nursing home quality of care initiatives began as the OHCA board approved changes directed by the Oklahoma 2001 Healthcare legislation. New rules required providers to submit monthly quality of care reports and pay quality of care fees. The per patient, per day, quality of care fee generated approximately $35 million state dollars this fiscal year. The total quality of care fund, when matched with federal dollars, was approximately $111 million this fiscal year. This fund pays for the increased staffing requirements, expanded benefits and increased provider reimbursement rates. Effective January 1, 2001 the regular, adult nursing home reimbursement rate for Medicaid clients increased to $90.49 per patient per day, an increase of 36 percent from SFY2000 rates.

OHCA Activated Phone Menu System

A new call tree, or menu, implemented in February 2001 directs provider and client callers to different resources within or outside the agency to resolve their needs more efficiently and timely. This enhanced telephone system helped increase the number of calls answered and the amount of calls brought to resolution. In addition to increasing OHCA's responsiveness, the system will free additional Customer Services Representatives' time and enable them to answer more calls within the same allotted period.

OHCA Implements Depression Collaboration Project

OHCA partnered with The Institute for Healthcare Improvement (IHI), the Centers for Medicare and Medicaid Services (CMS), and the Substance Abuse and Mental Health Services Administration (SAMHSA) to implement a chronic care model of treatment for members diagnosed with depression. The goal of the collaborative is to maximize the length and quality of life, satisfy member and caregiver needs, and maintain or decrease the total cost of care. Information and training on assessment and treatment of depression is provided to Primary Care Providers in targeted rural and urban areas of Oklahoma with linkage to local community mental health centers and other network providers for supportive therapy as appropriate.

Oklahoma Ranked No. 1 in Enrolling Uninsured Families

Oklahoma grabs top rank in the nation in something other than college football this year. According to an October 2000 report by the *Kaiser Commission on Medicaid and the Uninsured*, Oklahoma's total Medicaid enrollment experienced the largest percentage of participation growth in the nation from 282,500 in June 1997 to 393,100 in December 1999, a 39 percent increase. This enrollment growth can be directly attributed to the expanded eligibility of children and pregnant women enrolled in ***SoonerCare***, the state-managed health care insurance program.

Accomplishments (continued)

Provider Contracts Now Online

All providers delivering services to Medicaid clients under the Fee-for-Service and ***SoonerCare*** Choice programs can now download contracts and other forms from the agency website at www.ohca.state.ok.us. Providers can download the specific provider-type contracts and electronic funds transfer authorization forms to mail to the agency for approval, reducing contract processing time.

SoonerCare Helpline Logs 1 Millionth Call

OHCA's ***SoonerCare*** Helpline reached its one-millionth call in July 2000. The statewide helpline began in 1995 with the start of the ***SoonerCare*** managed care program. The helpline provides general information, enrollment assistance and education to Oklahoma's Medicaid clients.

SoonerCare Plus Extended Into 4 More Counties

On January 1, 2001, ***SoonerCare*** Plus managed care program expanded its services into four counties, Lincoln, Grady, McClain and Tillman. Medicaid clients in those counties received services under the ***SoonerCare*** Choice program and were transitioned into the Plus program. Extensive efforts such as enrollment fairs, site visits to county Department of Human Services (DHS) offices, and individualized enrollment counseling went into the expansion.

Tribal Provider Contracts Established

After several years of negotiation, the Oklahoma Health Care Authority has been allowed to amend the Section 1115(a) managed care waiver. This amendment allows providers affiliated with Indian Health Services (IHS), tribal health care systems and urban Indian clinics to contract with the agency and serve as primary care providers for qualified Native Americans in the ***SoonerCare*** Choice program. Oklahoma is the first state in the nation to allow tribal providers to contract with the state Medicaid managed care program.

Oklahoma Medicaid

What is Medicaid?

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

Medicaid is three programs in one:

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

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

Who is Eligible for Medicaid?

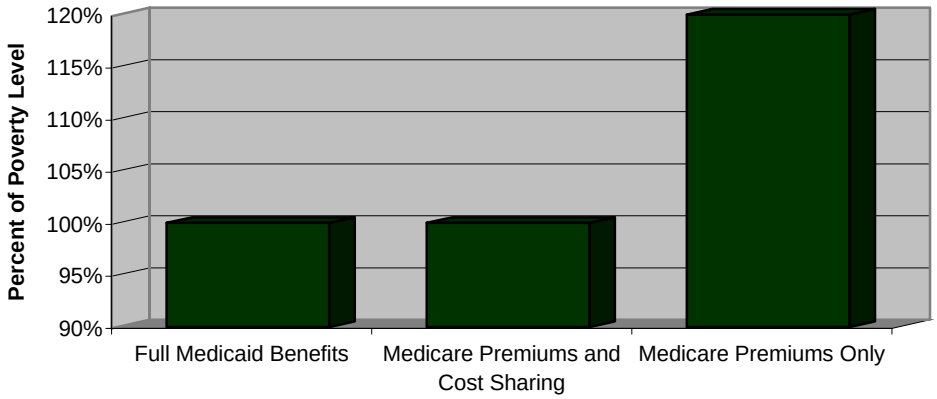
As required by state law, Oklahoma Medicaid eligibility is determined at each of the 77 county Department of Human Services offices. Each is governed by federal and state eligibility criteria. Most Medicaid eligibility criteria related to income levels are determined by federal poverty guidelines established by the U.S. Department of Health and Human Services. Medicaid serves as an insurance plan for many Oklahoma women of childbearing age and children. Women and children qualify for Medicaid based on income, resources and "categorical" status, that is, they are in a certain category such as TANF-related or low income pregnant women, hereafter referred to as the Temporary Assistance for Needy Families (TANF/AFDC) population. Preventive and acute primary care services constitute the majority of Medicaid service needs for the TANF/AFDC clients. As of the end of the June 2001, children age 18 and under alone comprised 65 percent of the total 442,387 Oklahoma Medicaid population.

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

Figure 1 Medicaid Eligibility Standards for Children and Pregnant Women

	Pregnant Women and infants under 1	1 to 5 years old	6 to 18 years old
Federally Mandated	133%	133%	100%
Oklahoma Option	185%	185%	185%

Figure 2 Medicaid Eligibility Standards for Elderly and Disabled



Who is Eligible for Medicaid? (continued)

Figure 3 General Age Breakdown of Medicaid Eligibles (as of June 2001)[1]

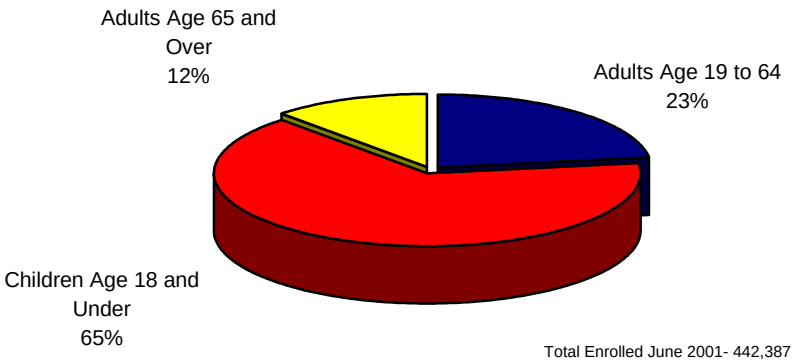
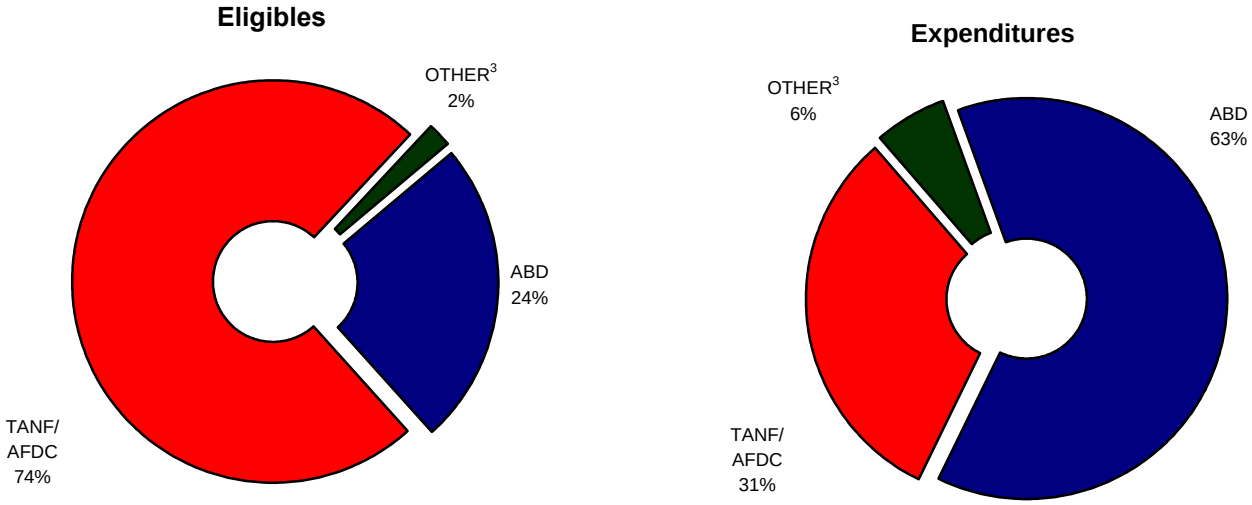


Figure 4 Breakdown of Medicaid Eligibles and Expenditures by Aid Category (as of June 2001)[2]



[1] Source: June 2001 data extracted from client eligibility files on July 9, 2001. Numbers frequently change due to retro-certifications and other factors. This figure is based on data within the system prior to 7/09/2001.
[2] Source: June 2001 data extracted from client eligibility files on July 9, 2001. Numbers frequently change due to retro-certifications and other factors. This figure is based on data within the system prior to 7/09/2001.
[3] OTHER Eligibility group encompasses Medically Needy, Tuberculosis patients, Qualified Medicare Beneficiaries, Special Low Income Medicare Beneficiaries, Refugees and Developmentally Disabled Supported Living.

Who is Eligible for Medicaid? (continued)

Figure 5 State of Oklahoma Population by Race[4]

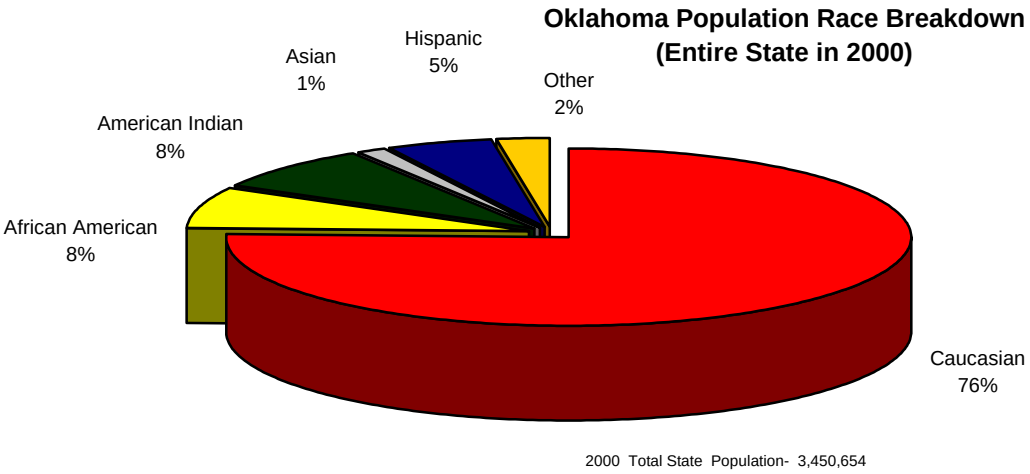
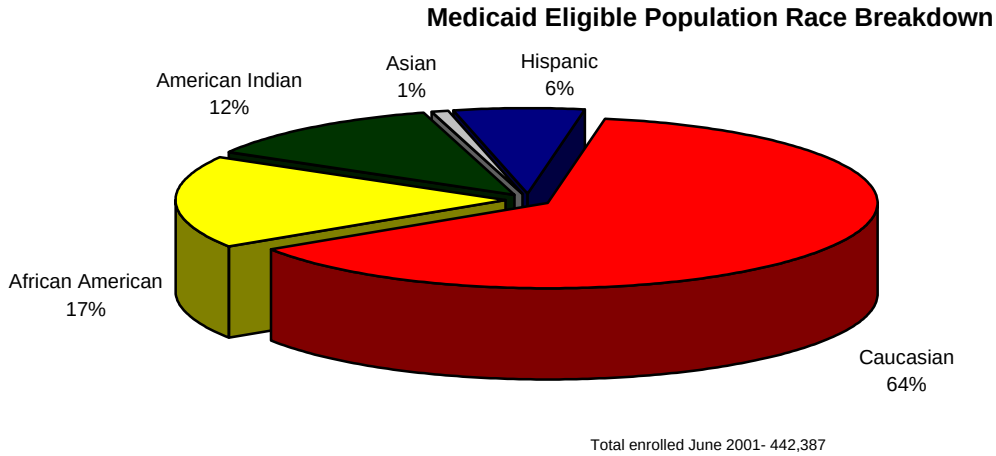


Figure 6 Oklahoma Medicaid Population by Race[5]



Nearly 1 in 6 Oklahomans Enrolled for Services

Most of the population figures contained in this annual report represent a "point in time" reference such as June 2001. The state Medicaid program assisted 603,537 individuals during the entire fiscal year. This is referred to as an unduplicated count. On average, approximately 432,000 individuals were enrolled each month of the fiscal year.

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

[5] Data extracted from client eligibility files on July 9, 2001. Numbers frequently change due to retro-certifications and other factors. This figure is based on data within the system prior to 7/09/2000.

How is Medicaid Financed?

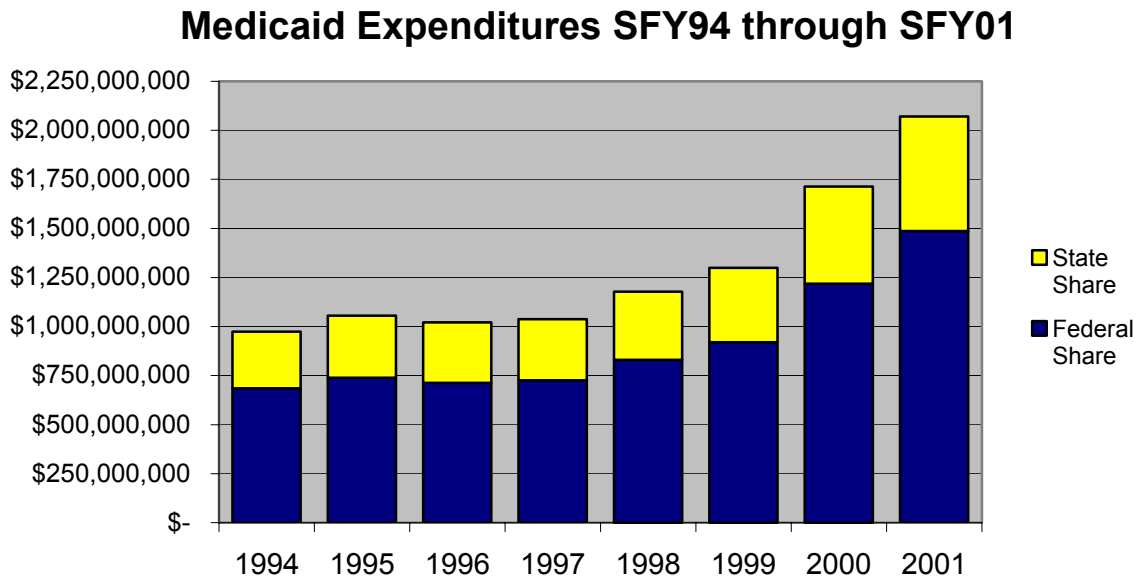
The federal and state governments share Medicaid costs. For program administration costs, the federal government contributes 50 percent for each state with enhanced funding provided for some administrative activities such as fiscal agent operations. For medical services provided under the program, the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

Figure 7 Condensed Summary of OHCA Revenues[6]

As of June 30, 2001

REVENUES	FY01 Budget YTD	FY01 Actual YTD	% Over/ (Under)
State Appropriations	$ 383,733,068	$ 383,733,082	0.0%
Federal Funds - OHCA	1,143,868,333	1,139,712,567	(0.4)%
Federal Funds for Other State Agencies	302,626,868	301,595,628	(0.3)%
Refunds from Other State Agencies	153,861,268	155,580,136	1.1%
Other Revenue	88,021,311	90,706,384	3.1%
TOTAL REVENUES	**$ 2,072,110,848**	**$ 2,071,327,796**	**(0.0)%**

Figure 8 Federal and State Share Expenditures–Oklahoma Medicaid[7]

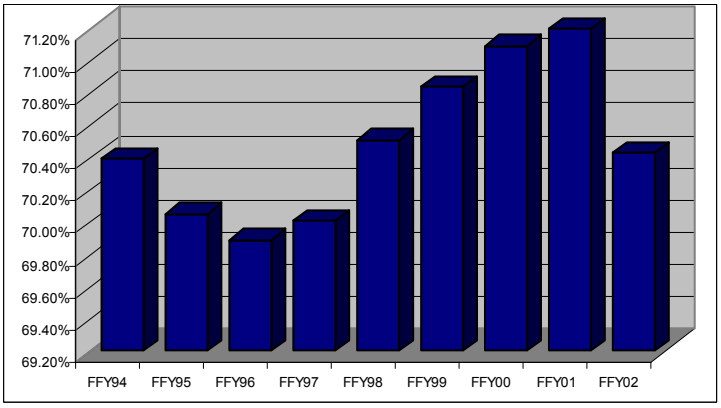


[6] Source: OHCA Finance Division (08/2001)
[7] Source: OHCA Finance Division (08/2001)

How is Medicaid Financed? (Continued)

Figure 9 Historical Federal Medical Assistance Percentage (FMAP)[8]

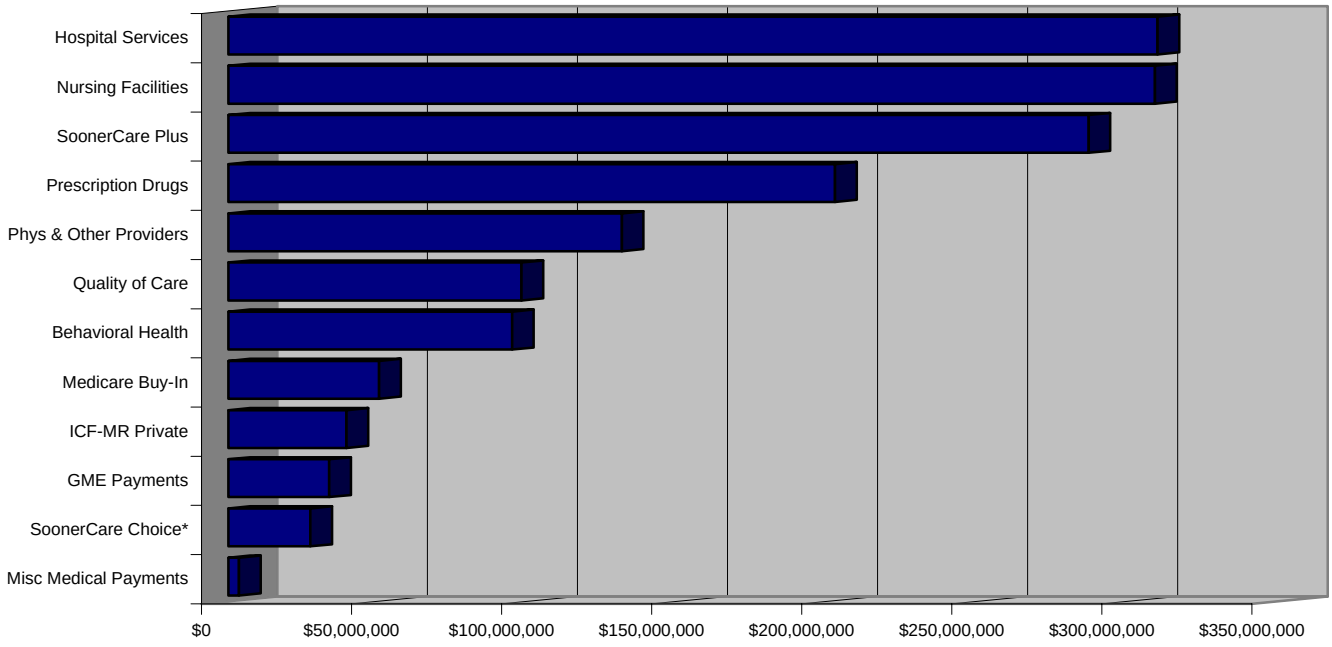
Federal Fiscal Year	FMAP Rate	SCHIP‡
FFY94	70.39%	
FFY95	70.05%	
FFY96	69.89%	
FFY97	70.01%	
FFY98	70.51%	79.36%
FFY99	70.84%	79.59%
FFY00	71.09%	79.76%
FFY01	71.24%	79.87%
FFY02	70.43%	79.30%



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

Where are the Medicaid Dollars Going?

Figure 10 Oklahoma Medicaid Actual Expenditures SFY2001[10]



[8] Source: OHCA Finance Division (07/2001)

[10] Source: OHCA Finance Division (08/2001). Unless stated otherwise expenditures are State and Federal dollars combined.

‡ SCHIP: State Children's Health Insurance Program, see additional information on Page 21.

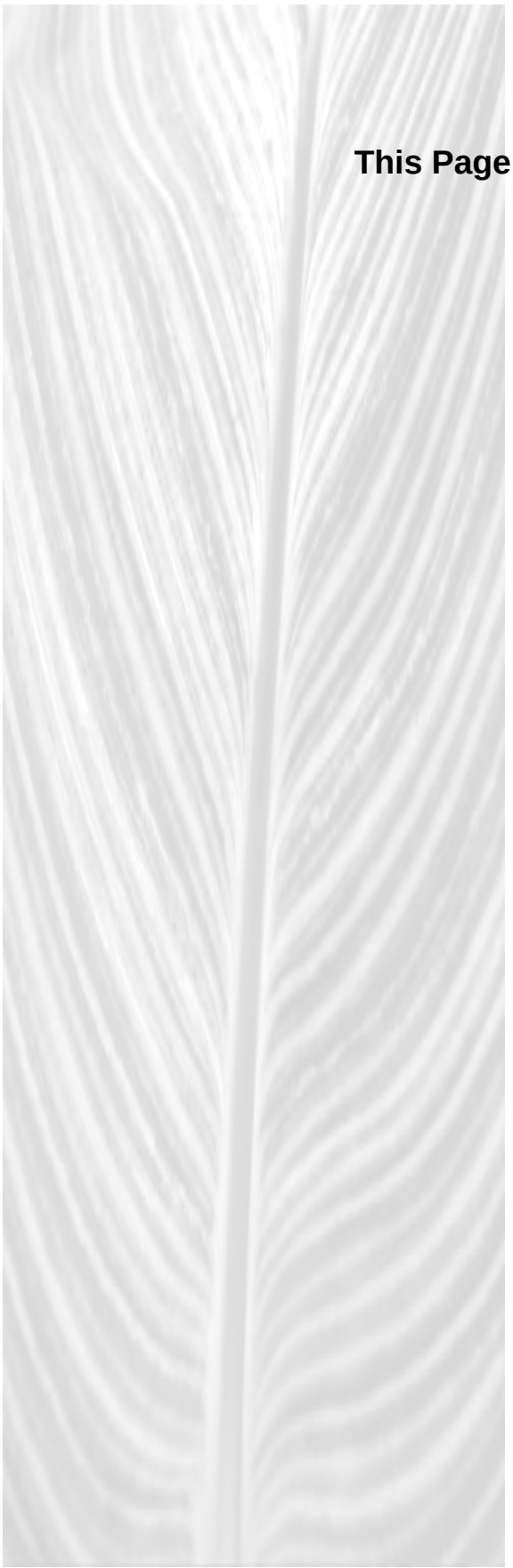
****SoonerCare*** Choice expenditure figures represent capitated payments only. Noncapitated services are not included in this amount.

Where are the Medicaid Dollars Going? (Continued)

Figure 11 Condensed Summary of OHCA Expenditures SFY2001[11]

As of June 2001 EXPENDITURES	FY01 Budget YTD	FY01 Actual YTD	% (Over) / Under
ADMINISTRATION	**$ 56,025,501**	**$ 48,895,071**	**12.7%**
ADMINISTRATION - QUALITY OF CARE	**386,708**	**386,708**	**0.0%**
OHCA MEDICAID PROGRAMS			
Managed Care:			
SoonerCare Plus	290,887,412	286,553,453	1.5%
SoonerCare Choice*	27,919,039	27,255,097	2.4%
Graduate Medical Education Payments	33,602,476	33,602,476	0.0%
Acute Fee for Service Payments:			
Hospital Services	309,011,343	309,513,865	(0.2)%
Behavioral Health	92,647,302	94,459,853	(2.0)%
Physicians & Other Providers	126,478,957	131,043,396	(3.6)%
Prescription Drugs	196,779,694	202,094,418	(2.7)%
Miscellaneous Medical Payments	3,452,962	3,513,065	(1.7)%
Other Payments:			
Nursing Facilities	307,915,292	308,634,294	(0.2)%
ICF-MR Private	39,237,051	39,320,435	(0.2)%
Medicare Buy-In	54,716,565	50,212,601	8.2%
Quality of Care Payments:			
Nursing Home Rate Adjustment	77,361,474	77,361,474	0.0%
NET - SoonerRide	194,584	194,584	0.0%
Personal Allowance Increase	4,000,000	4,000,000	0.0%
Coverage for DME and supplies	988,668	988,668	0.0%
Coverage of Qualified Medicare Beneficiaries	4,919,369	4,919,369	0.0%
ICF/MR Rate Adjustment	8,844,380	8,844,380	0.0%
Acute/MR Adjustments	921,245	921,245	0.0%
	$ 1,579,877,813	**$ 1,583,432,672**	**(0.2)%**
OTHER OHCA MEDICAL PROGRAMS	**$ 5,293,271**	**$ 6,102,534**	**(15.3)%**
Total OHCA	**$ 1,641,583,293**	**$ 1,638,816,985**	**0.2%**
OTHER STATE AGENCY PROGRAMS			
Non-Medicaid Programs	$ 20,659,710	$ 18,203,205	11.9%
Dept. of Human Services Medicaid (DHS)	354,156,559	373,538,264	(5.5)%
Oklahoma State Dept. of Health (OSDH)	3,000,000	2,295,888	23.5%
Office of Juvenile Affairs Medicaid (OJA)	10,338,045	10,345,066	(0.1)%
Dept. of Mental Health Medicaid (DMHSAS)‡	24,064,182	15,492,002	35.6%
Department of Health Medicaid (OSDH)‡	1,900,000	1,150,658	39.4%
Department of Education Medicaid (DOE)‡	15,000,000	9,983,709	33.4%
Total Other State Agency Programs	**$429,118,496**	**$431,008,792**	**(0.4)%**
TOTAL ALL EXPENDITURES	**$ 2,070,701,789**	**$ 2,069,825,778**	**0.0%**

[11] Source: OHCA Finance Division (08/2001). Unless stated otherwise expenditures are State and Federal dollars combined.
*_**SoonerCare**_ Choice figures represent capitated payments only. Noncapitated services are not included in this amount.
‡ Figures shown for DMHSAS, OSDH and DOE represent the federal share only of Medicaid program expenditures.



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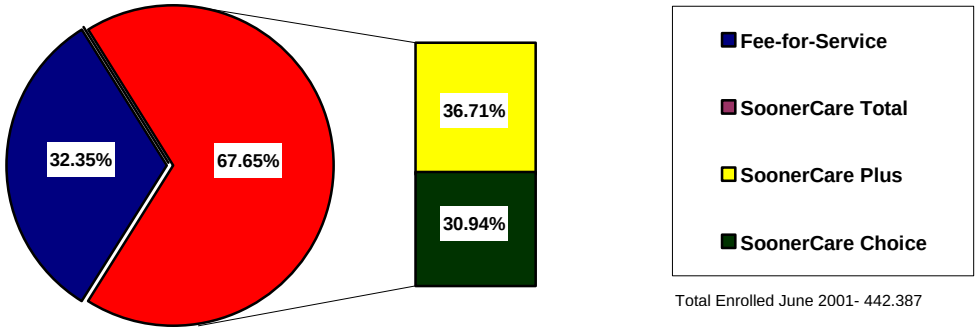
OHCA and Medicaid

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

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

Figure 12 Oklahoma Medicaid Breakout of *SoonerCare* and Fee for Service (June 2001)[12]



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

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

These employees work in partnership with:

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

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

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

Strategic Planning

The beginning of the twenty-first century presents a time of unparalleled change in our Nation's health care system. As new models of health care delivery systems continually evolve, and rapid advances in technology and communications revolutionize the provision of health care, so too must the Medicaid program adapt.

The Oklahoma Health Care Authority (OHCA) is responsible for overseeing the Medicaid program in Oklahoma. Medicaid has become an indispensable program for the most vulnerable segments of the population. For more than three decades, the Medicaid program has met the basic health care needs of Oklahomans who are elderly, disabled, or have a low-income.

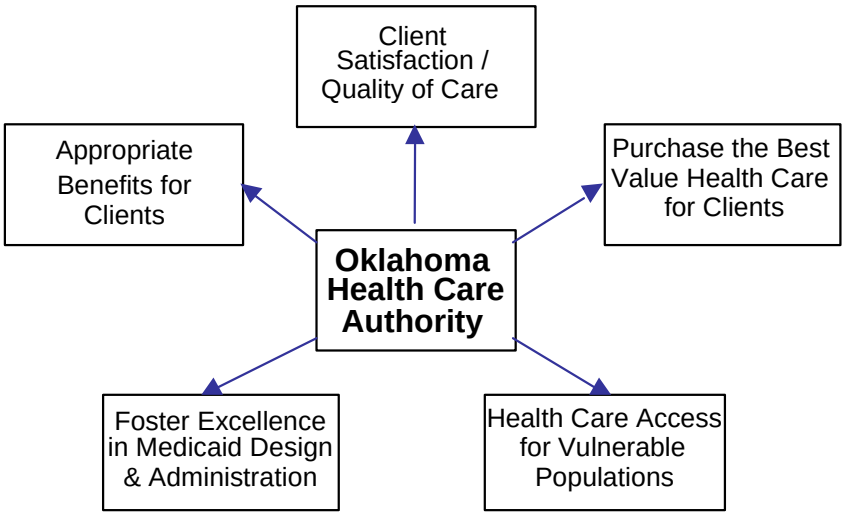
In carrying out its responsibilities, OHCA strives to be a leader in improving the delivery of cost-effective, appropriate, high quality health care for all of our clients, promoting and preserving client rights and protections, and in meeting the highest standards of administrative performance.

OHCA will set forth its goals and objectives for carrying out this work in a Strategic Plan. In the years ahead, OHCA will need to carry out its mandate to ensure access to high quality health care for the elderly, persons with disabilities, and certain low income populations in a rapidly changing health care environment. Like other purchasers of health care, OHCA's future success will depend on its ability to adapt to changes affecting both health care, in general, and Medicaid specifically. These principles affirm that OHCA is committed to a culture that will support its mission.

Broadly Stated Goals

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

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



Operating Principles

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

Our Client Focus

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

How We Work with Others in the Health Care System

- We will strive to be an even-handed and reliable business partner with plans, providers, states, contractors, and other stakeholders in our programs.
- We will work collaboratively with our colleagues throughout the Oklahoma and federal government, and territories, tribes, with accrediting bodies, beneficiary and provider advocacy groups, and elsewhere, to achieve mutual goals.
- We will demonstrate leadership in the public interest, consistent with our position as one of the largest public purchasers of health care in the 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 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.

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

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

Oklahoma Medicaid Services

What is a Waiver?

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

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. State demonstration projects are frequently aimed at saving money or extending Medicaid coverage to additional low-income and uninsured people. The federal government currently grants two kinds of Medicaid managed care waivers: Section 1915(b) "Freedom of Choice" waivers and Section 1115(a) "Research and Demonstration" waivers.

Section 1915(b) waivers permit states to require participants to enroll in managed care plans. To receive such a waiver, states must prove that these plans have the capacity to serve Medicaid participants who will be enrolled in the program. The purpose of freedom of choice waivers is to improve client access to care through enrollment in a guaranteed provider network that operates in a cost efficient manner. Such waivers also facilitate the monitoring of client quality of care. They frequently place participants in delivery systems in which there is greater emphasis on health education and preventive medicine.

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. Research and demonstration waiver authority can normally be granted for up to five years at a time. This permits states to try out a far greater range of policies than would otherwise be permissible in ordinary freedom of choice waiver programs.

CMS waivers allow for some state flexibility in the design of its managed care delivery system; and, managed care models can vary based on available community resources, geographic location and experience in managed care practices. Oklahoma initially implemented its Medicaid managed care program under a Section 1915(b) waiver in 1995 but transitioned to a Section 1115(a) waiver on July 1, 1996. Under its current waiver, Oklahoma has chosen to develop and implement two, distinct managed care delivery systems within its Medicaid program: ***SoonerCare*** Plus and ***SoonerCare*** Choice.

What is a Waiver? (Continued)

Home and Community Based Services (HCBS) Waivers

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

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

Community Waiver: Serves approximately 2,900 clients with mental retardation and certain persons with "related conditions". This waiver covers children and adults, with the minimum age being 3 years.

In-Home Supports Waiver for Adults: This waiver began in July of 1999 and is designed to assist the state in removing adult individuals (ages 18 years of age and older) with mental retardation from a waiting list. This waiver has an annual post eligibility cost cap of $16,950 per year per client for waiver services. This waiver serves approximately 500 adults.

In Home Supports Waiver for Children: This waiver, that also began in July of 1999, is designed to assist the state in removing children ages 3 through 17 years with mental retardation from a waiting list. This waiver has an annual post eligibility cost cap of $11,300 per client per year for waiver services. The reason for the lower cap for the In Home Supports Waiver for Children is that children are also entitled to receive services under the provisions of EPSDT. Combined with the services available under the Medicaid State Plan, children have a broader scope, amount and duration of services. This waiver serves approximately 200 children.

ADvantage Waiver: This waiver serves the "frail elderly" (Oklahomans whose age is 65 years and older) and adults with physical disabilities. The "frail elderly" comprise approximately 80 percent of this waiver's consumer population and the remaining 20 percent are adults with physical disabilities. Approximately 10,500 persons receive services through this waiver program.

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

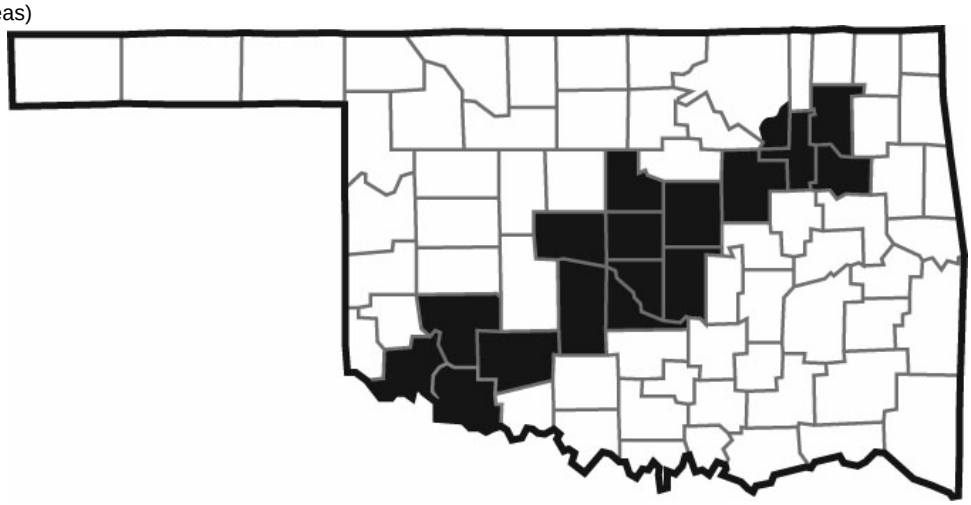
Oklahoma Managed Care-*SoonerCare* Plus

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

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

Figure 13 *SoonerCare* Plus Catchment Areas[13]

(Darkened Areas)



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

Southwest	**Central**	**Northeast**
Comanche	Canadian	Creek
Jackson	Cleveland	Rogers
Kiowa	Grady	Tulsa
Tillman	Lincoln	Wagoner
	Logan	Osage (limited)
	McClain	
	Oklahoma	
	Pottawatomie	

SFY2001 Specific Information…

- The $286,553,453 ***SoonerCare*** Plus dollars accounted for 17 percent of the total OHCA Medicaid dollars expended in SFY2001.
- As of June 30, 2001, the ***SoonerCare*** Plus program had 162,383 persons enrolled.
- For additional information on the ***SoonerCare*** Plus program, refer to the Service Efforts and Accomplishments beginning on page 51.

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

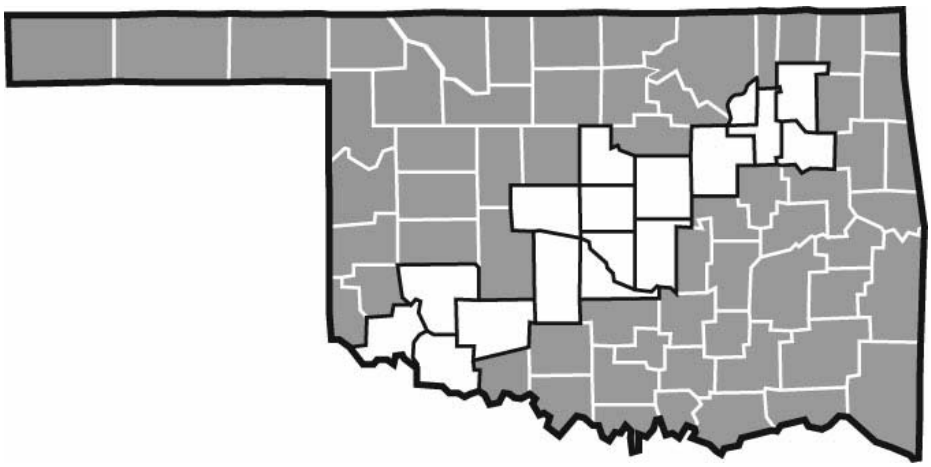
Oklahoma Managed Care-*SoonerCare* Choice

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

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

Figure 14 *SoonerCare* Choice Catchment Areas[14]

(Darkened Areas)



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

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

SFY2001 Specific Information…

- Dollars expended, including noncapitated services, in SFY2001 on behalf of ***SoonerCare*** Choice members totaled $237,922,861 or 15 percent of the total OHCA Medicaid expenditures.
- As of June 30, 2001, the ***SoonerCare*** Choice program had 136,889 persons enrolled.
- For additional information on the ***SoonerCare*** Choice program, refer to the Service Efforts and Accomplishments beginning on page 51.

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

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

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

And Then Came SCHIP…
Subsequently, the Federal Budget Act of 1997 made numerous Medicaid changes and also created the State Children's Health Insurance Program (SCHIP). The optional program, referred to as SCHIP or Title XXI, is designed to help states cover additional uninsured low-income children with a higher federal match assistance percentage (See Figure 7 Historical Federal Medical Assistance Percentage, Page 11).

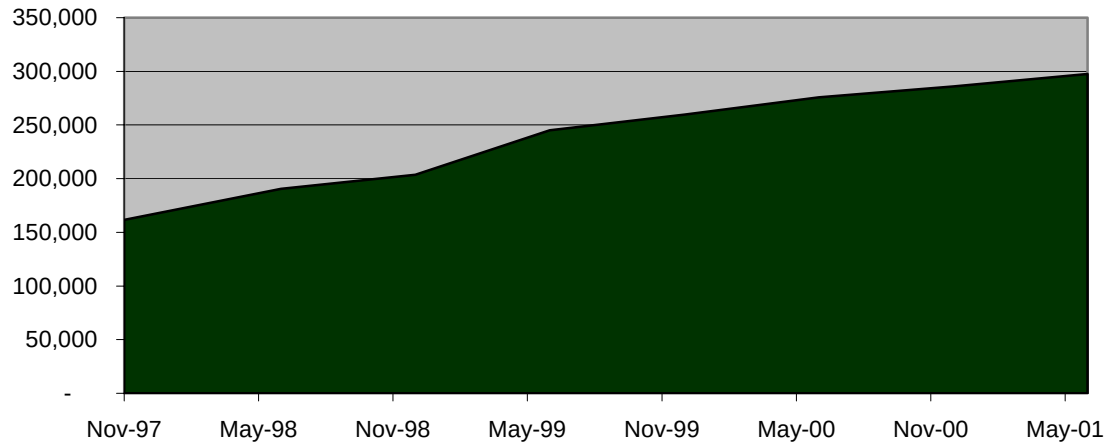
Oklahoma SCHIP defines eligibility for "targeted low-income children," as children who meet all of the following criteria:

- Have no creditable insurance;
- Family income below 185 percent of federal poverty guidelines;
- Under age 18; and
- Not eligible for Medicaid under eligibility criteria in effect prior to November 1997 or any other federal health insurance program. Uninsured children who meet previous eligibility standards must be enrolled in Medicaid, not SCHIP.

With SCHIP, the federal poverty guidelines for Oklahoma children were raised from 150 percent to 185 percent. This increased the allowable monthly income from $1,735 monthly gross to the current $2,255 monthly gross (both based on a family size of three).

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

Figure 15 Increased Enrollment of Children Since Implementing Expansion Programs*



* Children as defined above are only enrolled children under the age of 21.

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

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

Behavioral Health Services

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

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

SFY2001 Specific Information…

- Expenditures for the behavioral health program totaled $94,459,853 for SFY2001

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: Medicare, Medicaid, the Department of Defense and Veterans' Affairs.

Specific SFY2001 Information…

- Graduate medical education payments, under the ***SoonerCare*** program, totaled $33,602,476; this accounted for 2 percent of the SFY2001 ***SoonerCare*** expenditures.
- GME payments were made to the following: University of Oklahoma College of Medicine, both Oklahoma City and Tulsa locations, and Oklahoma State University's School of Osteopathic Medicine in Tulsa.
- For more information regarding the GME program go to page 71 of the Service Efforts and Accomplishments section.

Hospitals

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

Disproportionate Share Hospital (DSH) Payments

Hospitals provide healthcare 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 disproportionate burden of care for the under and uninsured.

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.

Direct Medical Education (DME)

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

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.

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; and
- Apply for certification by the OHCA prior to receiving payments for any quarter;
- Have a contract with OHCA to provide Medicaid Services;
- Belong to the Council of Teaching Hospitals or show proof of affiliation with an approved Medical Education Program.

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 hospital is the OU Medical Center, formerly University Health Partners, in Oklahoma City.

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.

SFY2001 Specific Information…

- Hospital expenditures, $309,011,343 accounted for 19 percent of OHCA's total Medicaid expenditures.
- During SFY2001, the Oklahoma Medicaid program had individual contracts with 265 hospitals.
- For more information regarding DME payments please refer to page 72 of the Service Efforts and Accomplishments.

Long Term Care

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

While much is being said about the future consequences of an aging population on society, Medicaid programs are facing significant long-term health care challenges today. The elderly growth rate is predicted to remain steady until 2010; however, by 2030 one in five Americans will be elderly. More significantly, the oldest population (85 years and over) is predicted to double between 1990 and 2010, and more than double again by 2040.[15] Because Medicaid is a major payer of long-term care services, states will face a much greater financial burden than they do today.

Quality of Care

The Quality of Care Program is part of a comprehensive health package, referred to as the "Oklahoma 2001 Healthcare Initiative", approved by Oklahoma's 47th Legislature. Effective July 1, 2000, part of the initiative is to monitor and report legislative directed outcomes.

With the legislation's mandated timeframes for implementation of the various staffing and minimum wage reports, fee collection, and rate adjustment activities related to the Quality of Care (QOC) reports and monitoring effective September 1, 2000, OHCA staff worked diligently to successfully meet the legislative requirements. The rules related to the Quality of Care fund and reporting requirements were presented to the Medical Advisory Committee on July 13, 2000, following several in-depth meetings with the provider associations and other state agencies. On August 3, 2000, the Oklahoma Health Care Authority Board adopted the rules.

Quality of Care Fee

The Quality of Care Program is intended to improve the quality of care received by long-term care residents. To this end, beginning October 1, 2000, a fee per patient day is collected from long–term care facilities and placed in the revolving fund. Monies from this fund are used to pay for the higher facility reimbursement rate; increased staffing requirements; program administrative costs; and expanded Medicaid benefits that include non-emergency transportation (SoonerRide) and attendants; eyeglasses and dentures; and personal needs allowance increases for long-term care Medicaid clients. The fund also provides for coverage of expanded durable medical equipment and supplies services for adults and Medicaid services for Qualified Medicare Beneficiaries.

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

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

Long Term Care (continued)

Quality of Care (continued)

Staffing Ratios

Effective September 1, 2000, nursing facilities are required to report compliance / noncompliance with the higher minimum direct care staff to resident ratios of:

Day Shift- one direct care staff to every eight residents,
Evening Shift- one direct care staff to every twelve residents, and
Night Shift- one direct care staff to every seventeen residents.

Specialized facilities (ICF/MRs) may be measured against a higher staffing ratio. All data regarding direct care staff to resident ratios is forwarded to the Oklahoma State Department of Health, as required by state law, for ultimate determination of compliance with Quality of Care and other applicable state and federal regulations.

Minimum Wage

To decrease staff turnover and improve quality of care, a new minimum wage of $6.65 for specified staff has been instituted effective November 1, 2000.

Penalties

Fee payments are due by the 10th of the month. Facilities failing to submit timely fee payments are subject to a penalty of 10 percent of the amount due and interest of 1.25 percent per month.

Facilities are required to submit monthly wage information in conjunction with staffing ratios to OHCA on a Quality of Care Report (QOCR) form on or before the 15th of each month. Facilities filing non-timely reports are subject to a penalty of $150 a day until a complete report is accepted.

The Oklahoma State Department of Health is charged with the determination of willful violation of staffing ratio regulations. Subsequently, as a penalty measure, the Oklahoma State Department of Health may request the Oklahoma Health Care Authority to withhold a percentage of Medicaid funds from the offending provider.

SFY2001 Specific Information…

- Expenditures for nursing facilities (NF) serving adults were $308,634,294; expenditures for intermediate care facilities for the mentally retarded (ICF/MR) were $39,320,435.
- Total Quality of Care Program revenues were $33,849,967 and the State share of the total $97,616,428 Quality of Care expenditures was $32,767,513.
- Total long term care expenditures accounted for 21 percent of the total Oklahoma Medicaid expenditures.
- Medicaid clients living in long term care facilities represented an estimated 6 percent of the total Medicaid clients.
- Medicaid funded 6,475,954 long term care facility bed days; this represents 72 percent of the total actual bed days for SFY2000 (last reported cost report data).

Medicare "Buy-In" Program

In order to help protect low-income Medicare beneficiaries from the Medicare program's cost-sharing requirements, Congress has enacted several programs. Under the Medicare Catastrophic Coverage Act (MCCA) of 1988, Congress required each state's Medicaid program to "buy-in" to Medicare for low-income beneficiaries and persons with disabilities by paying for Medicare premiums, deductibles and coinsurance. Medicare is made up of two parts, hospital insurance (Part A) and supplementary medical insurance (Part B). For hospital insurance expenses, Medicaid pays the coinsurance and deductible fees for hospital services and skilled nursing services for eligible persons. The deductible and coinsurance fees are also paid for supplementary medical insurance expenses that are primarily physician services.

Subsequent legislation was 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.

SFY2001 Specific Information…

- Medicare "Buy-In" expenditures accounted for 3 percent of the total Medicaid expenditures.
- "Buy-In" expenditures totaled $50,212,601 for SFY2001.
- 49,783 Part A premiums and 595,617 Part B premiums were paid for with Medicaid funding.

Pharmacy Program

Prescription drugs are currently covered by every state's Medicaid program, although coverage is optional under federal law. All states have opted to cover pharmaceuticals because use of medications often provides an alternative to expensive surgery, results in shorter hospital stays and prevents illness. Nevertheless, prescriptions drugs can be costly. Federal law governing Medicaid prescription drug reimbursements seeks to contain costs through limits on pharmacy reimbursement and mandatory rebates on pharmaceutical products.

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

SFY2001 Specific Information…

- Prescription drug program expenditures accounted for $202,094,418 or 12 percent of the total Oklahoma Medicaid expenditures.
- The average cost per prescription funded by Medicaid was $47.17.
- The average prescription cost per patient funded by Medicaid was $168.69.
- 40 million dollars were collected through the Drug Rebate program.
- For additional information, see page 76 of the Service Efforts and Accomplishments.

Physicians and Other Practitioners

Oklahoma Medicaid includes both private and public providers such as physicians, nurse practitioners, physician assistants and other health care professionals. Oklahoma pays medical providers to deliver Medicaid services and provide access to enrolled individuals. Oklahoma reimburses providers for services at state-determined rates from annual state and federal appropriations.

Participating providers are the cornerstone of the Medicaid program coordinating and providing the health care needs of individuals in the Oklahoma Medicaid program.

SFY2001 Specific Information…

- Fee for Service expenditures for Physicians and Other Practitioners accounted for $126,478,957 or 8 percent of Oklahoma's total Medicaid expenditures.
- For additional information on Physicians and Other Practitioners, refer to the Service Efforts and Accomplishments section of this report.

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, vision problems and are more medically at risk. Treatment of these conditions can improve classroom attendance and participation.

OHCA is focusing an outreach initiative in places where we know we can find uninsured children such as schools. 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. This package of enhanced health care services for children is known as EPSDT or Early Periodic Screening, Diagnosis and Treatment. This program includes a broad range of services beyond the general Medicaid program such as comprehensive screenings, immunizations and dental services. The main goal is to help parents receive preventive care for their children rather then just rely on emergency care. This program allows families to identify potential health problems early.

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

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

SFY2001 Specific Information…

- OHCA contracted with 362 school based providers in 75 counties.
- During SFY2001, OHCA paid $11,394,359 for the Early Intervention (EI/SoonerStart) program.
- School based providers were reimbursed $13,913,696 for SFY2001.
- For additional information regarding the School Based Services go to page 65 of the Service Efforts and Accomplishments section of this report.

SoonerRide (Non-Emergency Transportation)

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

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

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

In an effort to provide budget predictability and increased accountability of the non-emergency transportation program under Oklahoma's fee-for-service Medicaid program, the Authority moved in early 1999 to institute a transportation brokerage system of reimbursement for mileage paid to clients outside the fully-capitated ***SoonerCare*** Plus program. Similar to a managed care health care delivery system, the contracted transportation broker is reimbursed on a per-member-per-month (PM/PM) basis.

Specific SFY2001 Information…

- The non-emergency transportation program cost $5,927,583; this represented less than 1 percent of the total Oklahoma Medicaid expenditures.
- Non-emergency transportation expenditures increased by 16 percent from SFY2000 to SFY2001.
- For more information, refer to page 64 of the Service Efforts and Accomplishments.

Medicaid and Native Americans

The State of Oklahoma is home to 39 tribal governments.[16] Thirty-eight are federally recognized as sovereign nations and another has applied for federal recognition. Some tribes still obtain all of their healthcare services for tribal members through Indian Health Services (IHS). However, the role of IHS in Oklahoma is being increasingly changed and diminished through the evolution of some very sophisticated individual tribal healthcare systems such as the Cherokee, Chickasaw, Creek and Choctaw Nations. None of these systems are exactly alike and each system needs different types of resources and levels of support from OHCA. CMS (formerly HCFA) central office initiated several policies that give tribes a greater role in the development and operations of the state Medicaid program as they affect tribal members. CMS has structured the implementation of these policies in such a way that the responsibility for day-to-day operations has been shifted from the federal government (CMS) to individual state Medicaid programs.

In response to the CMS policies regarding Native Americans, representatives from 15 state Medicaid programs with large numbers of tribal members, including Oklahoma, formed an informal "Indian Health Work Group". OHCA is also participating in quarterly meetings of the Oklahoma City Area Inter-Tribal Health Board. At the annual Health summit held by the Oklahoma City Area Inter-Tribal Health Board OHCA provided eligibility and outreach materials to the 35 tribes represented. The goal of participation in these groups, as well as a Tribal "roundtable" in January 2001, is to gain awareness of policy implications, Native American service needs, provider issues and training, strategies for maximum efficiency and for a general exchange of information.

SoonerCare *and Native Americans*

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

Though this model initially served to facilitate member access to I/T/U facilities it also created an administratively cumbersome coordination and referral process. In 1998 members of the Choctaw Nation met with OHCA to discuss expansion of the role of I/T/U providers. Over the next two years OHCA worked in collaboration IHS and Tribal leaders and CMS to develop a new managed care model for the ***SoonerCare*** Choice program, which would allow I/T/U providers to serve as primary care physicians (PCPs). Under this new model, I/T/U providers can provide culturally sensitive case management to Native American ***SoonerCare*** Choice members. The I/T/U providers acting as PCPs and make referrals and coordinate additional services such as specialty care, and hospitalization when patients access care facilities which are not operated by Tribes or IHS. This model was approved by CMS in March 2001 and will be implemented beginning in July 2001.

Specific SFY2001 Information…

- The State of Oklahoma has an estimated Tribal population of 559,155.
- For the month of June 2001 there were 54,335 persons categorized as American Indian enrolled in Medicaid.
- Oklahoma spent approximately $28,340,814 or 1.69 percent of the total Medicaid expenditures on Indian Health Services.

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

Figure 16 Medicaid Program- Overview of Benefits (as of June 2001)

Benefit	Fee-For-Service	*SoonerCare* Choice	*SoonerCare* Plus	Benefit Notes and/or Limitations
Assistive Technology	**1**	**1**	**2**	**1)** Children only and requires a prior authorization. **2)** Does not require a prior authorization and includes cognitive and developmental aids and augmentative and communication aids.
Behavioral health services	**X**	**X**	**X**	
Case management services	**X**	**X**	**X**	
Dental services	**1**	**1**	**2**	**1)** Limited to emergency extractions. **2)** Adults are not covered except for reconstructive surgery and emergency extractions. ABD adult members of ***SoonerCare*** Plus limited to emergency dental care, extractions and dentures.
Diabetic Supplies	**X**	**X**	**X**	One glucometer, one spring loaded lancet device, and three replacement batteries per calendar year as well as 100 glucose strips and 100 lancets per month.
Durable medical equipment including medical supplies	**1**	**2**	**3**	**1)** Includes oxygen, oxygen concentrators—(respirator and ventilator rentals require a prior authorization). **2)** Includes oxygen, oxygen concentrators, respirators and ventilators. **3)** Includes oxygen, oxygen concentrators, respirators and ventilators-aids for daily living and personal care, mobility and positioning aids, standing and walking aids, hearing aids and visual aids.
Early Periodic Screening, Diagnosis & Treatment (EPSDT) for children	**X**	**X**	**X**	6 visits before age 1- 2 visits between ages 1 and 2- 1 yearly visit for ages 2 though 5 – 1 visit every other year for ages 6 through 20. **Includes:** Physical exam, eye and hearing exam, dental exam, nutritional review, lead screening, lab tests, speech screening, visit for behavioral health and substance abuse problems.
Educational Classes			**X**	
Exceptional Needs Coordinator for ABD members			**X**	
Family planning services	**X**	**X**	**X**	
Home health care services	**1**	**1**	**2**	**1)** Limited to 36 visits per calendar year. **2)** Unlimited.
Inpatient hospital services	**1**	**1**	**2**	**1)** Limited to 24 days per state fiscal year. (July 1 through June 30) **2)** Unlimited.

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

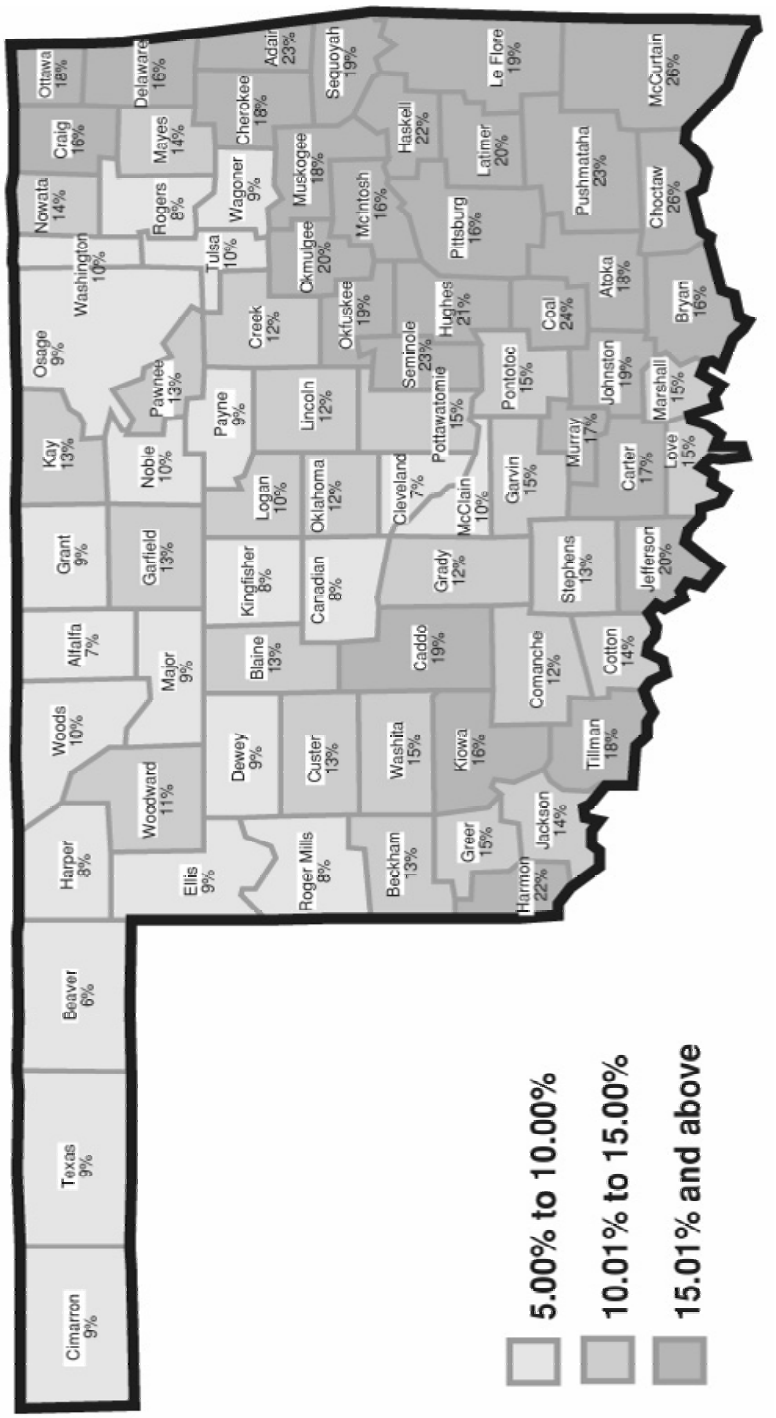
Figure 16 Medicaid Program- Overview of Benefits (continued)

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

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

Statewide SFY2001 Figures

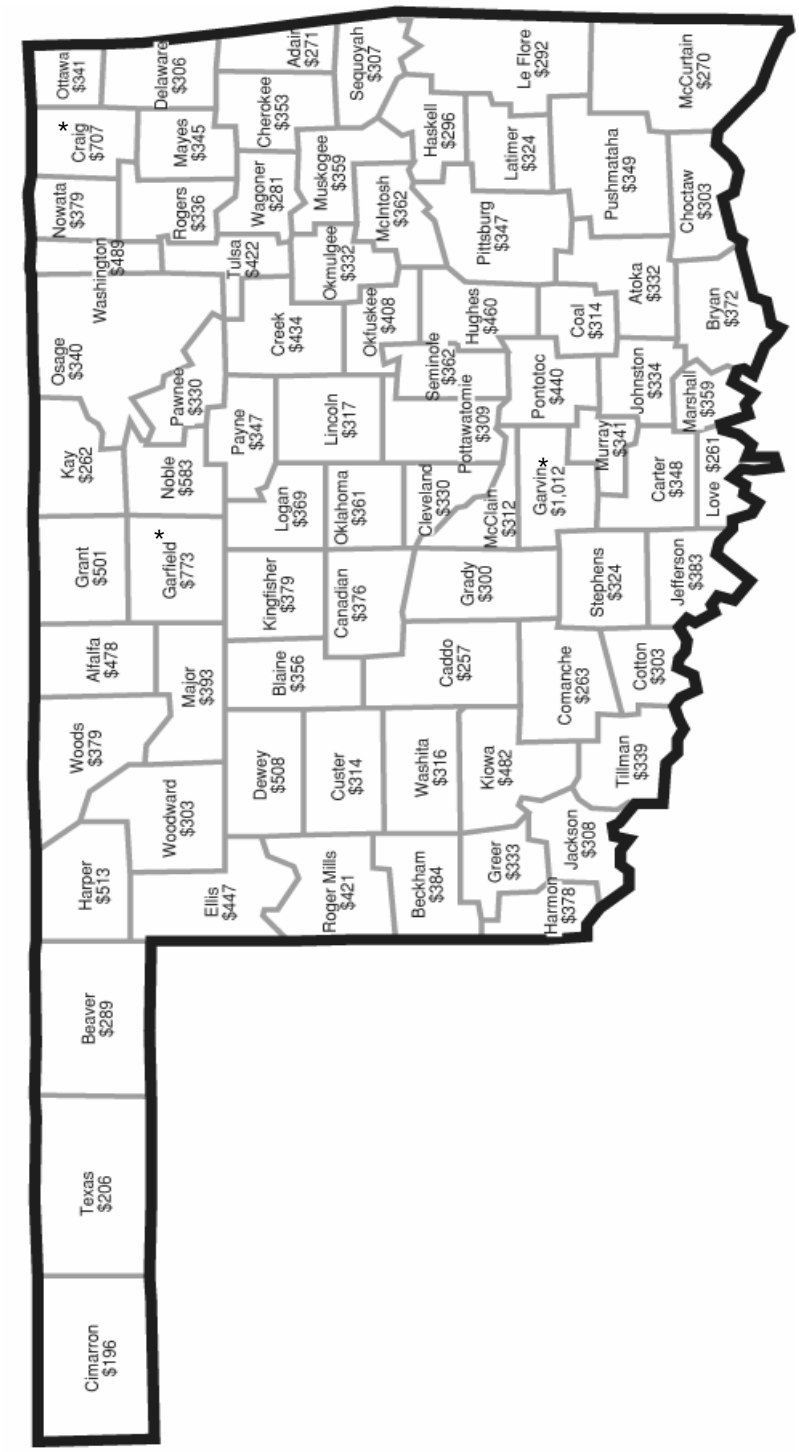
Figure 17 Percent of Oklahoma Population Enrolled in Medicaid (as of June 30, 2001)[17]



[17] Source: Data is based on persons enrolled in Medicaid in June of 2001, as a percent of year 2000 Census data from the Oklahoma Department of Commerce.

Statewide SFY2001 Figures (continued)

Figure 18 Average Dollars Spent per Medicaid Client per Month[18]



* Note: 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 client to be higher than the norm. If public ICF/MR costs are removed the following are the results: Garfield- $424 and Garvin- $374 per Medicaid client. If the private ICF/MR costs are removed the average cost per client for Craig County is $627.

[18] Source: Data extracted from client eligibility files on July 9, 2001. Numbers frequently change due to retro-certifications and other factors. Claim dollars were extracted from the claim history file for claims *paid* within the quarter.

Figure 19 Statewide Medicaid Figures

County	Population 2000 Census [19]	Rank	Clients [20]	Rank	Pop.Covered by Medicaid	Rank
ADAIR	21,038	38	4,778	31	22.71%	5
ALFALFA	6,105	67	406	72	6.65%	76
ATOKA	13,879	48	2,517	45	18.14%	20
BEAVER	5,857	70	366	73	6.25%	77
BECKHAM	19,799	40	2,951	40	14.90%	36
BLAINE	11,976	51	1,593	58	13.30%	44
BRYAN	36,534	26	5,841	23	15.99%	29
CADDO	30,150	32	5,862	22	19.44%	14
CANADIAN	87,697	5	6,678	16	7.61%	74
CARTER	45,621	16	7,830	10	17.16%	23
CHEROKEE	42,521	21	7,792	11	18.33%	19
CHOCTAW	15,342	44	4,055	35	26.43%	1
CIMARRON	3,148	77	283	75	8.99%	65
CLEVELAND	208,016	3	15,312	3	7.36%	75
COAL	6,031	69	1,419	60	23.53%	3
COMANCHE	114,996	4	14,154	4	12.31%	50
COTTON	6,614	66	944	65	14.27%	41
CRAIG	14,950	45	2,331	46	15.59%	30
CREEK	67,367	9	7,922	9	11.76%	52
CUSTER	26,142	36	3,293	38	12.60%	48
DELAWARE	37,077	25	5,999	20	16.18%	27
DEWEY	4,743	72	416	71	8.77%	66
ELLIS	4,075	73	351	74	8.61%	67
GARFIELD	57,813	11	7,348	14	12.71%	46
GARVIN	27,210	35	4,103	33	15.08%	34
GRADY	45,516	17	5,561	25	12.22%	51
GRANT	5,144	71	474	70	9.21%	63
GREER	6,061	68	927	66	15.29%	31
HARMON	3,283	76	709	69	21.60%	8
HARPER	3,562	74	278	76	7.80%	73
HASKELL	11,792	53	2,604	43	22.08%	7
HUGHES	14,154	46	2,930	41	20.70%	9
JACKSON	28,439	33	4,087	34	14.37%	40
JEFFERSON	6,818	65	1,340	61	19.65%	11
JOHNSTON	10,513	59	1,947	53	18.52%	17
KAY	48,080	15	6,427	17	13.37%	43
KINGFISHER	13,926	47	1,175	64	8.44%	70
KIOWA	10,227	60	1,645	56	16.08%	28
LATIMER	10,692	57	2,126	48	19.88%	10
LEFLORE	48,109	14	9,363	7	19.46%	13
LINCOLN	32,080	31	3,723	36	11.61%	53
LOGAN	33,924	29	3,340	37	9.85%	57
LOVE	8,831	63	1,310	62	14.83%	37
MCCLAIN	27,740	34	2,549	44	9.19%	64
MCCURTAIN	34,402	28	8,884	8	25.82%	2

Figure 19 Statewide Medicaid Figures (continued)

County	Total Annual Expenditures	Rank	Annual Per Capita	Rank	Monthly Per Client	Rank
ADAIR	$15,524,819	35	$738	22	$271	70
ALFALFA	$2,331,000	72	$382	69	$478	10
ATOKA	$10,014,392	45	$722	24	$332	48
BEAVER	$1,267,593	76	$216	75	$289	68
BECKHAM	$13,598,503	41	$687	30	$384	19
BLAINE	$6,811,386	57	$569	42	$356	33
BRYAN	$26,101,068	21	$714	28	$372	26
CADDO	$18,111,399	31	$601	38	$257	75
CANADIAN	$30,162,095	14	$344	70	$376	25
CARTER	$32,715,954	12	$717	27	$348	36
CHEROKEE	$33,038,397	10	$777	16	$353	34
CHOCTAW	$14,759,480	38	$962	8	$303	63
CIMARRON	$664,052	77	$211	77	$196	77
CLEVELAND	$60,612,943	4	$291	73	$330	50
COAL	$5,351,119	61	$887	12	$314	55
COMANCHE	$44,594,228	7	$388	66	$263	72
COTTON	$3,436,527	67	$520	49	$303	62
CRAIG	$19,771,100	30	$1,322	2	*$707	3
CREEK	$41,293,971	8	$613	36	$434	14
CUSTER	$12,393,193	42	$474	54	$314	56
DELAWARE	$22,033,999	26	$594	39	$306	61
DEWEY	$2,535,246	71	$535	47	$508	6
ELLIS	$1,882,582	73	$462	56	$447	12
GARFIELD	$68,187,653	3	$1,179	3	*$773	2
GARVIN	$49,850,960	6	$1,832	1	*$1,012	1
GRADY	$20,031,207	29	$440	60	$300	65
GRANT	$2,851,122	70	$554	44	$501	7
GREER	$3,700,064	66	$610	37	$333	46
HARMON	$3,212,179	69	$978	6	$378	24
HARPER	$1,709,902	74	$480	53	$513	5
HASKELL	$9,234,769	48	$783	15	$296	66
HUGHES	$16,177,692	34	$1,143	4	$460	11
JACKSON	$15,094,131	36	$531	48	$308	59
JEFFERSON	$6,153,066	60	$902	11	$383	20
JOHNSTON	$7,809,050	54	$743	21	$334	45
KAY	$20,177,143	28	$420	62	$262	73
KINGFISHER	$5,340,467	62	$383	67	$379	22
KIOWA	$9,507,614	47	$930	10	$482	9
LATIMER	$8,264,013	53	$773	18	$324	52
LEFLORE	$32,799,241	11	$682	31	$292	67
LINCOLN	$14,181,014	39	$442	58	$317	53
LOGAN	$14,804,467	37	$436	61	$369	27
LOVE	$4,103,674	64	$465	55	$261	74
MCCLAIN	$9,529,268	46	$344	71	$312	57
MCCURTAIN	$28,745,904	16	$836	13	$270	71

Figure 19 Statewide Medicaid Figures (continued)

County	Population 2000 Census [19]	Rank	Clients [20]	Rank	Pop.Covered by Medicaid	Rank
MCINTOSH	19,456	41	3,165	39	16.27%	26
MAJOR	7,545	64	716	68	9.49%	60
MARSHALL	13,184	49	1,970	52	14.94%	35
MAYES	38,369	24	5,405	27	14.09%	42
MURRAY	12,623	50	2,099	50	16.63%	24
MUSKOGEEE	69,451	7	12,157	5	17.50%	22
NOBLE	11,411	56	1,181	63	10.35%	55
NOWATA	10,569	58	1,524	59	14.42%	39
OKFUSKEE	11,814	52	2,274	47	19.25%	16
OKLAHOMA	660,448	1	82,376	1	12.47%	49
OKMULGEE	39,685	22	7,745	12	19.52%	12
OSAGE	44,437	18	4,179	32	9.40%	61
OTTAWA	33,194	30	6,087	19	18.34%	18
PAWNEE	16,612	43	2,109	49	12.70%	47
PAYNE	68,190	8	6,390	18	9.37%	62
PITTSBURG	43,953	19	7,172	15	16.32%	25
PONTOTOC	35,143	27	5,373	28	15.29%	32
POTTAWATOMIE	65,521	10	9,895	6	15.10%	33
PUSHMATAHA	11,667	54	2,709	42	23.22%	4
ROGER MILLS	3,436	75	274	77	7.97%	72
ROGERS	70,641	6	5,905	21	8.36%	71
SEMINOLE	24,894	37	5,640	24	22.66%	6
SEQUOYAH	38,972	23	7,575	13	19.44%	15
STEPHENS	43,182	20	5,519	26	12.78%	45
TEXAS	20,107	39	1,723	54	8.57%	69
TILLMAN	9,287	61	1,639	57	17.65%	21
TULSA	563,299	2	56,527	2	10.03%	56
WAGONER	57,491	12	4,936	29	8.59%	68
WASHINGTON	48,996	13	4,793	30	9.78%	58
WASHITA	11,508	55	1,672	55	14.53%	38
WOODS	9,089	62	883	67	9.72%	59
WOODWARD	18,486	42	2,078	51	11.24%	54

* Note: 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 client to be higher than the norm. If public ICF/MR costs are removed the following are the results: Garfield- $424 and Garvin- $374 per Medicaid client. If the private ICF/MR costs are removed the average cost per client for Craig County is $627.

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

[20] Clients listed above represent an unduplicated count of individuals that were enrolled in Medicaid for the month of June 2001. The data does not represent the number of individuals eligible within the year.

Figure 19 Statewide Medicaid Figures (continued)

County	Total Annual Expenditures	Rank	Annual Per Capita	Rank	Monthly Per Client	Rank
MCINTOSH	$13,758,231	40	$707	29	$362	28
MAJOR	$3,372,529	68	$447	57	$393	18
MARSHALL	$8,495,929	50	$644	35	$359	31
MAYES	$22,396,069	25	$584	40	$345	39
MURRAY	$8,594,479	49	$681	32	$341	40
MUSKOGEEE	$52,366,014	5	$754	19	$359	32
NOBLE	$8,265,198	52	$724	23	$583	4
NOWATA	$6,923,963	56	$655	34	$379	23
OKFUSKEE	$11,131,509	44	$942	9	$408	17
OKLAHOMA	$356,957,173	1	$540	46	$361	30
OKMULGEE	$30,825,856	13	$777	17	$332	47
OSAGE	$17,040,358	32	$383	68	$340	42
OTTAWA	$24,898,755	22	$750	20	$341	41
PAWNEE	$8,359,682	51	$503	51	$330	49
PAYNE	$26,610,548	20	$390	65	$347	38
PITTSBURG	$29,883,855	15	$680	33	$347	37
PONTOTOC	$28,372,724	17	$807	14	$440	13
POTTAWATOMIE	$36,652,100	9	$559	43	$309	58
PUSHMATAHA	$11,358,818	43	$974	7	$349	35
ROGER MILLS	$1,385,531	75	$403	64	$421	16
ROGERS	$23,818,353	24	$337	72	$336	44
SEMINOLE	$24,475,840	23	$983	5	$362	29
SEQUOYAH	$27,950,374	19	$717	26	$307	60
STEPHENS	$21,454,422	27	$497	52	$324	51
TEXAS	$4,268,619	63	$212	76	$206	76
TILLMAN	$6,672,236	58	$718	25	$339	43
TULSA	$286,120,487	2	$508	50	$422	15
WAGONER	$16,622,824	33	$289	74	$281	69
WASHINGTON	$28,126,869	18	$574	41	$489	8
WASHITA	$6,348,926	59	$552	45	$316	54
WOODS	$4,014,258	65	$442	59	$379	21
WOODWARD	$7,549,849	55	$408	63	$303	64

[19] County Population 2000 Census figures were downloaded from the Oklahoma Department of Commerce website. (www.odoc.state.ok.us)

[20] Clients listed above represent an unduplicated count of individuals that were enrolled in Medicaid for the month of June 2001. The data does not represent the number of individuals eligible within the year.

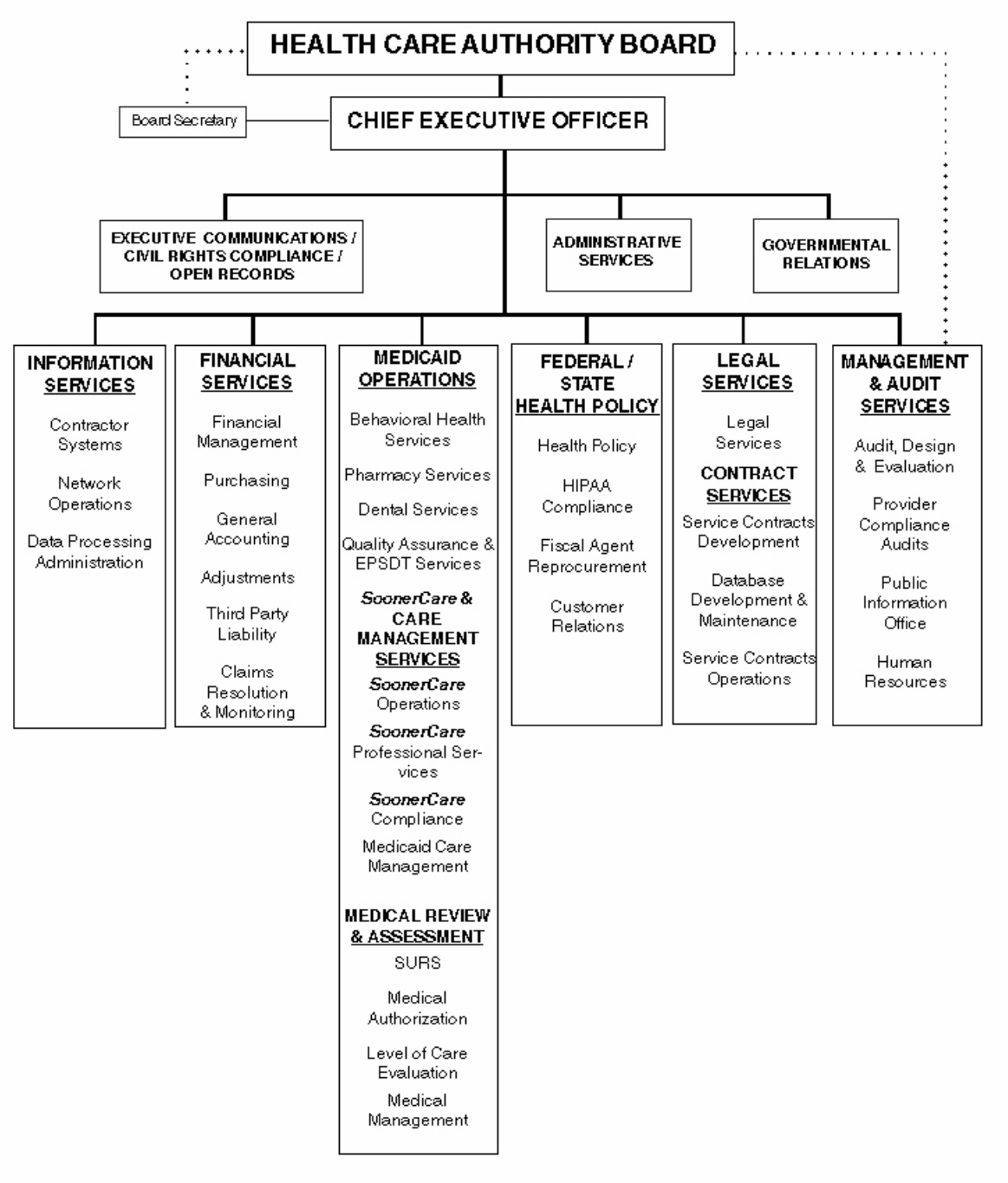
Figure 20 Dollars Paid to Providers and Clients by County in SFY2001

County	Total Dollars Paid by Provider County	Total Dollars Paid by Client County	% of Dollars Staying in County
ADAIR	$7,922,001	$15,524,819	51%
ALFALFA	$1,406,604	$2,331,000	60%
ATOKA	$6,061,252	$10,014,392	61%
BEAVER	$925,692	$1,267,593	73%
BECKHAM	$11,585,450	$13,598,503	85%
BLAINE	$5,294,808	$6,811,386	78%
BRYAN	$31,456,255	$26,101,068	121%
CADDO	$12,462,083	$18,111,399	69%
CANADIAN	$11,676,581	$30,162,095	39%
CARTER	$28,710,366	$32,715,954	88%
CHEROKEE	$23,870,589	$33,038,397	72%
CHOCTAW	$9,323,198	$14,759,480	63%
CIMARRON	$468,853	$664,052	71%
CLEVELAND	$41,990,079	$60,612,943	69%
COAL	$2,807,906	$5,351,119	52%
COMANCHE	$42,953,481	$44,594,228	96%
COTTON	$1,650,712	$3,436,527	48%
CRAIG	$16,989,889	$19,771,100	86%
CREEK	$42,610,906	$41,293,971	103%
CUSTER	$11,118,819	$12,393,193	90%
DELAWARE	$14,471,111	$22,033,999	66%
DEWEY	$1,928,176	$2,535,246	76%
ELLIS	$1,610,438	$1,882,582	86%
GARFIELD	$59,195,868	$68,187,653	87%
GARVIN	$42,891,003	$49,850,960	86%
GRADY	$11,578,539	$20,031,207	58%
GRANT	$1,938,859	$2,851,122	68%
GREER	$2,441,520	$3,700,064	66%
HARMON	$2,489,281	$3,212,179	77%
HARPER	$1,261,888	$1,709,902	74%
HASKELL	$11,687,507	$9,234,769	127%
HUGHES	$7,519,201	$16,177,692	46%
JACKSON	$7,873,255	$15,094,131	52%
JEFFERSON	$4,273,554	$6,153,066	69%
JOHNSTON	$4,669,263	$7,809,050	60%
KAY	$15,574,009	$20,177,143	77%
KINGFISHER	$6,738,960	$5,340,467	126%
KIOWA	$8,152,024	$9,507,614	86%
LATIMER	$3,852,547	$8,264,013	47%
LEFLORE	$23,281,542	$32,799,241	71%
LINCOLN	$7,184,857	$14,181,014	51%
LOGAN	$8,127,206	$14,804,467	55%
LOVE	$1,992,650	$4,103,674	49%
MCCLAIN	$6,528,668	$9,529,268	69%
MCCURTAIN	$21,404,785	$28,745,904	74%

Figure 20 Dollars Paid to Providers and Clients by County in SFY2001 (continued)

County	Total Dollars Paid by Provider County	Total Dollars Paid by Client County	% of Dollars Staying in County
MCINTOSH	$10,944,937	$13,758,231	80%
MAJOR	$2,319,891	$3,372,529	69%
MARSHALL	$5,140,899	$8,495,929	61%
MAYES	$9,950,732	$22,396,069	44%
MURRAY	$5,155,771	$8,594,479	60%
MUSKOGEEE	$52,646,891	$52,366,014	101%
NOBLE	$6,208,394	$8,265,198	75%
NOWATA	$5,253,186	$6,923,963	76%
OKFUSKEE	$7,861,568	$11,131,509	71%
OKLAHOMA	$520,740,181	$356,957,173	146%
OKMULGEE	$21,363,695	$30,825,856	69%
OSAGE	$5,848,925	$17,040,358	34%
OTTAWA	$20,789,137	$24,898,755	83%
PAWNEE	$6,236,812	$8,359,682	75%
PAYNE	$23,332,607	$26,610,548	88%
PITTSBURG	$25,711,237	$29,883,855	86%
PONTOTOC	$32,753,885	$28,372,724	115%
POTTAWATOMIE	$18,590,438	$36,652,100	51%
PUSHMATAHA	$8,417,350	$11,358,818	74%
ROGER MILLS	$592,228	$1,385,531	43%
ROGERS	$15,517,935	$23,818,353	65%
SEMINOLE	$17,784,595	$24,475,840	73%
SEQUOYAH	$21,990,148	$27,950,374	79%
STEPHENS	$16,987,463	$21,454,422	79%
TEXAS	$4,114,525	$4,268,619	96%
TILLMAN	$3,447,731	$6,672,236	52%
TULSA	$357,317,098	$286,120,487	125%
WAGONER	$5,798,889	$16,622,824	35%
WASHINGTON	$20,167,414	$28,126,869	72%
WASHITA	$3,161,891	$6,348,926	50%
WOODS	$3,038,199	$4,014,258	76%
WOODWARD	$7,133,119	$7,549,849	94%

Figure 21 OHCA's Organizational Chart



Organization as of June 30, 2001.
FY2001 authorized FTE 276.5

Core Function Summary

Executive Office Support

Executive Communications/Open Records documents, controls and distributes for informational purposes and for timely responses to requests, all federal, state and other customer correspondence which comes addressed only to OHCA or which agency personnel have authorized the unit to process. *Director, Donna Huckleberry (405) 522-7452.*

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

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

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

Medicaid Operations

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

Behavioral Health Services interfaces with other state agencies, consumer groups, providers and internal OHCA units regarding Medicaid policies related to behavioral health services, provides operational monitoring and support for Oklahoma Foundation for Medical Quality (OFMQ) prior authorizations and review services, as well as evaluates and coordinates requests for placement in out of state residential treatment. Behavioral Health Services also develops new purchasing methodologies and behavioral health services in order to improve efficiency and effectiveness to care purchased by the Medicaid program. *Director, Terrie Fritz, L.C.S.W. (405) 522-7377*.

Pharmacy Services performs concurrent and retrospective reviews for drug claims for quantity abnormalities, drug rebates and reversals of claims that result in recoupment of Medicaid dollars and provides a service to providers regarding Federal Upper Limits (FUL) and service to providers and clients regarding compensability and eligibility. The Drug Rebate Unit within Pharmacy Services, plans, coordinates and processes activities of the Medicaid Drug Rebate Program which includes invoicing and collecting rebates and interest, adjusting erroneous pharmacy claims, resolving rebate disputes and federal reporting of receipts and receivables.
Director, Nancy Nesser, R.Ph. (405) 522-7325.

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

Core Function Summary (continued)

Medicaid Operations (continued)

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

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

SoonerCare Operations consists of Member Services and Contractor Services. Member Services coordinates and facilitates resolution to issues / concerns addressed in internal reports, incident reports and telephone calls. Member Services additionally researches and resolves members' calls and issues related to dire medical needs and follows up with members on as needed basis to ascertain care received, as well as identifies and participates in member outreach activities to promote member selection of PCP / CM or health plan as county residency dictates and works in collaboration with the DHS county offices to resolve issues regarding member eligibility and identifies system "barriers" that promote inaccurate transmission of data from DHS to OHCA, advising and supporting resolution of these barriers. Another aspect of ***SoonerCare*** Operations is Contractor Services which facilitates, coordinates and participates in provider contracting relating to the ***SoonerCare*** program, which 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. Additionally, Contractor Services also researches and advises regarding provider requested member disenrollment and actively participates in recruitment efforts for ***SoonerCare*** providers to maintain and monitor network capacity and access to care. *Member Services Supervisor, James Reese (405) 522-7345; Contractor Services Supervisor, Nancy Austin (405) 522-7333*.

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

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

Medicaid Care Management administers and facilitates care management services related to medically complex / special health care need members, effectuates and coordinates access to care as it relates to specialty providers initiated by requests for PCP/CMs, incident reports, member calls, interagency referrals and legislative requests, as well as develops disease management processes in collaborations with designated OHCA team to promote "quality of life" by improved monitoring / compliance with selected disease entities. Medicaid Care Management also plans, develops and operationalizes enhanced are Management outreach to select identified Choice and Fee-for-Service population. *Manager, Charlene Benson, R.N., CPUR (405) 522-7488*.

Core Function Summary (continued)

Medicaid Operations (continued)

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

Surveillance Utilization Review Subsystem (SURS) develops comprehensive statistical profiles and utilization patterns of health care delivery and reveals suspected instances of fraud and abuse by individual providers and clients. This unit also provides education and training to providers, through SURS review processes, regarding acceptable utilization and appropriate maintenance of file documentation and claim filings. *Manager, Jana Webb, R.N. (405) 522-7112*.

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

Level of Care Evaluation Unit (LOCEU) coordinates the federal PASRR (Pre-Admission Screening and Resident Review) program statewide, Level I screening all clients entering Medicaid certified nursing facilities (NFs) for possible Mental Retardation (MR) and/or Mental Illness (MI) and conducting Level II assessments to insure that this population requires NF level of care and receives proper treatment for MI and / or MR. LOCEU approves all Medicaid clients for ICF/MR & DDSD Home and Community-Based Waiver level of care and provides medical determination for disability and incapacity of DHS clients. The unit also audits the ADvantage and DDSD ICF/MR and In Home Supports and Community-Based Waiver programs. *Manager, John Russell, M.Ed. (405) 522-7309*.

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

Core Function Summary (continued)

Federal / State Health Policy

Charles Brodt, Director of Federal / State Health Policy

Health Policy develops and presents upcoming policy issues to the Medical Advisory Committee (MAC) for the purpose of receiving direction from the members regarding additional research and / or consideration in addition to receiving requests from the members to research and subsequently report on other policy issues. Health Policy coordinates with the CMS regional office on questions related to Medicaid policy, issues of noncompliance, expenditures and the State Plan, as well as directs 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. Another function of Health Policy is to monitor, analyze and review financial and operational data applicable to specific waiver programs, assuring that each specific waiver program meets all associated federal requirements and is operated within its conditions and limits, in addition to assisting in the preparation and submission of waiver applications and amendments, as well as, required annual reports to the appropriate CMS offices for specific waivers. *Director, Jim Hancock (405) 522-7268*.

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

Fiscal Agent Reprocurement is responsible for preparing the Invitation to Bid (ITB) for a new fiscal agent, as well as plans and implements details relating to the contracting of a fiscal agent, such as coordination of the contracting entity, consultants for OHCA and OHCA staff for timely contract award and implementation. *Coordinator, Richard Evans (405) 522-7101*.

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. The unit answers a large volume of incoming telephone inquiries and correspondence from providers, vendors, clients, DHS county offices, legislators, other state Medicaid agencies and others relating to agency and federal Medicaid policy and OHCA procedures for all Medicaid programs. Customer Relations also reviews and authorizes processing for those specialized claims requiring additional medical documentation. The Provider Training aspect of the unit offers individual and group information and instruction regarding Medicaid policy and claims processing for both ***SoonerCare*** and Fee-for-Service, non-school-based contracted providers in order that these providers may know what healthcare services are covered under Medicaid, understand the Medicaid claim filing process and learn to utilize the system effectively and efficiently to obtain appropriate reimbursement in a timely manner. *Director, Susan Nicholson (405) 522-7360*.

Core Function Summary (continued)

Information Services Division

John Calabro, Director of Information Services

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

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

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

Finance Division

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

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

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

General Accounting draws administrative and Medicaid program federal matching funds in accordance with the US Treasury CMIA Agreement and maintains the general ledger for accounting of all funds, including balancing cash to the Office of State Finance (OSF) and the State Treasurer's Office (STO), and posting of all receipts and expenditures of agency funds. This unit prepares the monthly financial statement reports, quarterly cost allocation schedules and annual Generally Accepted Accounting Principles (GAAP) conversion packages for the statewide Comprehensive Annual Financial Report (CAFR). General Accounting also tracks and reconciles adjudication reports produced by the fiscal agent before authorizing weekly payment tapes to be transmitted to the STO for production of medical warrants, in addition to preparing and processing all agency payrolls, as well as processing all Medicaid provider garnishments and tax levies and reconciling and approving annual 1099 and W2 information.
Director, Carrie Evans (405) 522-7359.

Core Function Summary (continued)

Finance Division (continued)

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

Third Party Liability ascertains the legal liability of third parties to pay for care and services furnished to Medicaid clients and seeks reimbursement from third parties. This unit uses the cost avoidance method of payment when there is a probable existence of TPL at the time the claim is filed, unless a waiver has been approved by CMS, in addition to demonstrating effective and timely submission of third party resource data into the TPL data base, as well as effective and timely recovery of paid claims upon identification of a third party source. *Manager, Lisa Gifford, J.D. (405) 522-7427.*

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

Legal Services

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

Legal Services coordinates all litigation for the agency, renders legal opinions and advises CEO, Board members and agency management on administrative legal issues. This unit also coordinates and hears all Administrative Law Judge (ALJ) appeals filed by providers and clients and represents the agency before administrative, state and federal courts or tribunals.
Director, Howard Pallota, J.D. (405) 522-7431.

Contract Services – Manager, Rolando Davila, J.D.

Service Contracts Development oversees the procurement and / or development of health plan contracts for the ***SoonerCare*** Plus and Choice programs, MMIS Fiscal Agent and the agency's professional services contracts, as well as insures that the agency is adhering to statutory laws, administrative procedures and agency regulations in the procurement of contracted services and interagency agreements, and provides technical expertise to program staff in the development and writing of contractual terms and conditions. *Manager, Debra Johnson (405) 522-7246.*

Service Contracts Operations area develops, maintains and oversees the Professional Provider Contract Procurement System and provides assistance to program providers regarding the contract processes, renewals, payment and reporting requirements, which includes whether they need a Fee for Service or Managed Care contract, contract status, provider numbers and / or effective contract dates, as well as, maintains current database system for sanctioned and terminated providers. *Manager, Peggy Hanson, (405) 522-7370.*

Core Function Summary (continued)

Management and Audit Services

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

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

Provider Compliance Audits develops and collects monthly-submitted Quality of Care Reports from long term care (LTC) facilities statewide and performs monthly desk audits and on-site audits related to verification of submitted information pertaining to resident to staffing ratios, minimum wage for specified staff, and determine penalties for non-compliance. Provider Compliance Audits also coordinates related operational activities with the Finance and Legal Divisions in the determination and collection of any assessed penalties and dissemination of reported information related to the billing of assessment fees, in addition to developing a case-mix Medicaid reimbursement system for all LTC facilities through collaboration with other agencies, interim study groups and the applicable internal OHCA units. *Manager, Teri Dalton (405) 522-7209.*

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

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

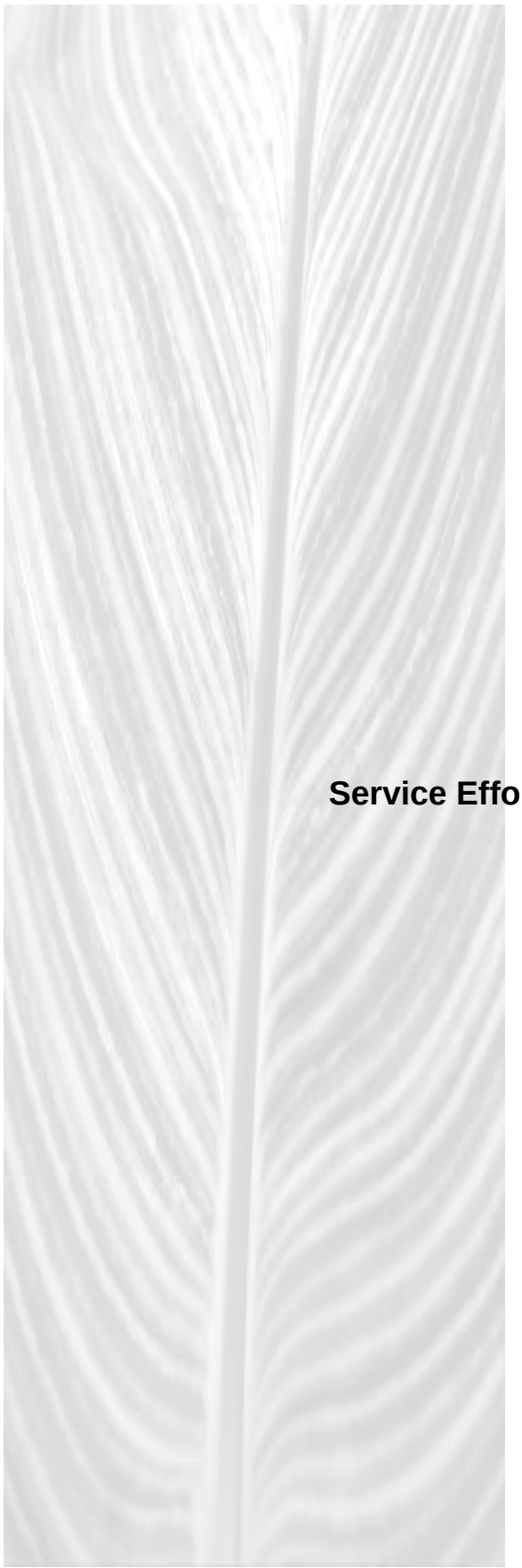
Glossary of Terms

ABD	The **A**ged, **B**lind and **D**isabled Medicaid population.
Capitated Payment	A monthly payment of a predetermined amount, per person, for an individual's required health care services within managed care.
Client	A person enrolled in Oklahoma Medicaid.
CMS	**C**enters for Medicare and **M**edicaid **S**ervices, formally known as Health Care Financing Administration (HCFA), establishes and monitors Medicaid funding requirements.
Eligible	For this report, an individual who is qualified and enrolled in Medicaid, who may or may not have received services during the reporting quarter.
Fee-For-Service (FFS)	The method of payment for the Medicaid population that is not covered under managed care. Claims are generally paid on a per service occurrence basis.
FFY	**F**ederal **F**iscal **Y**ear**.** The federal fiscal year starts on October 1 and ends September 30 each year.
FMAP	**F**ederal **M**edical **A**ssistance **P**ercentage - The federal dollar match percentage.
ICF/MR	**I**ntermediate **C**are **F**acility for the **M**entally **R**etarded.
EPSDT	**E**arly **P**eriodic **S**creening**, D**iagnosis and **T**reatment
SCHIP	**S**tate **C**hildren's **H**ealth **I**nsurance **P**rogram for children under age 18 that have no creditable insurance and meet income requirements. (Title XXI)
SFY	**S**tate **F**iscal **Y**ear. The state fiscal year starts on July 1 and ends June 30 each year.
TANF/AFDC	**T**emporary **A**ssistance for **N**eedy **F**amilies, formerly known as **A**id to **F**amilies and **D**ependant **C**hildren.
Title XIX	Federal Medicaid statute enacted in 1965 under the Social Security Act financed by both federal and state dollars.

Figure 22 Technical Notes

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

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



Service Efforts and Accomplishments
(SEAs)