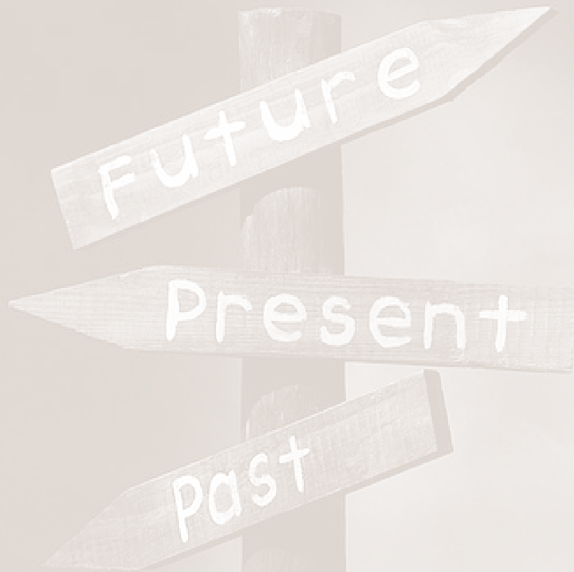
July 2007 - June 2008



Oklahoma Health Care Authority

Service Efforts & Accomplishments

SFY2008

Executive Summary

First and foremost, the Oklahoma Health Care Authority (OHCA) strives to ensure that low-income Oklahomans have access to the health care they need. Through current programs and services as well as the development of new ones, OHCA is continuously working to offer health care choices at the most reasonable cost to the citizens who depend on us. There have been a few detours along the way, but we continue to make headway in our efforts.

SoonerCare operates as the Medicaid funded health insurance program in Oklahoma. As a public service organization, OHCA's destination of a healthy Oklahoma differs from that of private insurance companies who must make a profit. OHCA's interest is not only the cost of purchasing services, but also the use and impact of services on the overall health of Oklahomans.

At the end of state fiscal year (SFY) 2008, 599,598 Oklahomans were enrolled in SoonerCare, a 2 percent drop in enrollment from June 30, 2007 (OHCA Total Enrollment Fast Facts Archives at www.okhca.org/research/statistics and data). The drop in enrollment can be attributed in part to a new federal law that went into effect in July 2007 creating a barrier to health care coverage for many Oklahomans. The federal government and Oklahoma have enacted regulations that require all SoonerCare members and applicants to prove their citizenship. As of July 2008, 53,460 members lost eligibility because "proof" of citizenship had not been provided. To date, no one has been dropped from the rolls due to "lack" of citizenship. As of August, 2008, 46 percent of disenrolled members have returned.

Insure Oklahoma/O-EPIC has seen tremendous growth this year as more and more people become aware of its availability. Over 11,000 Oklahomans employed by more than 2,700 participating businesses were covered through the employer sponsored plan during the year. The individual plan had covered almost 3,000 members by the end of SFY2008.

In 2007, legislation passed expanding Insure Oklahoma/O-EPIC plans to businesses with up to 250 employees and increased the member household income threshold to 250 percent of the federal poverty level (FPL), up from 185 percent. Current information suggests

that the impact on enrollment could be coverage of over 12,000 additional individuals. A waiver to implement these changes has been submitted and the agency is awaiting CMS approval.

Several initiatives were undertaken in SFY2008 to improve access to SoonerCare by easing the enrollment process.

The Electronic Newborn-1 (eNB1) allows newborns to be added to the SoonerCare rolls literally moments after birth. Participating hospitals are able to add newborns through the eNB1 web portal in real time and the enrollment process is completed before mother and baby are released from the hospital. Newborns leave for home with SoonerCare insurance. Mothers choose their babies' primary care providers at the time of enrollment eliminating auto-enrollment, a source of member dissatisfaction in the past.

The provider receives immediate notification of initial eligibility and member information for the baby and can immediately submit claims for services provided. No more waiting for paperwork to go through the system. The average number of days to complete the total process is 3.7 with 94 percent of all eligible newborns being added in less than 10 days. As of June 2008, 1,570 newborns have been added to SoonerCare through 19 participating hospitals. This system will roll out statewide during SFY2009.

The agency is developing a new online-enrollment process through the "No Wrong Door" initiative. This system will provide access to the application process 24 hour-a-day, 7 day-a-week access. Consumers will be able to enroll in SoonerCare and receive real time determination of eligibility. Additionally, the system will inform the user of other services of the state for which the applicant may qualify. No Wrong Door is currently under development and is expected to be in use by October 2009.

These are just some of the developments that have taken place over the year. OHCA is constantly seeking ways to better meet the health care needs of Oklahomans. This report describes some of the key measures tracked by the agency to ensure that our efforts are consistent with the strategic goals and objectives set forth by the Board of Directors.

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Performance Highlights

The following are key indicators to provide a brief look at OHCA's performance. It should be noted that these measures, as well as others, are reported in detail in the sections of the report dedicated to the individual goals. Those sections cover more information which may include trends over the past three years, benchmarks, and / or explanatory data to provide greater context. The page numbers of the sections are provided for easy reference to detail.

Goal 1: Eligibility Measures *(page 17)*

▲ *Outcome: Percent of Oklahomans Enrolled in SoonerCare and Insure Oklahoma/O-EPIC*

▲ *Output: Unduplicated Number of Members Enrolled in SoonerCare and Insure Oklahoma/O-EPIC*

Figure 1: Highlights - Eligibility Measures

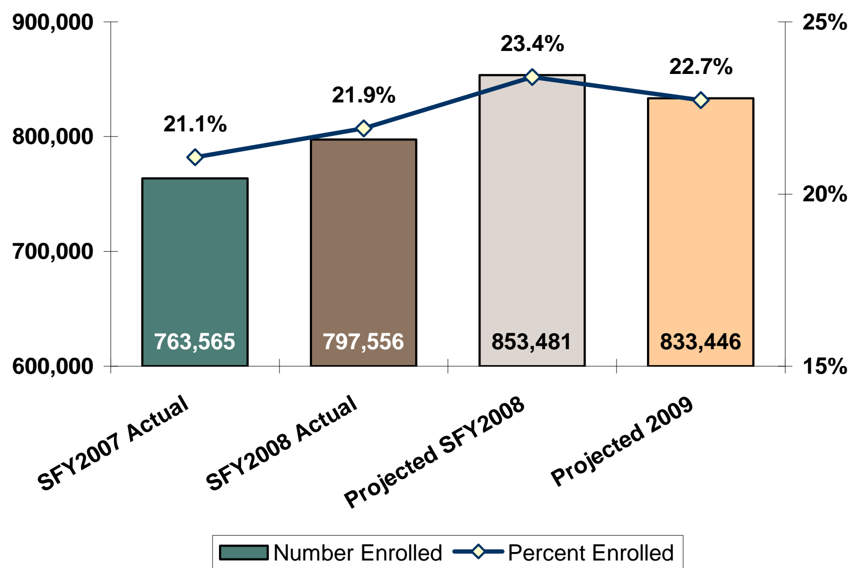


Figure 2: Highlights - Satisfaction & Quality Measures

Goal 2: Satisfaction & Quality Measures (page 27)

▲ *Outcome: Ratio of Appeals Filed to Total Enrolled* *<1/4 of 1%*

▲ *Outcome: Quality Review Scores*

• *Quality Assessment*	*1*
• *Enrollee Rights*	*1*
• *Health Services Management*	*1*
• *Delegation*	*1*

Goal 3: Personal Responsibilities *(page 39)*

Outcome: Well-Child Visits

- *First Fifteen Months*
- *3 - 6 Years*
- *Adolescents*
- *Outcome: Immunization Rate*

Figure 3: Highlights - Personal Responsibilities Measures (1)

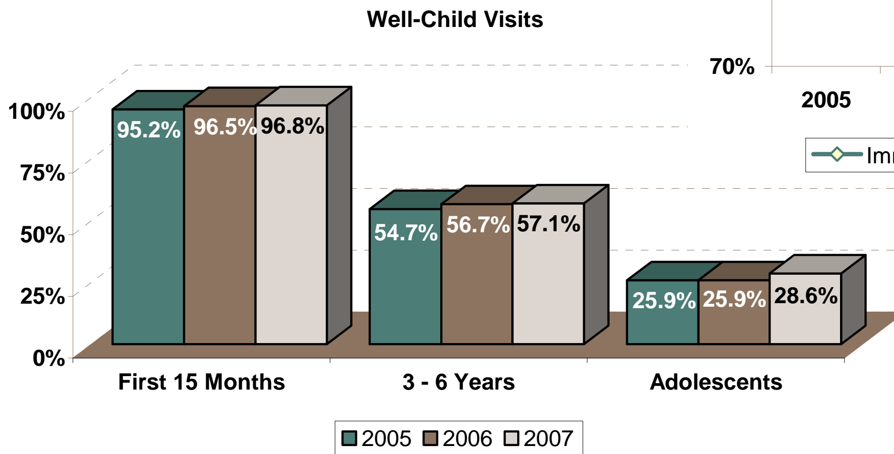
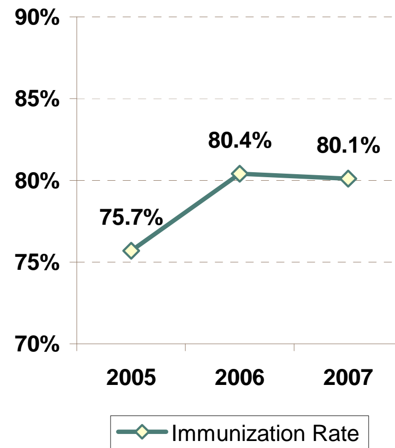


Figure 4: Highlights - Personal Responsibilities Measures (2)



Goal 4: Member Benefits *(page 55)*

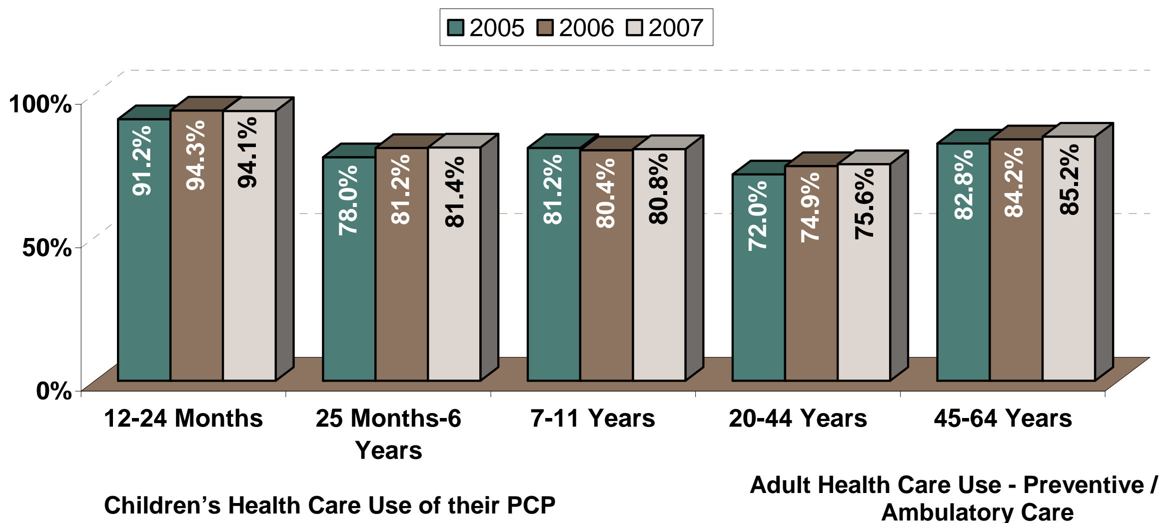
Outcome: Children's Health Care Use of their PCP

- *12 - 24 Months*
- *25 Months - 6 Years*
- *7 - 11 Years*

Adult Health Care Use - Preventive / Ambulatory Care

- *20 - 44 Years*
- *45 - 64 Years*

Figure 5: Highlights - Member Benefits Measures



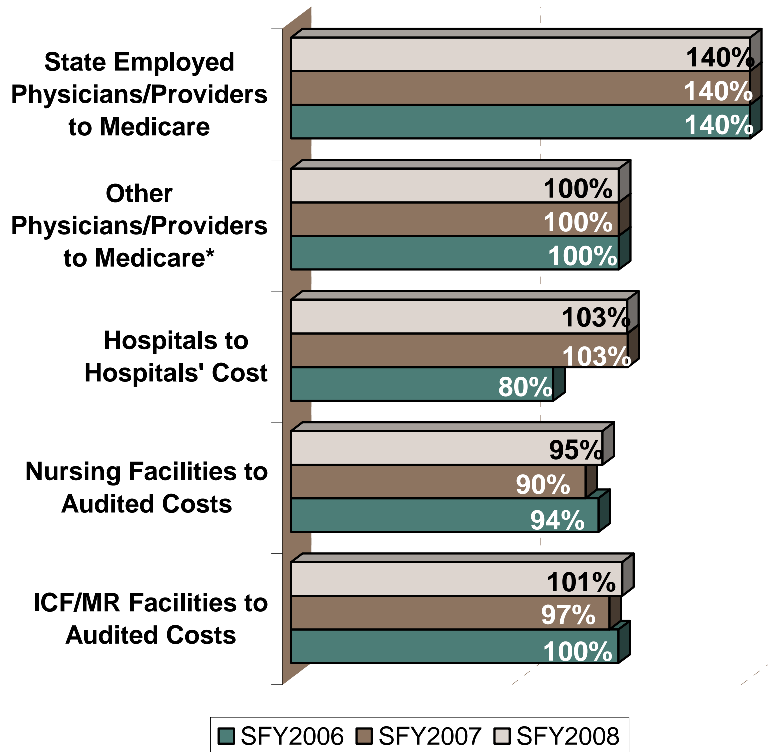
Goal 5: Responsible Purchasing (page 67)

Outcomes: Reimbursement

- State Employed Physicians Compared to Medicare Rates
- Physicians / Other Providers Compared to Medicare Rates*
- Hospital Rates as a Percent of Cost
- Nursing Facilities Rates as a Percent of Cost
- ICF / MR Rates as a Percent of Cost

* *Rounded up from 99.99%; See page 70 for details.*

Figure 6: Highlights - Responsible Purchasing Measures



Goal 6: Administration (page 83)

Outcomes

- Percent of Time Administration Costs Remain Within Budget

Output: Claims

- Processed
- Paid

Output

- Payment Integrity Recoveries

Output

- Calls Answered - Providers & Members

Figure 7: Highlights - Administration Measures

Percent of Time Administration Costs Within Budget

SFY2006 - SFY2008 100%

Claims Processed / Claims Paid / Percent Paid

	Claims Processed	Claims Paid	Percent Paid
SFY2006	$29,878,186	$23,621,535	79.1%
SFY2007	$30,255,290	$23,332,124	77.1%
SFY2008	$32,696,348	$25,309,251	77.4%

	Payment Integrity Recoveries	Calls Answered Providers / Members
SFY2006	$8,969,963	286,531
SFY2007	$9,261,371	334,016
SFY2008	$6,394,754	339,355

Figure :7
Highlights - Administration

Introduction to OHCA's 9th Annual SEA Report

OHCA's Vision

For Oklahomans to enjoy optimal health status through having access to quality health care regardless of their ability to pay.

Why does OHCA report service efforts and accomplishments? The purpose of providing performance information is to ensure that you, who have taken an interest in our mission, have the information you need to evaluate our organization. By providing you with performance data about the resources we've used (inputs), the services we have provided and their impact (outputs and outcomes), as well as efficiency indicators (comparing resources to outputs or outcomes) we hope to offer you the ability to assess our progress and participate in the future health of our state by becoming actively involved in reaching OHCA's vision.

What does this SEA report cover? This report provides information on the overall performance of the SoonerCare program and the Insure Oklahoma/O-EPIC program which constitute 100 percent of OHCA's operations. The report covers state fiscal years (SFY) 2006, 2007 and 2008. State fiscal years begin in July and end in June, i.e. SFY2008 began July 1, 2007 and ended June 30, 2008.

The report provides a high level overview of performance of both insurance programs as well as the administration of the agency including actual past performance and either (1) estimates for future performance, (2) targets for which the agency is striving, or (3) benchmarks to which our performance can be compared. It should be noted that other state agencies, such as the Oklahoma Department of Human Services (OKDHS) and the Office of Juvenile Affairs (OJA) acquire administrative costs related to Medicaid funding. This report is limited to administration costs incurred by OHCA.

Both financial and non-financial data is provided for a complete picture of the agency's use of resources and to clearly distinguish how the resources serve the goals and objectives of the agency.

What might Stakeholders learn from this report:

- *Oklahoma's Citizens* - How has OHCA put to use the resources we've provided?
- *Members & Providers* - What progress has OHCA made in areas such as benefits offered and reimbursement matters?
- *Elected Officials* - What resources should be provided to meet the health care needs of Oklahomans?
- *OHCA's Board of Directors* - How has the agency progressed in meeting our mission and goals?
- *Researchers* - How does OHCA's performance compare to relevant benchmarks or targets?

How is the report laid out? For ease of navigating the report for specific degrees of interest, the report has three levels of detail.

> *Highlighted Performance Measures.* The results of a few key indicators for each goal of the agency is provided to allow a quick summary of the agency's performance.
>
> *Detailed Performance Measures.* Detail sections give a more in-depth look at the highlighted indicators plus additional measures. These sections are also laid out by goal and provide information on the purpose of each measure, three years of results, comparative data (estimates, targets or benchmarks), an explanation of the results, and any actions taken by the agency that may affect the measure or subject area.
>
> *Performance Measures Tables.* Each measure is reported from SFY2004 through 2011 (when available) along with comparative data. The measures are reported by goal in a table format for quick review and trend analysis.

Some measures are pertinent to more than one goal and will be mentioned under each goal to which it is relevant. Detail information will be presented in the section where the measure is first reported. Following notations of the measure will be abbreviated and will refer the reader back to the detail.

Is this information reliable? The purpose of this report can only be achieved by providing information and data that is perceived as accurate. Following is a description of several of the reliability controls in place to monitor the accuracy of data supplied by OHCA's systems, programs and operations. All measures reported will include the source of the information, i.e. MMIS, Unit or Department within the agency, etc.

No information provided in this report is known to be inaccurate or misleading.

Medicaid Management Information System (MMIS). Much of the data provided in this report originates from the MMIS which is the data processing system used to administer claims payment for OHCA programs. The system handles over 30 million claims per year averaging 2.5 million claims per month.

> CMS Certification. OHCA's MMIS has been certified by our federal oversight agency meaning that the Centers for Medicare and Medicaid Services (CMS) has reviewed our system and deemed it efficient, economical and effective for the administration of funding. Because of this certification, OHCA receives a higher federal funding match rate - 75 percent as opposed to the 50 percent we would receive without it.

SAS 70 Audit. The MMIS also undergoes an annual SAS 70 audit based on the standards developed by the American Institute of Certified Public Accounts. This audit, conducted by an independent audit firm, reviews the policies and procedures designed to ensure accurate payment of claims associated with the management information systems and processes. The in-depth review evaluates and tests controls to determine that they are working as intended and performing effectively.

Oversight and Accountability. SoonerCare and Insure Oklahoma/O-EPIC are funded by a federal and state partnership to provide health care for Oklahomans. In doing so, both governments have a responsibility to monitor and account for the two plans' resources and their use. As a steward of those resources, OHCA undergoes scrutiny from a variety of sources.

External Oversight:
Federal. Our federal oversight agency, the Centers for Medicare and Medicaid (CMS), reviews OHCA programs quarterly to ensure the "prudent use of program funds" and a "reasonable degree of assurance" that those funds are being spent properly as outlined in the Social Security Act and Oklahoma's State Plan. Ad hoc reviews are also conducted based on policy and procedures related to federal funding.

OHCA was one of the first states CMS picked for review of claims payment accuracy for the federal fiscal year 2006 (claims paid during the period of October 1, 2005 and September 30, 2006). The Payment Error Rate Measurement (PERM) review, as named in legislation, has been completed and the results are reported in the Administration section of this report on page 87. The agency will be due to undergo another PERM review for federal fiscal year 2009 service claims. OHCA also conducts an internal PERM review very similar to the external federal review.

The agency was chosen as one of the first states to undergo a Medicaid Integrity Program review. This review examined the agency's procedures related to program integrity, such as provider and utilizations audits and provider enrollment procedures.

State. OHCA is audited annually by the Oklahoma State Auditor and Inspector's office under the Single Audit Act of 1984. The Act requires non-federal entities receiving federal assistance to be reviewed to ensure suitable use of the funds based on the parameters on which it was obtained. The audit is performed on the state as a whole and is intended to satisfy all federal agencies providing funds to the state. The most recent report available at the time of this report is for SFY2007 and can be located at http://www.sai.state.ok.us/Search%20Reports/database/OKSingleAudit07.pdf.

Internal Accountability Controls:
Program Integrity (PI) at OHCA resides in the Policy, Planning and Integrity Division. The responsibilities of the PI Department include provider audits,

utilization reviews of services and internal processes and procedures reviews. The Department works closely with other Units and Departments throughout the agency to ensure that program integrity is maintained.

As previously mentioned, OHCA annually conducts an internal PERM review. The process was developed during the agency's participation in the Payment Accuracy Measurement Grant program which eventually resulted in the PERM legislation and the federal reviews discussed in the External Oversight section.

Consistency. The agency consistently reports the same measures annually to provide the reader with a look at performance over time as well as assure the reader of full disclosure. Measures are not changed or dropped because the results are not positive.

With that said, performance measurement is an evolutionary process that requires constant evaluation of the usefulness of individual indicators as well as the need for concise but comprehensive information. Occasionally, better methodologies, the availability of new information or discontinuation of previously reported information makes change necessary.

If any change in reporting takes place, the reason for the change and its impact will be fully disclosed in the detail section of the report.

Citizen Involvement

In the past several years, governments at all levels have acknowledged the need to listen to the individuals they serve, and therefore, an important part of performance includes ensuring that citizens have opportunities to participate or provide input into strategies and decisions. OHCA offers many avenues through which Oklahomans can take part in the process.

Annual Board Retreat. OHCA holds a two day board retreat every year in August. This provides OHCA an opportunity to inform all interested stakeholders on current trends and directions in topics that affect the agency. Time is taken to review the agency's goals, update stakeholders on actions and projects occurring during the year and discuss potential strategies for the future. From this event, the agency develops its strategic plan for the coming year.

The board retreat is always open to the public. Interest in the process has been growing over the years. This year, the agency had to increase the size of the venue to accommodate the approximately 150 attendees - including elected officials, member advocacy groups, and providers. The online registration, new this year, assisted the agency in assuring that all attendees had the information, materials and space to engage in the process. Additionally, the

use of polling equipment allowed individuals and group representatives to take an active role in decision making.

Monthly Board Meetings. Board meetings are held monthly at locations around the state. These meetings inform board members and attendees about current issues affecting the agency, recent performance, and opportunities available to OHCA. These meetings are open to the public and meeting dates are posted on the agency's public website at www.okhca.org/about us/boards.

Medical Advisory Committee (MAC). The MAC is comprised of medical professionals and consumer organizations who meet bi-monthly to discuss the interests and needs of the SoonerCare population. The committee reviews and advises the agency on best practices and medical policies and procedures. MAC meetings are open to the public and are often attended by providers and advocacy groups who actively participate. These meetings are open to the public and meeting dates are posted on the agency's public website at www.okhca.org/about us/boards.

Learn more about

OHCA Boards and Committees

as well as links to meeting dates and agendas at:

www.okhca.org/about us/boards

Drug Utilization Review (DUR). The DUR board is comprised of medical professionals with expertise in pharmaceuticals. The board meets monthly and advises OHCA on appropriate use and best practices related to medications. The DUR reviews such topics as drug therapies and formularies and also reviews public requests related to medication. These meetings are open to the public and are often attended by providers, pharmacy organizations and consumer advocacy groups who actively participate in the meetings. Meeting dates are posted on the agency's public website at www.okhca.org/about us/boards.

Comments and Suggestions.

Do you have a recommendation on how to make this report more informative or relevant to your interests or those of other stakeholders? Please feel free to call or send your input to:

Carol McFarland
Performance & Internal Audits
405.522.7448
Carol.McFarland@okhca.org

Goals & Objectives

OHCA Mission

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.

Agency Goal # 1 - Eligibility

To provide and improve health care access to the underserved and vulnerable populations of Oklahoma.

- *To partner with others to reduce the number of Oklahomans without access to medical coverage.*
- *To strive to enroll qualifying children, parents and other adults into SoonerCare.*

Agency Goal # 2 - Satisfaction & Quality

To protect and improve member health and satisfaction, as well as ensure quality with programs services and care.

- *To maintain a rate of less than 1 percent of the total annual SoonerCare population whose issues elevate to formal appeals.*
- *To seek and evaluate member feedback on satisfaction with services received when accessing SoonerCare benefits.*
- *To achieve and maintain standard quality ratings for the partially capitated care management system (SoonerCare Choice) at the highest rating.*
- *To partner with Oklahoma's Survey and Certification agent to strive for quality long-term care facilities.*
- *To maintain a quality provider community by following appropriate procedures to identify noncompliant providers and determine the appropriate course of action to resolve issues.*

Agency Goal # 3 - Personal Responsibility

To promote members' personal responsibilities for their health services utilization, behaviors, and outcomes.

- *To strive for SoonerCare children to receive necessary preventive care through Child Health / EPSDT services.*
- *To partner with other child serving organizations in the state to strive for Oklahoma's children to meet the federal immunization goal of 90 percent compliance.*
- *To decrease emergency room utilization by increased use of ambulatory services.*
- *To educate members on the use of pharmacy services and monitor their behavior through the Lock-In program.*
- *To increase the number of pregnant women seeking medical care before delivery.*

Agency Goal # 4 - Benefits

To ensure that programs and services respond to the needs of members by providing necessary medical benefits to our members.

- *To strive for SoonerCare members to have Health Care Use that meets or exceeds the national Medicaid standards.*
- *To provide necessary benefits as indicated by the number of member appeals whose benefit complaints elevate to the appeals process compared to total members.*
- *To ensure that long-term care members are correctly placed in the appropriate level of care facilities.*
- *To strive for Oklahoma SoonerCare children to meet or exceed the national Medicaid average for Child Health / EPSDT well-child visits.*
- *To assist members' ability to attend health care appointments by providing transportation through SoonerRide.*

Agency Goal # 5 - Responsible Purchasing / Financing

To purchase the best value health care for members by paying appropriate rates and exploring all available valid options for program financing to ensure access to medical services by our members.

- *To reimburse providers, when applicable Medicare rates are available, at 100 percent of Medicare rates.*
- *To reimburse hospital providers a reasonable percentage of costs.*
- *To reimburse long-term care facilities a reasonable percentage of costs.*
- *To appropriate reimburse providers within state and federal regulations.*

Agency Goal # 6 - Administration

To foster excellence in the design and administration of the SoonerCare program.

- *To consistently perform administrative responsibilities within funding budgeted.*
- *To pay SoonerCare claims within an accuracy rate of at least 97 percent, considering policy and systems issues and member eligibility.*
- *To accurately forecast, based upon available information, and subsequently report agency revenues in a timely manner.*
- *To maintain and / or increase program and payment integrity efforts which may result in recoveries.*
- *To actively pursue all third-party liability payers, rebates, and fees and recover or collect funds due to the SoonerCare and federal Medicaid program.*
- *To train and educate SoonerCare providers, both on an "as-needed" and a proactive basis, through group and / or individual training and other communication.*

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Goal #1 Eligibility

Goal #1 Eligibility

To provide and improve health care access to the underserved and vulnerable populations of Oklahoma.

Uninsured in Oklahoma

According to the Census Bureau's Current Population Survey (CPS), more than 640,000 Oklahomans were uninsured in 2007 including nearly 128,000 children under 18 years old.

A typical uninsured adult in Oklahoma is under 35 years of age, has children, works, earns a salary in the low to middle income range and is unable to afford health insurance. For most uninsured Oklahomans (84 percent), at least one person in the family works either full-time or part-time. The majority (53 percent) have family members who work full time all year.

Nationally, adults who are ineligible for Medicaid represent more than half of the uninsured poor. Low-income, uninsured adults who fall outside federal eligibility categories are a diverse group—ranging from young adults entering the work world to empty nesters in their 50s and 60s. Among uninsured adults ages 19-27, 57 percent go without essential medical services due to the fact they cannot afford the cost of care.

Source: AARP Public Policy Institute, Millions of Low-Income Americans Can't Get Medicaid: What Can Be Done, Stan Dorn, JD, The Urban Institute, September 2008.

Federal Medicaid law restricts who may be covered by Medicaid. Allowable populations include children, pregnant women, the elderly and the disabled. Parents of Medicaid-covered children may also qualify if they earn income at or below 57 percent of the federal poverty level (FPL). This leaves many low-income, childless couples and single adults without needed medical coverage.

Children without health care coverage have substantially less access to health care services compared to insured children. This includes preventive care that ensures childhood immunizations are up to date and that vision and hearing screening and routine dental care have been provided. Statistically, care for these children is far more likely to be delayed due to cost.

Accessibility to medical services for low-income Oklahomans is critical to improving the health of our state. Enrollment in OHCA's insurance plans have grown by 4.5 percent during 2008. The growth is partially attributable to increased enrollment in Insure Oklahoma/O-EPIC (13,800 up from 1,060 in 2006).Insure Oklahoma/O-EPIC consists of two separate plans both financed by the Oklahoma Tobacco tax and matching funds from our federal partner.

Insure Oklahoma/O-EPIC - ESI. The Employee Sponsored Insurance (ESI) plan is offered through the private insurance market by qualified health plans. The number of people covered through Insure Oklahoma/O-EPIC has grown 10 times from 850 enrolled in June 2006 to 8,700 enrolled in June 2008.

ESI is a health coverage subsidy to help small business owners provide health insurance to their lower to moderate income employees and their spouses. Employer participation has increased significantly, from 480 businesses in June 2006 to 2,742 businesses in June 2008. This plan partnership between employers, employees and the state help to make private health insurance affordable for both the employer and the employee. Pending CMS approval, the program intends to expand increasing the size of businesses from 50 employees up to 250 employees.

Insure Oklahoma/O-EPIC - IP. Insure Oklahoma/O-EPIC also has the Individual Plan (IP) that provides coverage to Oklahomans who are self-employed, working for an employer not participating in ESI or unemployed seeking work. Self-employed Oklahomans made up over 49 percent (1,438) of the IP Plan enrollees on June 30, 2008.

"The program has grown significantly since its inception and 90 percent of employers credit Insure Oklahoma as one of the most, or the most, important factors in their decision to offer coverage," said Bert Marshall, president of Blue Cross and Blue Shield of Oklahoma, a division of Health Care Service Corp.

Source: The Journal Record 9/24/08

Objective: To partner with others to reduce the number of Oklahomans without access to medical coverage.

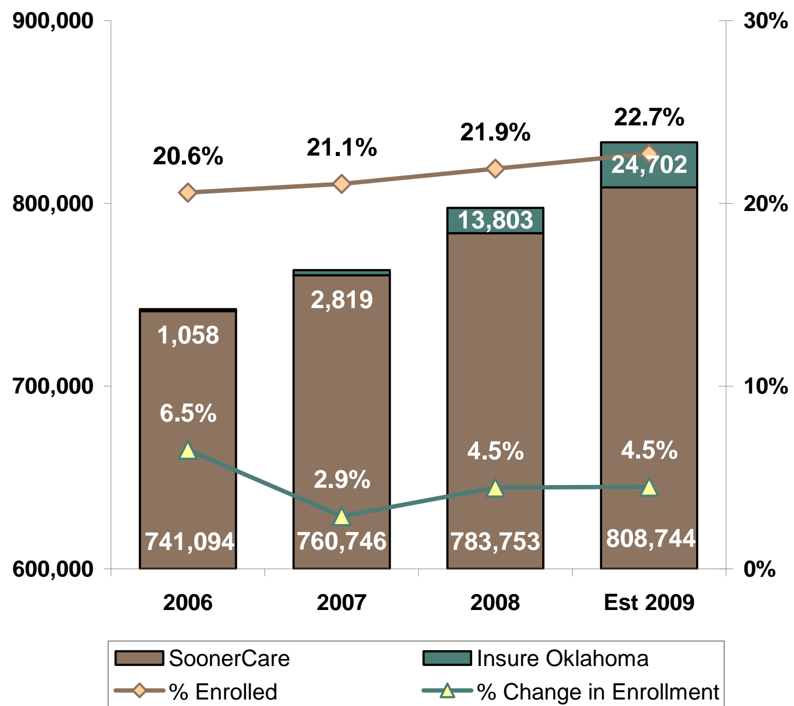
Outcome: Percent Enrolled in SoonerCare and Insure Oklahoma/O-EPIC - *Estimate / See Figure 8*
Output: Unduplicated SoonerCare Enrollment - *Estimate / See Figure 8*
Output: Unduplicated Insure Oklahoma/O-EPIC Enrollment - *Estimate / See Figure 8*
Outcome: Percent Change in Enrollment - *Estimate / See Figure 8*

What does this report? These measures report the number and percent of Oklahomans enrolled in SoonerCare and Insure Oklahoma/O-EPIC and the percent of change from year to year. They reflect OHCA's contribution to reducing the number of uninsured Oklahomans.

What do we compare our performance to? The results can be compared to previous years performance.

Has OHCA set a target for these measures? The agency does not set specific enrollment targets.

Figure 8: SoonerCare & Insure Oklahoma/O-EPIC Enrollment



Source: OHCA MMIS, US Census Bureau

Why report these measures?

Children. Sixty-six percent of the overall SoonerCare population in 2008 were children. Health care coverage for children is important for several different reasons, such as receiving preventive care like immunizations, vision and hearing screenings, early intervention for childhood illnesses and education for a safe and healthy lifestyle. A recent press release by the Robert Word Johnson Foundation indicates that in 2007, 31

percent of uninsured children ages 0 to 17 did not visit a doctor compared to nine percent of insured children; 45 percent did not have a well-child visit compared to 23 percent of insured children.[1]

Adults. It has long been understood that healthy parents are vital to the stability of a family. Medical coverage plays a significant role in the likelihood of adults receiving necessary health care services. A recent article in the Journal of the American Medical Association discussed the results of the effect of insurance coverage on short-term health changes related to unintentional injury and onset of chronic conditions in adults. The study showed that the uninsured were significantly less likely to see a clinician following such an injury or chronic condition. They were also significantly more likely not to receive or complete recommended follow-up care. In the chronic condition sample, the uninsured had significantly more emergency room visits.[2]

What is OHCA doing that might impact these measures. There has been much activity at the federal and state level attempting to improve access to medical care. The federal Deficit Reduction Act of 2005 (DRA) challenged states to develop and implement changes to their Medicaid programs to increase access, quality and cost effectiveness. In Oklahoma, the Legislature was already researching the state's unique needs and in 2006 enacted the Medicaid Reform Act (MRA). These two major legislative acts offered many opportunities and potential enhancements to SoonerCare and Insure Oklahoma/O-EPIC.

> *"An estimated 18,000—22,000 Americans die each year because they don't have health coverage"*
>
> *Source: Dorn, S. "Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality." Urban Institute, 2008, www.urban.org/publications/411588.html.*

[1]*Robert Wood Johnson Foundation, Press Release, Report: Kids With Health Insurance Get Needed Care, While Uninsured Kids Go Without, August 14, 2008, http://covertheuninsured.org/media/releases/index.php?ReleaseID=2017*

[2]*Jack Hadley, PhD, Insurance Coverage, Medical Care Use, and Short-term Health Changes following an Unintentional Injury or the Onset of Chronic Condition, Journal of the American Medical Association (JAMA), Reprinted April 25, 2007, Vol. 297, No 16*

The Oklahoma Legislature has enacted the All Kids Act, allowing SoonerCare to cover children with family income up to 300 percent of the federal poverty level (FPL). In August of 2007, the Centers for Medicare and Medicaid Services (CMS) issued a directive requiring states to enroll at least 95 percent of children below 200 percent of the FPL, that qualify for Medicaid or SCHIP, before they will consider funding higher income children. OHCA has met this requirement and has submitted a waiver to increase the FPL threshold. The agency is awaiting CMS approval of the waiver.

"Confusion over who qualifies for Medicaid or SCHIP and an enrollment process that can be difficult have left one-quarter of the uninsured without coverage despite being eligible for these programs.?

Source: J. Holahan, A. Cook, and L Dubay, 2007 "Characteristics of the Uninsured: Who is Eligible for Public Coverage and Who Needs Help Affording Coverage" KCMU (#7613 October), www.kff.org/uninsured/7613.cfm

Through the Deficit Reduction Act, OHCA received an $6 million dollar transformation grant from CMS to develop an improved application process for individuals seeking to qualify for the program. With these resources, OHCA has developed an online enrollment process. The project known as No Wrong Door (NWD) will make enrollment a web-based process available at any time and anywhere the internet can be accessed. The applicant will receive immediate feedback regarding his eligibility for membership in SoonerCare. Additionally, the application will link to other State programs to inform the applicant of other services he/she may qualify for as well.

The NWD program is a collaboration with Oklahoma Department of Human Services (OKDHS), Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), Office of Juvenile Affairs (OJA), and Oklahoma State and Education Employees Group Insurance Board (OSEEGIB) and has the objective of eliminating many of the barriers that prevent potential members from applying for SoonerCare.

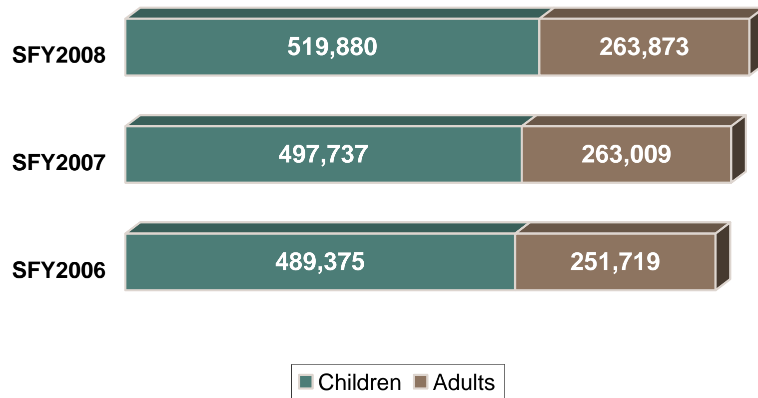
Enrollment Demographics

Objective: To strive to enroll qualifying children, parents and other adults into SoonerCare.
Output: Unduplicated Number of Children Enrolled in SoonerCare
Output: Unduplicated Number of Adults Enrolled in SoonerCare
**No benchmarks are established for demographic information.*

Qualifying For SoonerCare

Along with income criteria related to the FPL, other qualifying criteria must be met. Once the financial and category qualifications are met, applicants become eligible for all benefits available based on the plan in which they are enrolled.

Figure 9: SoonerCare Enrollment by Children & Adults



Source: OHCA MMIS. This information is provided to enhance understanding of the demographics of SoonerCare and therefore, no estimates are made for SFY2009.

Figure 10 reports enrollment information regarding these qualifying categories. Individuals may be counted in more than one qualifying category. For instance, a member may be counted in the Aged, Blind and Disabled (ABD) population and also be considered a dual eligible and/or TEFRA member.

Figure 10: Qualifying Enrollment Categories

QUALIFYING CATEGORY	SFY2006	SFY2007	SFY2008
SCHIP	58,731	66,570	60,651
ABD *	N/A	148,895	143,895
TEFRA	80	176	229
Oklahoma Cares	6,343	7,818	7,541
SoonerPlan	29,997	34,549	34,260
Dual Eligibles	79,236	89,334	96,197

**The ABD population number has been restated from the SFY2010 budget request to correctly reflect unduplicated members in the category.*

Source: OHCA MMIS. This information is provided to enhance understanding of the demographics of SoonerCare and therefore, no estimates are made for SFY2009.

More information can be found for each of these populations on the agency's website at www.okhca.org/research/statistics & data/monthly enrollment fast facts.

SCHIP. This qualifying category was created by the federal government to increase enrollment of uninsured children and offers states a higher rate of financial assistance for children who qualify under this category. SCHIP allows Oklahoma to cover children above the original income limit of 133 percent of FPL up to 185 percent. The funding for these children was hotly debated during the recent federal legislative session due to the approaching expiration date of SCHIP. The result was that SCHIP has been approved for continued federal funding through March 2009.

Aged / Blind / Disabled (ABD). Members in the Aged/Blind/Disabled (ABD) category make up a small percentage of the whole, but make up over half the expenditures of the program. The high cost of their medical care includes nursing home expenditures. Due to changes made to reporting of this population comparable data is not available for SFY2006.

TEFRA. The TEFRA (Tax Equity and Fiscal Responsibility Act) population is made up of children under the age of 19 with physical or mental disabilities who would not ordinarily qualify for Social Security Income due to their parents resources. TEFRA allows these children, who meet the criteria for institutional care but do not qualify for SoonerCare, to remain in the home and receive SoonerCare benefits. This population is a subset of the ABD population.

Oklahoma Cares. This qualifying group is comprised of individuals under the age of 65 who have been diagnosed with breast or cervical cancer, or who need further testing due to abnormal findings or precancerous conditions. Oklahoma Cares members have access to all SoonerCare services until they no longer need treatment related to breast or cervical cancer or no longer meet financial qualifications.

SoonerPlan. A family planning benefits package is available to men and women over age 19 with income below 185 percent of the federal poverty level. This package is limited to family planning only and does not include other SoonerCare services. For SFY2007, the average monthly members in SoonerPlan consisted of 95.4 percent female and 4.6 percent male enrollees.

Dual Eligibles. Dual eligible enrollees are members who qualify for both Medicare and Medicaid.

In 2004, Oklahomans passed a tobacco tax increase designating the collections to be allocated to health improvement issues. OHCA was allocated funds from this tax and tasked with the responsibility to research and develop a premium assistant program for low-income Oklahomans who do not qualify for SoonerCare.

Federal regulations do not allow state Medicaid funds to be used for childless adults. Many parents of SoonerCare children do not meet the income requirements (57 percent of the FPL, $12,084 annual income for a family of four) to qualify for SoonerCare benefits.

Insure Oklahoma/O-EPIC was created to fill the insurance gap for Oklahoma. The program has been rolled out in two phases, Employer Sponsored Insurance (ESI) and Individual Plan (IP).

Figure 11: Insure Oklahoma/O-EPIC Enrollment / Cost Data

Insure Oklahoma (O-EPIC Enrollment)	June 30, 2006	June 30, 2007	June 30, 2008
Number of Businesses Approved	480	1,030	2,742
Number Enrolled: ESI	854	2,416	8,761
Average Premium Assistance Paid: ESI	$244.40	$238.42	$226.83
Number Enrolled: IP	N/A	403	2923
Average Premium Assistance Paid: IP	N/A	$29.58	$34.42

Source: OHCA Reporting & Statistics, Communication Services Division

Figure 12: Insure Oklahoma/O-EPIC Demographics

2008 Enrollment Status	Male	Female
ESI: Employee	3,624	3,687
Spouse	377	1,073
Sub Total	4,001	4,760
ESI Total		**8,761**
IP: Employee	994	1,210
Spouse	164	555
Sub Total	1,158	1,765
IP Total		**2,923**
Total Enrollment		**11,684**

Source: OHCA Reporting & Statistics, Communication Services Division

Figure 13: Insure Oklahoma/O-EPIC Enrollees By Employment Status

2008 IP Employment Status	Enrolled
Employed	1,385
Self-Employed	1,438
Unemployed	95
Working Disabled	5
Total	2,923

Figure 14: Insure Oklahoma/O-EPIC Enrollees By Age

2008 Enrolled By Age	ESI	IP
19-25 Years Old	1,566	260
26-40 Years Old	3,865	1,043
41-55 Years Old	2,484	1,057
56-64 Years Old	846	563
Sub-Totals	8,761	2923
Total Enrolled		**11,684**

Source: OHCA Reporting & Statistics, Communication Services Division

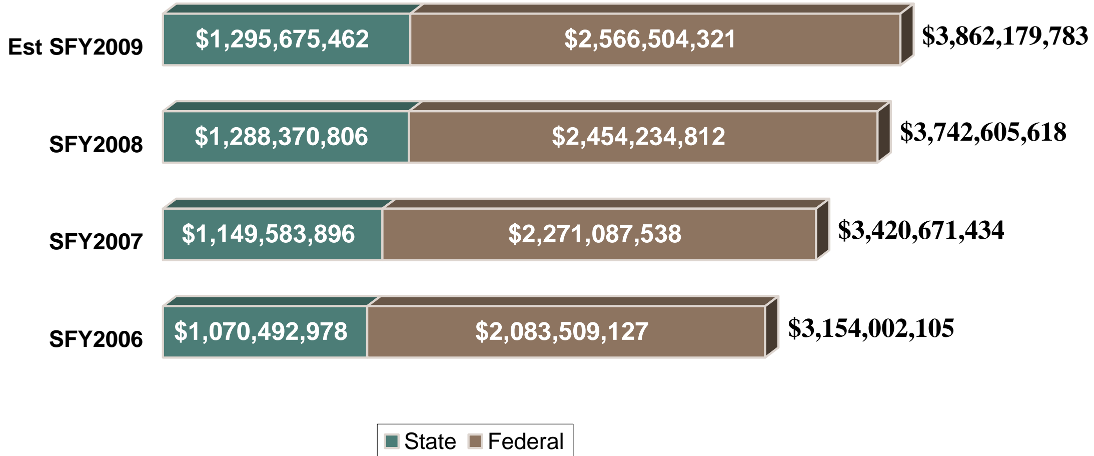
Implemented in November of 2005, Employer Sponsored Insurance (ESI) is a partnership between employers, the insurance community, and state government. Designed for working Oklahomans, qualifying individuals must be employed by participating businesses (50 or fewer employees). Employees and their spouses may participate if their household income is 185 percent or less of FPL. In November 2007, Insure Oklahoma/O-EPIC income criteria was increased to 200 percent of the federal poverty level.

Employers and employees pay a portion of the premiums and employees are responsible for deductibles and co-pays.

In March of 2007, the Individual Plan was implemented to assist individuals meeting the income qualifications. The applicant must be (1) self-employed, (2) working for a business with 50 or fewer employees that is not participating in ESI, (3) unemployed and eligible to receive unemployment benefits, or (4) disabled working for any size employer. Participants pay minimal premiums and any deductibles and co-pays.

Cost Measures

Figure 15: Cost of SoonerCare: State & Federal

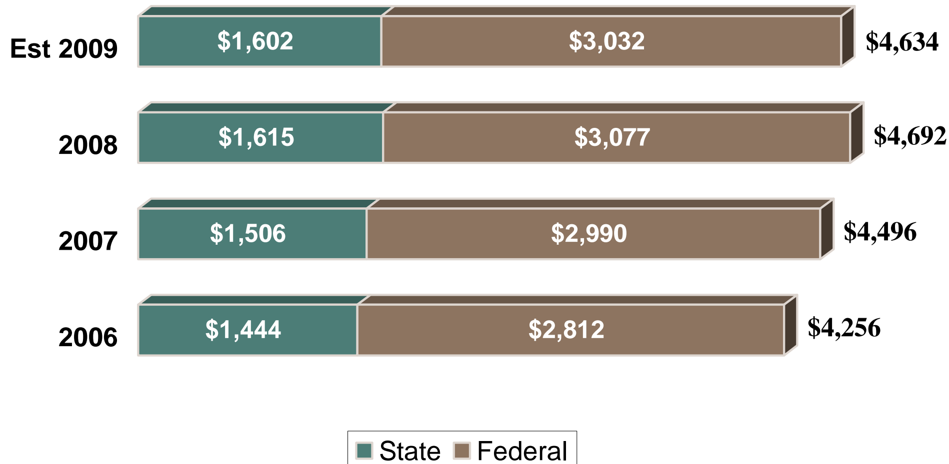


Source: OHCA Financial Services Division

Cost information is essential to understanding the full impact of Medicaid funds on Oklahoma. SoonerCare requires significant resources, but in turn contributes to the economy by bringing in much needed federal dollars. Increasing enrollment in SoonerCare contributes to lowering the number of uninsured, improves the health of our citizens and decreases the burden of uncompensated care on the health care industry.

Competition for shrinking resources and rising health care costs keep Medicaid in the forefront of budget decisions at both the federal and state levels. SoonerCare resources account for a major portion of our health care expenditures, directly impacting the state's economy, specifically the medical community, through the attraction of federal dollars and the circulation of resources throughout Oklahoma.

Figure 16: Cost of SoonerCare Per Member: State & Federal



Source: OHCA Financial Services Division

Goal #2 Satisfaction & Quality

To protect and improve member health and satisfaction, as well as ensure quality, with programs, services and care.

At OHCA, one of our main goals is to strive for member satisfaction with health care services through the plans we offer. Satisfaction and quality are difficult areas to measure because of their constant progression. To continue to satisfy our members, we take on many new challenges and pursue new opportunities, participate in research and studies that could affect our members and constantly monitor our current responsibilities. OHCA keeps the mission and goals in sight when planning new ideas, projects, actions and activities in order to anticipate the impact to our consumers, our providers, and our state.

Through key performance measures, this section informs stakeholders of the agency's continuing efforts for excellence in the quality of services offered to our members.

For your information:

OHCA participates in two processes that contribute and/or measure our success in satisfying our members and providing quality services.

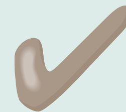
CAHPS®: The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys are developed by the Agency for Healthcare Research and Quality (AHRQ) and the National Committee for Quality Assurance (NCQA) for the purpose of evaluating patients' satisfaction with their health plans.

To evaluate the services received by SoonerCare Choice members, surveys are directed at several topics. These topics range from rating their health plan and healthcare services to how they feel about their physician and his or her office staff. The CAHPS survey is conducted annually, alternating between an adult survey or a child survey every other year.

Quality Scores. Previously, the Quality Improvement System for Managed Care (QISMC) was used to assess the quality of the infrastructure, operations, and strengths and weaknesses of SoonerCare Choice. Recently, CMS discontinued QISMC for Medicaid managed care programs. Because of the oversight value of the tool, an equivalent review of 122 measures was developed and executed. The measures are divided into four domains and are reviewed by a peer review organization. The results are reported as outcomes in the SoonerCare "Choice Quality Score".

For your information:

The Quality Assurance Committee (QAC) at OHCA evaluates the health care provided to SoonerCare members to ensure that it is adequate and appropriate. They also make sure that procedures are in place to assure quality in agency operations. The committee informs administration of the results of their efforts, and when necessary, reports information to regulatory and governing bodies.



The QAC also reviews and makes recommendations on quality intervention issues, clinical studies, administrative service issues, utilization review, and quality assessments.

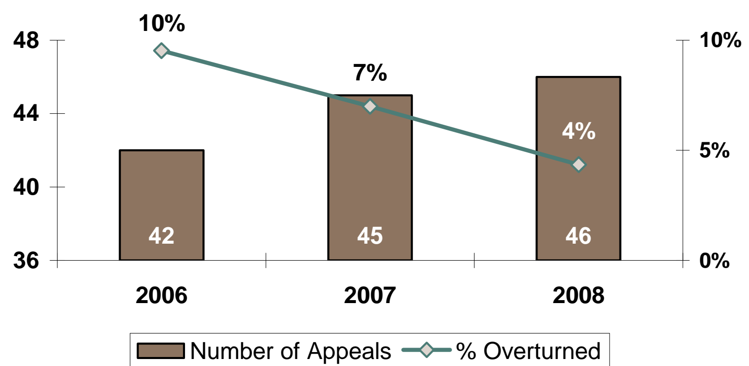
Minding Our P's & Q's. In order to promote quality programs and satisfied members, OHCA participates in several quality initiatives through grants, studies and other opportunities. For the past several years, OHCA has been reporting on the quality initiatives undertaken by the agency in the annual Minding Our P's & Q's - Performance and Quality report. The reports are available on OHCA's website at www.okhca.org/research/studies.

Objective: To partner with others to reduce the number of Oklahomans without access to medical coverage.
Outcome: Number of Member Appeals Filed During the Period - *Benchmark / <40**
Outcome: Ratio of Appeals Filed to Total SoonerCare Population - *Target / <1/4 of 1%*
Output: Percent of OHCA's Decisions Overturned in the Appeals Process - *Target / <10%*

What does this report? These measures report how many formal appeals are filed during the year and how it compares to our membership numbers. Also reported is the percent of those appeals that resulted in OHCA's decision being overturned.

What do we compare our performance to? The results of the measures are compared to the agency's performance over time.

Figure 17: Appeals and Decisions Overturned



Ratio of Appeals to the Total SoonerCare Population

SFY2005 - SFY2007: <1/4 of 1%

Source: OHCA Legal Division

Has OHCA set a target for this measure? The agency would most definitely like to see members completely satisfied resulting in no appeals. But the truth of the matter is, OHCA is limited by federal and state regulations, resources, and competing interests.

*OHCA has no interest in creating barriers or circumventing the appeals process. While it is often challenging, the process offers protection for our members and can reveal issues that require attention at the appropriate level, whether within the agency, or at the state or federal level. Therefore, we report a benchmark of <40 not as a goal to achieve, but rather as a yardstick for trend analysis.

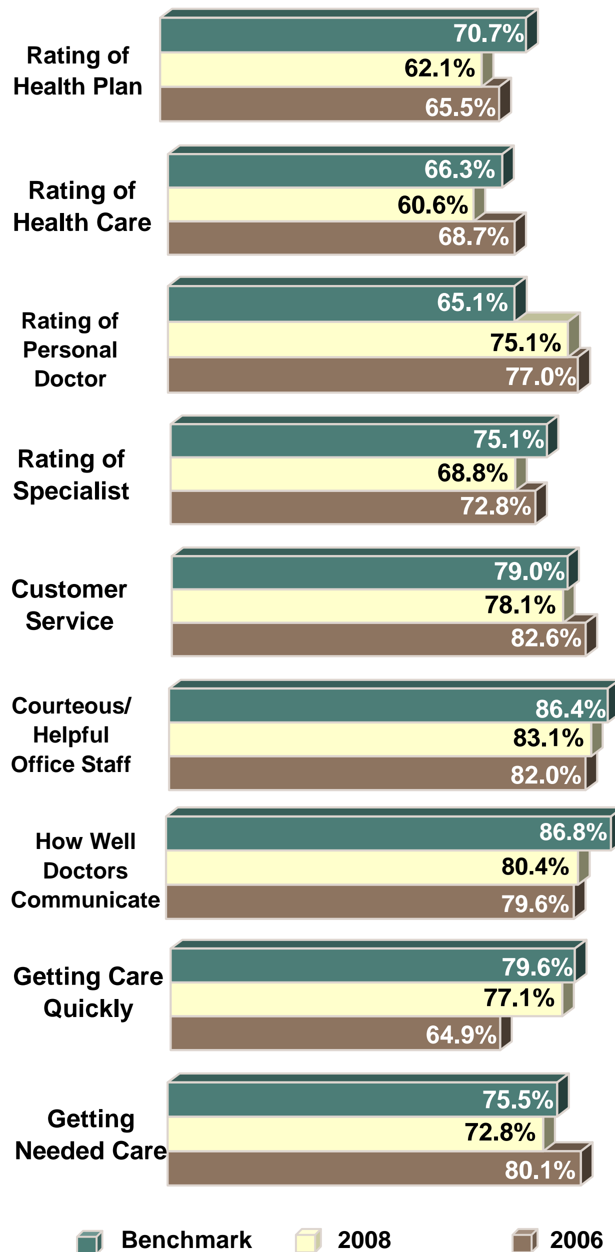
Why report this measure? This measure represents one avenue of measuring member satisfaction with SoonerCare programs and services. Through the appeals process, members can elevate a concern or complaint to a formal grievance where it is externally reviewed. OHCA uses the information from the appeals process to gage the satisfaction of our members and identify areas to address through policy, procedures, and education.

The chart shows that appeals have remained fairly steady over the past three years, however, the percent of OHCA decisions that have been overturned through the appeals process has declined. This indicates that external reviews have generally resulted in agreement with the agency's findings on grievance issues.

Objective: To seek and evaluate member feedback on satisfaction with services received when accessing SoonerCare benefits.

Outcome: Customer Satisfaction Survey Results - *Target / To meet or exceed the national benchmark*

Figure 18: Customer Survey (CAHPS®) Results



Source: The Myer Group, CAHPS® 2008 Medicaid Adult Survey, Oklahoma Health Care Authority Final Report, Project Number 44714.

What does this report? These measures report SoonerCare members' responses to a survey regarding their perception of various aspects of their health care experience. Because the adult survey is conducted every other year, data is reported for calendar years 2006 and 2008.

What do we compare our performance to? The CAHPS numbers reported are compared to the Medicaid national mean benchmark information reported by The Myers Group taken from the NCQA 2007 Quality Compass®. This report is a sample of 108 Medicaid Summary Rates that chose to report their numbers publicly to NCQA. By comparing the results of our survey to those of other Medicaid funded plans, OHCA is able to assess SoonerCare and its providers' performance through the opinion of our members.

There are some limitations to comparability with the national mean benchmark. For instance, regions around the nation have differing health care needs and status which may affect the perceptions of the members. Additionally, Medicaid funded plans around the nation are structured differently and/or have varying levels of resources available to them.

Has OHCA set a target for these measures? OHCA would prefer to have all members completely satisfied with their health care experience. However, the agency does not set specific targets for these measures, but uses the information to inform projects and service structures.

Why report these measures? Keeping members satisfied and giving them quality medical care involves more than just their encounter in the exam room. Their experience extends to interaction with the office staff, how quickly they are able to see their doctor, how well the doctor communicates with them, etc. Literature reports that a positive experience with the medical process correlates to the likelihood of individuals following medical advice and scheduling follow-up appointments.

The CAHPS survey conducted every year reports how the SoonerCare members perceive their health care plan and identifies areas of dissatisfaction. Adult SoonerCare members, for the most part, indicated that their level of satisfaction has deteriorated in the time period between surveys. While members reported a slight improvement in the areas of customer service and getting care quickly, all other areas declined. Significant decreases were noted in the areas of rating health care and their personal doctor.

What is OHCA doing that might impact these measures? The agency is currently transitioning to the “medical home” model of reimbursement in the partially capitated care management (PCCM) plan. In this model, providers receive a small capitated payment for care management services provided to their SoonerCare patients. This fee varies based on the characteristics of the SoonerCare patients they agree to serve, the types of services offered, and quality initiatives undertaken by the provider. In return, the provider is able to bill fee-for-service for care given to the members that previously would have been considered part of the capitated payment.

In the “medical home” model, providers’ reimbursement is better aligned with the services provided. Providers are not required to provide specific services in return for a capitated fee which may or may not be sufficient to cover costs. Nor do they receive payment for services not performed. OHCA anticipates that this will improve the cost/benefit ratio for providers and facilitate members getting in to see their physicians appropriately.

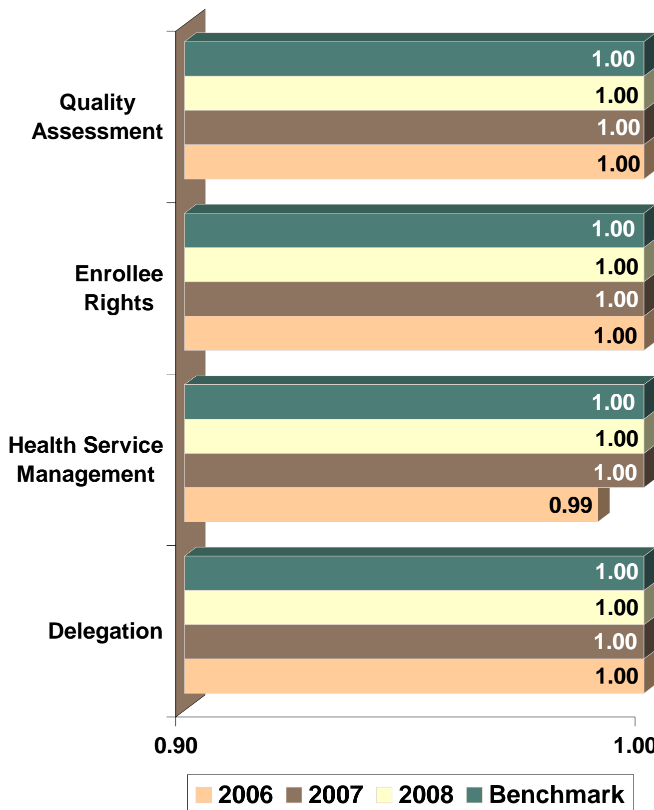
Objective: To achieve and maintain standard quality ratings for the partially capitated care management system (SoonerCare Choice) at the highest rating.

Outcome: SoonerCare Choice Quality Scores - *Target* / *1.00*

- Domain 1: Quality Assessment
- Domain 2: Enrollee Rights
- Domain 3: Health Services Delivery
- Domain 4: Delegation

What does this report? The quality review evaluates two valuable items, quality control and quality assurance. By evaluating quality control, it reports OHCA's success at adhering to quality standards. By evaluating quality assurance, it reports how well OHCA is maintaining quality standards. This review evaluates criteria divided into four different areas (domains):

Figure 19: SoonerCare Choice Quality Scores



Source: OHCA External Quality Review Report, SoonerCare Choice, Report for State Fiscal Year 2008, July 2008, Submitted by APS Healthcare

- Quality Assessment / Performance Improvement focuses on the Quality Assurance Program, the policy-making bodies in place to administer the program, the projects it generates to improve quality services and the data system in place to ensure accurate, timely and complete data collection.

- Enrollee Rights confirms that the organization articulates enrollees' rights, promotes the exercise of those rights and ensures that its staff and affiliated providers are familiar with enrollee rights. This section highlights the importance of enrollees' interactions with the organization and its providers.

- Health Services Delivery covers six distinct areas of health care service delivery: (1) availability and accessibility, (2) continuity and coordination of care, (3) services authorization, (4) practice guidelines and new technology, (5) provider qualifications and selection, and (6) enrollee health records and communication of clinical information.

- Delegation - reviews how the organization oversees and is accountable for any functions or responsibilities described in the previous domains that are delegated to other entities.

What do we compare our performance to? The Choice Quality Scores are compared to OHCA's previous scores to trend performance over time. OHCA has consistently scored high in all domains. OHCA's score has improved from the .99 score received in the Health Services Delivery domain in 2005 and 2006.

Has OHCA set a target for these measures? OHCA strives for a 1.00 in all four domains.

Why report this measure? OHCA reports this information as a measure of the quality initiatives undertaken by the agency and the high standards maintained. Previously, the results of this measure were reported as the QISMC scores. For more information on the change, see the Quality Scores section on page 28.

More information on the results:

Quality Assessment / Performance Improvement: The agency was in full compliance with the standards measured which included quality studies such as the CAHPS customer satisfaction survey, the ER utilization project and the SoonerCare Choice perinatal care project.

Enrollee Rights: The agency was in full compliance with the standards measured which included a review of the various ways members are notified or ensured of their rights to such things as choice of primary care provider (PCP), provider program compliance, availability of specialty services and a formal grievance process.

Health Services Delivery: OHCA continues to rate high in this domain that focuses on the provision of services and the organizational infrastructure sufficient to support the programs essential for providing necessary services to our members.

Delegation: The SoonerCare Choice program does not delegate services to other organizations. Only operational functions are delegated, i.e. transportation and call center services. OHCA monitors these functions and has contractually retained the right of revocation or other remedies if inadequate performance is identified.

Objective: To partner with Oklahoma's Survey and Certification agent to strive for quality long term care facilities.

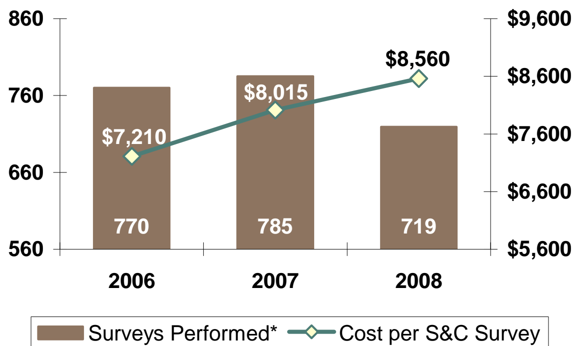
Output: Number of Survey & Certification (S&C) Surveys Performed*

Efficiency: Cost per S&C Survey*

Input: Cost of S&C Contract - *Estimate SFY2009*

** Results for this measure are based on data provided by the Oklahoma Department of Health. No estimate of future performance has been provided; therefore no estimates or projections are made for these measures.*

Figure 20: Certification Surveys Performed / Cost Per Survey



Cost of Survey & Certification Contract

SFY2006: $5,551,738
SFY2007: $6,291,593
SFY2008: $6,154,327
Estimated SFY2009: $6,561,000

Source: Oklahoma Department of Health; OHCA Financial Services Division

What does this report? This measure reports the number of Survey and Certification (S&C) Surveys completed by the Oklahoma State Department of Health (OSDH), the cost of the S&C contract and the average cost per survey.

In Oklahoma, the responsibility for monitoring the quality of nursing home care is shared between OHCA, OSDH, and CMS. OHCA contracts with OSDH to conduct S&C surveys of all nursing homes. Qualified health professionals from OSDH visit nursing homes and evaluate the facilities against federal and state regulatory standards. They look at a broad range of items from facilities' structural condition to reviewing medical records and interviewing residents. This information is used to determine the facilities' eligibility to provide services to Medicaid members. To see results from the S&C process, go to CMS' website, Nursing Home Compare at www.medicare.gov.

What do we compare our performance to? OHCA compares this information to that of previous years to determine trends and project future costs.

Has OHCA set a target for this measure? S&C Surveys are performed by the OSDH who provides us with the number of surveys performed. A target for this measure is not reported by OSDH. We have reported the estimated contract cost for SFY2009, but have not attempted to project a cost per survey.

Why report these measures? Many Oklahomans currently have family members who live in long-term care facilities or live in a nursing home themselves. As Oklahoma's population ages, many will be faced with long-term care decisions for themselves and / or loved ones.

Reasons for entering nursing homes vary depending on the health status of the individual. Some may only use nursing home services for a short time because they need sub-acute care like skilled nursing or therapies. Other people use nursing homes for long term care. They need a broad range of personal, social and medical services due to functional or cognitive limitations that impair their ability to take care of themselves in an independent living situation. Ensuring that members in this environment have safe and healthy living conditions and access to necessary medical care is vital to our members and our state.

In recent years, the number of surveys conducted have remained somewhat consistent while costs have swelled significantly. Much of this can be attributed to the increased costs of travel to perform onsite visits.

Figure 21: Percent of Quality of Care Fees Collected

Source: OHCA Financial Services Division

What is OHCA doing that might impact these measures? With Oklahoma's aging population and the rising cost of health care, the importance of quality nursing home services is critical. OHCA has several ongoing initiatives that contribute to this effort.

Quality of Care Fees - OHCA collects a quality of care fee from all state licensed nursing facilities. These resources are used to help fund certain benefits for nursing home residents, such as eye glasses, ombudsmen, and nursing facility inspectors.

Focus on Excellence (FOE) - OHCA has launched *Focus on Excellence*. The program reviews and rates participating nursing homes on ten performance measures looking at areas such as quality of life, resident/family satisfaction, clinical measures, staffing ratios and employee satisfaction.

As an incentive for continuous quality improvement, Medicaid licensed facilities performing well may be eligible for an enhanced reimbursement rate of up to 4 percent. Results of the reviews are posted quarterly to the Nursing Home Compare

website at www.oknursinghomeratings.com where individuals may search for a nursing home by location and star rating.

Certified Nurse Aide (CNA) Training - OHCA continues its partnership with Oklahoma State University (OSU) to develop and conduct CNA training. The goals of this program are to improve the quality of life for members residing in long-term care facilities and to decrease staff turnover rates. Individuals who agree to work in a Medicaid contracted long-term care facility for 12 to 24 months after successfully completing the course and meet other specific qualifications can receive the training free of charge. For more information, see OHCA's website at www.okhca.org/providers/free Certified Nurse Aide Training.

Community Care

Receiving services in a community setting is typically the most attractive to members and is usually the most cost effective. Home and Community Based Services (HCBS) waivers have allowed the agency to develop resources in the community to allow our members access to health care outside of a nursing home setting when appropriate.

Personal Care Aide (PCA) Training. The agency has added a PCA training regimen through continued collaboration with OSU. The two day training course is geared to "train the trainer," teaching individuals who work with providers of personal care in the community. Training is provided in such topics as understanding mental health behaviors, managing people, personality perceptions and self direction. The training was first held in September 2007 in Oklahoma City, another has been held in Tulsa and more courses are planned for the future. If you would like more information on this program, contact LaQueda Viewins, Projects Coordinator at OHCA, (405) 522-7538.

Money Follows the Person (MFP). The agency has been awarded a $41 million grant by CMS to develop a process that allows individuals to self-direct their long-term care services. Current goals include developing procedures to transition over 2,000 individuals with disabilities or long-term illness out of institutional settings and into the community. These members will have the opportunity to self-direct the use of allotted funds for appropriate long–term care services.

This rebalancing initiative will shift emphasis from long-term care institutional settings, offer options in a home or community-based setting and provide members more control over what services they receive and how. The operational protocol has been approved by CMS effective July 1, 2008 and plans are underway to begin transferring qualifying individuals from institutions into the community beginning in November 2008.

Objective: To maintain a quality provider community by following appropriate procedures to identify noncompliant providers and determine the appropriate course of action to resolve issues.

Output: Number of Involuntary Provider Contract Terminations - *Benchmark / <32*

What does this report? This measure reports the number of providers whose performance indicates they are either unable or unwilling to carry out the contractual obligations required to serve SoonerCare members.

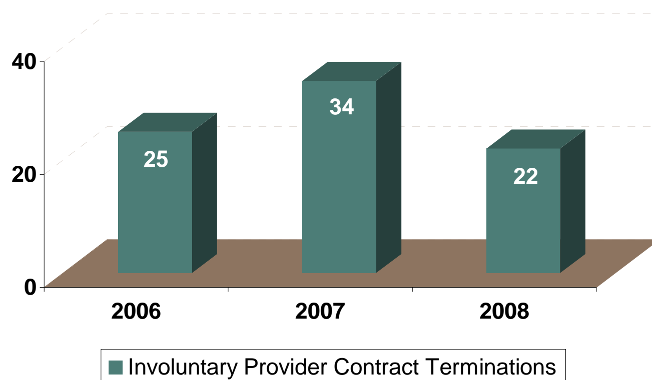
What do we compare our performance to? This information is reported over time for trend analysis.

Has OHCA set a target for this measure? The benchmark reported for this measure is a five year average and used as a tool to assess trends.

Why report this measure? By tracking this information, trends can be followed, subject material for provider training can be identified and monitoring of specific characteristics and issues can be carried out by OHCA.

Quality of services and integrity of operations is vital to successful health care delivery. When an issue or concern is raised, the agency works with providers to deal with obstacles and challenges. Termination is reserved for issues of poor quality of care, unethical billing practices and other problems that negatively impact OHCA stakeholders in which the provider does not take the necessary actions to resolve.

Figure 22: Involuntary Provider Contract Terminations



Source: OHCA's MMIS

What is OHCA doing that might impact this measure? OHCA works to ensure that providers have the information and resources they need to maintain a relationship with the agency. Provider education is offered in a variety of venues throughout the year. Additionally, provider representatives are available to work with providers and their staff to answer questions and give one-on-one assistance when needed.

The SFY2007 number has been changed from 14 contract terminations to 34. The 14 contract terminations included physicians only. The additional 20 contract terminations were providers other than physicians.

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Goal #3 Personal Responsibility

Goal #3 Personal Responsibility

To promote members' personal responsibilities for their health services utilization, behaviors and outcomes.

Members Taking Charge of Their Health

Much literature about improving health outcomes and creating quality services indicates that individuals must take the lead role in their choices and behaviors; choices like seeking care, following up on recommendations and utilizing services correctly. This is particularly true of individuals accessing Medicaid services.

Medicaid serves low income individuals who statistics show are the most likely to report themselves in poor health. A large percentage of the expenditures by Medicaid agencies are spent on those eligible for long term care (21 percent of Oklahomans on SoonerCare account for 58 percent of SoonerCare expenditures).

Figure 23: Health Ranking 2007: Oklahoma & Surrounding States

Source: America's Health Rankings™, A Call to Action for People & Their Communities, 2007 Edition, United Health Foundation

In 2007, the United Health Foundation ranked Oklahoma's health as 47th in the nation (see Figure 23). The study looks at several components including personal behaviors (smoking, obesity, etc.) community environment (poverty, crime, etc.), public health policies (health insurance coverage, etc.) and clinical care (primary care physicians, prenatal care, etc). Figure 23 shows Oklahoma's ranking in comparison to surrounding states.

The Oklahoma Department of Health's (OSDH) 2007 State of the State's Health Report indicates that Oklahoma ranks very high in deaths due to stroke (47th), heart disease (49th) and lung cancer (40th). Oklahoma's average life expectancy is two years less than the national average.

Oklahomans must take responsibility for their health habits. Accessing health care, following recommendations of their medical providers and maintaining a healthy lifestyle are critical to our citizens.

To make the most of the benefits available to them, SoonerCare members need to access preventive and early intervention services. A relationship with a primary care provider is critical:

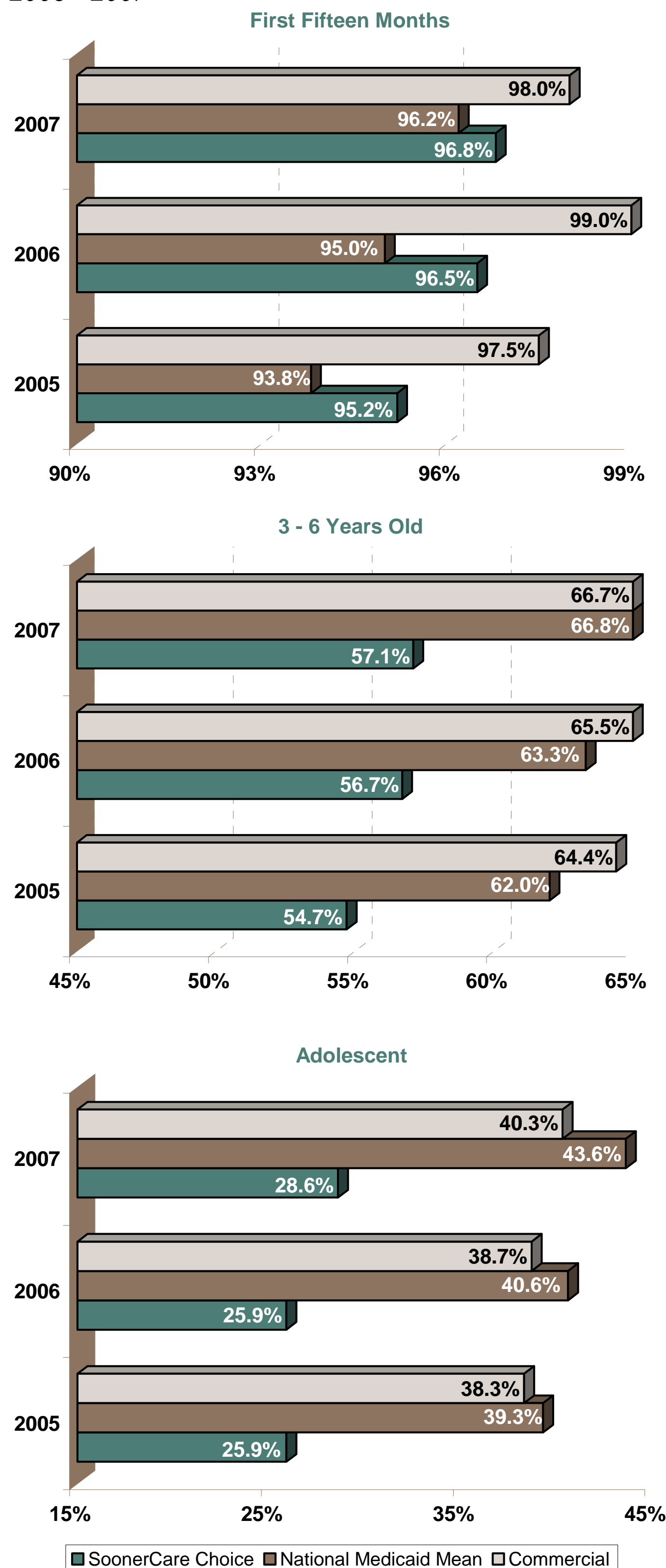
- To ensure members have access to preventive and early intervention care;
- To give providers the ability to track their SoonerCare patients' growth and development and provide continuity of care;
- To give providers the opportunity to educate members on healthy behaviors;
- To give providers the chance to catch health and development concerns early for the most effective care; and
- To provide guidance to members as they negotiate through the health care delivery maze.

For your information:

OHCA utilizes HEDIS® measures to analyze specific behaviors. The Health Plan Employers Data System (HEDIS) is a set of standardized performance measures originally developed to compare health insurance plans. CMS collaborated with NCQA to modify measures to make them functional for Medicaid. OHCA utilizes the HEDIS national Medicaid mean as a benchmark to indicate how SoonerCare compares to other participating Medicaid programs.

This year, the results for commercial insurance have also been included to add a dimension for comparison. HEDIS will be referenced when used for measurement.

Figure 24: Well-Child Visits by Age - Calendar Years 2005 - 2007



Source: OHCA's MMIS Claims Processing System using HEDIS criteria. See page 40 for explanation of HEDIS.

Objective: To strive for SoonerCare children to receive necessary preventive care through Child Health (EPSDT) services.

Outcome: Percent of Children Accessing Well-Child Visits - Child Health / EPSDT

- First fifteen months
- 3 - 6 years
- Adolescents

Target / To meet or exceed the national benchmark

What does this report? The percent of SoonerCare children who visited their primary care provider for a well-child visit during the calendar years 2005, 2006 and 2007. The data is calculated using HEDIS criteria.

What do we compare our performance to? To provide perspective, the National Medicaid Mean and Commercial Insurance Mean, also calculated on HEDIS criteria, are reported for the same periods.

Has OHCA set a target for these measures? No external target has been identified for this measure. OHCA has a schedule of well-child visits recommended based on age and it can be located at www.okhca.org/individuals/programs/child health.

Why report these measures? Well-child visits give a primary care provider the opportunity to evaluate a child physically, behaviorally, developmentally, and emotionally. The provider can detect

disabilities or developmental delays leading to early intervention and better outcomes for the child. The well-child visit also allows the physician to promote healthy behaviors and provide age-appropriate counseling.

As is apparent by the charts in Figure 24, in the First Fifteen Months category, SoonerCare children fair very well in comparison to the National Medicaid Mean. Unfortunately, the same does not hold true for SoonerCare children in the 3 to 6 Year Olds and the 7 to 11 Year Olds categories.

As literature suggests, commercially insured children fair much better than children in Medicaid funded programs. Interesting to note that this is not the case in the 7 to 11 Year Old category, where the National Medicaid Mean has outpaced commercial insurance.

What's the agency doing about this? Ensuring health care coverage for children is a critical issue at all levels of government and all communities. OHCA partners with providers to encourage members to make and attend well-child appointments. In support of their efforts, OHCA offers a bonus to providers who meet or exceed the target Child Health Check-up rate for their patient panel. In 2008, the Child Health Check-up standard was set at 65 percent. OHCA paid almost $900,000 to over 300 providers for meeting or exceeding the target rate.

In addition to the Child Health Check-up bonus program, OHCA has participated, along with 32 other organizations, on a Child Health workgroup. The membership of the workgroup consisted of OHCA and other state agencies, provider organizations and medical and dental health sciences colleges. The product from their efforts was the implementation of a new periodicity schedule (recommended exam schedule) for well-child visits. You can see the new schedule at www.okhca.org/individuals/programs/Child Health EPSDT. Changes include adding a newborn visit in the hospital and recommending that after age six, a child receive a check up every even year of the child's age (i.e. 8, 10, 12, etc.).

Objective: To partner with other child serving organizations in the state to strive for Oklahoma's children to meet the federal immunization goal of 90 percent compliance.

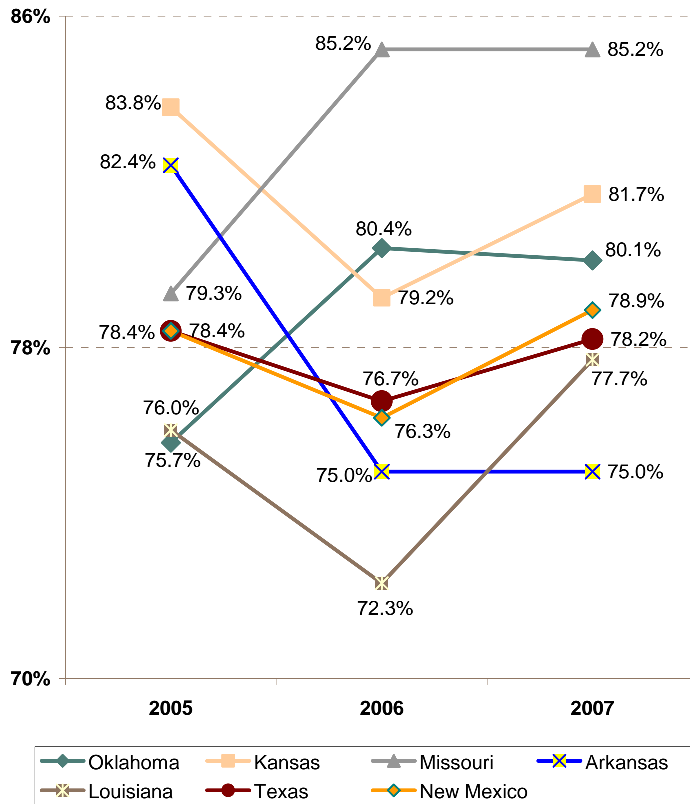
Outcome: Oklahoma's percent compliance with Healthy People by 2010 Campaign - Immunization Rate - *Target / 90%*

What does this report? This measure reports the percentage of Oklahoma's children receiving recommended immunizations in the age group of 19 - 35 months based on 4:3:1:3:3 vaccines. This indicates OHCA's participation in efforts by the state and the Health Care Community to immunize Oklahoma's children.

Medication / Doses in the 4:3:1:3:3 Category

4 - DTP
3 - polio
1 - MCV (measles)
3 - Hib (bacterial meningitis)
3 - Hepatitis B

Figure 25: Immunization Rates for Oklahoma and Surrounding States for Calendar Years 2005 - 2007



Source: Centers for Disease Control, National Immunization Program at www.cdc.gov/vaccines/stats-surv/imz-coverage.htm#chart

What do we compare our performance to? OHCA compares Oklahoma's performance over time as well as reporting surrounding state's immunization rates as reported by the Centers for Disease Control and Prevention.

Has OHCA set a target for these measure? OHCA strives to meet the Healthy People 2010 goal of 90 percent.

Why report these measures? Childhood immunizations play a significant role in prevention of disease and securing a healthy future. Children with a vaccine-preventable disease can experience physical pain, discomfort, trauma,

Figure 26: Recommended Immunization Schedule for Persons Aged 0 - 6 Years

Recommended Immunization Schedule for Persons Aged 0–6 Years—UNITED STATES • 2008

For those who fall behind or start late, see the catch-up schedule

Vaccine ▼ Age ▶	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years
Hepatitis B[1]	HepB	HepB		*see footnote 1*	HepB						
Rotavirus[2]			Rota	Rota	Rota						
Diphtheria, Tetanus, Pertussis[3]			DTaP	DTaP	DTaP	*see footnote 3*	DTaP				DTaP
Haemophilus influenzae type b[4]			Hib	Hib	*Hib*[4]	Hib					
Pneumococcal[5]			PCV	PCV	PCV	PCV				PPV	
Inactivated Poliovirus			IPV	IPV	IPV						IPV
Influenza[6]					Influenza (Yearly)						
Measles, Mumps, Rubella[7]						MMR					MMR
Varicella[8]						Varicella					Varicella
Hepatitis A[9]						HepA (2 doses)				HepA Series	
Meningococcal[10]										MCV4	

Range of recommended ages

Certain high-risk groups

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2007, for children aged 0 through 6 years. Additional information is available at www.cdc.gov/vaccines/recs/schedules. Any dose not administered at the recommended age should be administered at any subsequent visit, when indicated and feasible. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components of the vaccine are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. **Providers should consult the respective Advisory Committee on Immunization Practices statement for detailed recommendations, including for high risk conditions**: http://www.cdc.gov/vaccines/pubs/ACIP-list.htm. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete VAERS form is available at www.vaers.hhs.gov or by telephone, 800-822-7967.

The Recommended Immunization Schedules for Persons Aged 0–18 Years are approved by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/recs/acip), the American Academy of Pediatrics (http://www.aap.org), and the American Academy of Family Physicians (http://www.aafp.org).

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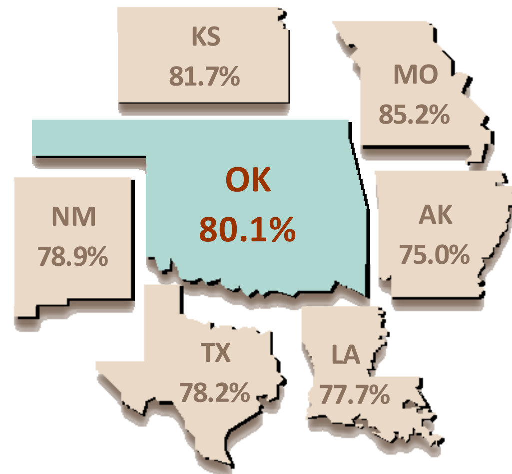
long-term disabilities or even death. A sick child can infect members of a family or others with whom he or she comes in contact. Sick children miss school; with chickenpox, children can miss one or more weeks.

Childhood illness can have a devastating effect on finances due to the cost of time off work for parents. According to the Center for Disease Control and Prevention (CDC), for every dollar invested in the Diptheria/Tetanus/Pertussis (DTaP) vaccine, the United States saves $27 in costs such as work-loss, death and disability.

Figure 27: Immunization Rates for Oklahoma and Surrounding States Calendar 2007



Source: Centers for Disease Control and Prevention, National Immunization Program at www.cdc.gov/vaccines/stats-surv/imz-coverage.htm#chart

In a press release dated September 4, 2008, the Centers for Disease Control and Prevention updated statistics on national immunization rates.[3] National data indicates that childhood immunization rates remain at or near record levels. Of the recommended series, all but one of the individual vaccines had at least 90 percent coverage.

Additionally, there were no differences between racial or ethnic groups for the whole series. Rates did vary substantially among states with the high reported by Maryland (91.3 percent) and the low in Nevada (63.1). Figure 27 shows 2007 rates for Oklahoma and the surrounding states.

> *More than 77 percent of children were fully vaccinated with all vaccines in the series of recommended vaccines. . . . Importantly, less than 1 percent of children had received no vaccines by age 19 months to 35 months.*
>
> *CDC Press Release, September 4, 2008, www.cdc.gov/media/pressrel/2008/r080904.htm*

[3]*CDC Press Release, August 30, 2007, www.cdc.gov/od/oc/media/pressrel/2007/r070830.htm*

Objective: To decrease emergency room utilization by increased use of ambulatory care services.

Outcome: Percent of Adults' - Health Care Use of Preventive / Ambulatory Care

- 20 - 44 years old
- 45 - 64 years old

Target / To meet or exceed the national benchmark

What does this report? This measure reports HEDIS calculation results for adults who have accessed ambulatory care indicating they sought preventive or early intervention decreasing the likelihood for the need of emergency care. The information is calculated on a calendar year basis and 2007 is the most recent information available.

What do we compare our performance to? The National Medicaid Mean and Commercial Insurance Mean are calculated based on HEDIS criteria and are also reported for the same periods.

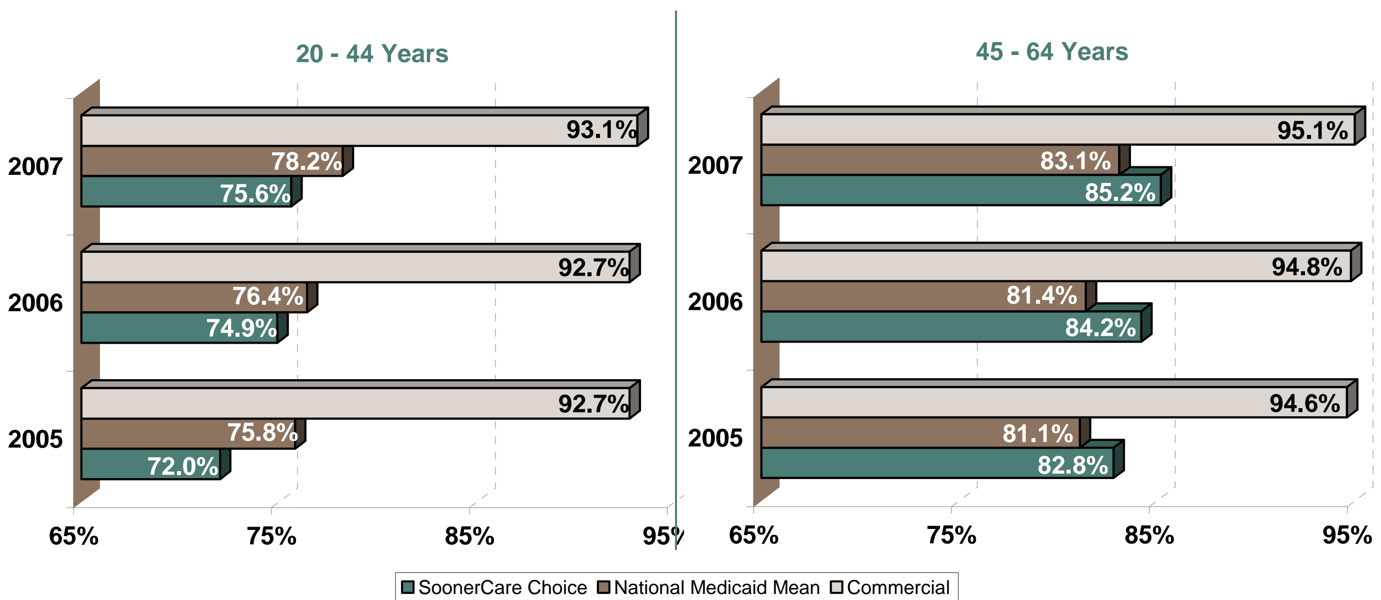
Has OHCA set a target for this measure? The target is to meet or exceed the national benchmark.

Why report these measures? Ambulatory care provides access to early intervention and prevention services, potentially reducing the risk of life threatening or chronic conditions. According to a report by the Center for Disease Control and Prevention, emergency room utilization by 20-49 year olds is up by 15 percent and the 50-64 age category was up by 17 percent. The Kaiser Family Foundation reports that for high emergency room utilizers, chronic condition related issues represented 31 percent of the reason for the visits.

SoonerCare adults continue to outpace the average Medicaid adult in the 45 - 64 year age category and remains behind in the 20 - 44 year old range. In comparison, the average adult on Medicaid (National Medicaid Mean) and SoonerCare members lag significantly behind commercially insured adults.

What is OHCA doing that might impact these measures? In February 2008, OHCA launched the SoonerCare Health Management Program (HMP). The program has been designed to benefit both SoonerCare Choice members and SoonerCare Choice primary care providers (PCP). The predictive modeling software selects members, who based on their medical history, are at the highest risk for adverse outcomes. These members will receive intervention from nurse care managers (NCM) who will provide education support specific to their condition, help coordinate care and improve self-management skills. Initially the program will target 5,000 Choice members.

Figure 28: Adults Use of Preventive / Ambulatory Care by Age for Calendar Years 2005 - 2007



Source: OHCA's MMIS Claims Processing System using HEDIS criteria. See page 40 for explanation of HEDIS.

The program will also work with PCPs by providing practice facilitation to enhance the quality and efficiency of their operations. HMP will also offer quality conferences and regional collaborative training sessions to providers.

NCM will serve as links between members, their PCP and other resources such as behavioral health services, pharmacotheraphy management and community services.

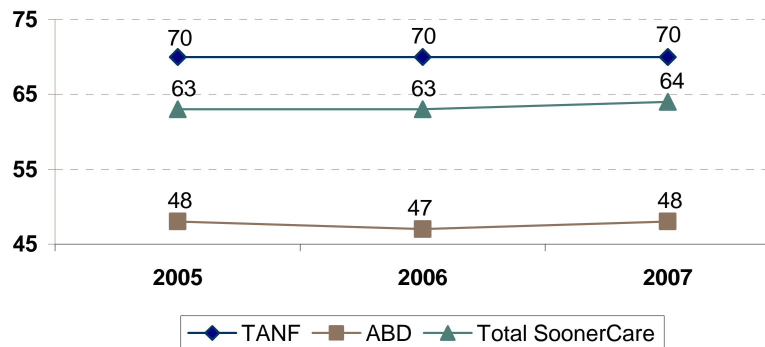
Objective: To decrease emergency room utilization by increased use of ambulatory care services.

Output: Emergency Room Visits Per 1,000 Member Months

- TANF (Temporary Assistance to Needy Families) Population
- ABD (Aged, Blind and / or Disabled) Population
- Total SoonerCare Population

No target or estimate is set for this measure due to the evolving nature of the project.

Figure 29: Emergency Room Visits per 1,000 Member Months by Selected Populations for SFY2005 - 2007



Restated: See "What does this report?"
Source: OHCA MMIS

What does this report? This measure reports SoonerCare members' use of ER services per 1,000 member months of eligibility. The data is disaggregated by members qualifying through TANF (Temporary Assistance to Needy Families) and Aged, Blind and/or Disabled (ABD) criteria. The information is calculated on a quarterly basis and as of the time of this report, only two quarters of 2008 information was available. That data indicates little change *(Information has been restated to accurately reflect emergency room visits. Previously reported: TANF: 2005 - 69, 2006 - 69; ABD: 2005 - 41, 2006 - 41; Total SoonerCare: 2005 - 63, 2006 - 69.)*

What do we compare our performance to? The results are reported for previous years to provide context for evaluation.

Has OHCA set a target for these measure? This project, while on-going for four years, has been modified throughout based on experience gained. Because of this, the project continues to provide trend information without making projections for future years.

Why report these measures? A study released in October 2007 by the Kaiser Family Foundation found that the following characterizes individuals at risk of being high emergency services utilizers: (1) publicly insured (Medicare and/or Medicaid), (2) chronic health conditions, (3) poor perceived health status, and (4) lower income.

Medicaid-insured individuals make up nine percent of the nation's population and account for approximately 15 percent of emergency room (ER) visits. Of high ER utilizers (4 or more visits over the two year study), 23 percent were Medicaid members. The report suggested that this was somewhat expected since Medicaid funding is intended for the elderly, disabled and those in poverty.[4]

During SFY2004, OHCA undertook a quality initiative to evaluate the emergency room (ER) utilization of SoonerCare Choice members. Concern was that many of the high utilizers might be substituting ER services for accessing prevention and early intervention care. Two projects emerged, one for providers and the other for members.

Providers. The provider facet of the initiative notifies primary care providers (PCP) of the ER utilization of their SoonerCare patients based on paid claims and encounter data. Outreach to providers includes information to assist in develop strategies related to member care.

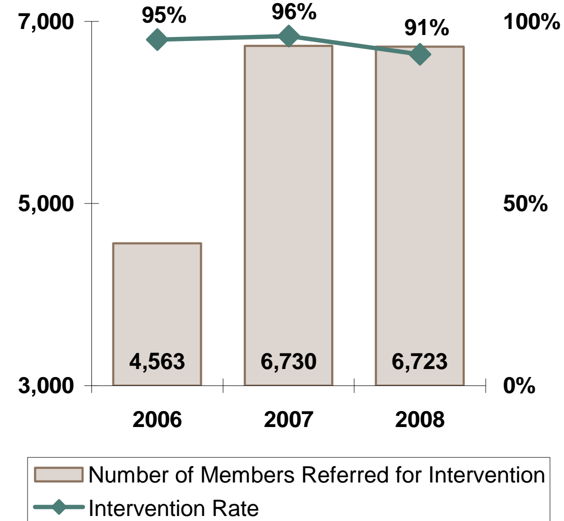
Twice a year OHCA sends ER utilization profiles to many SoonerCare Choice PCPs showing office visits and ER visits for the providers' member panels in comparison to their peers. The results are risk-adjusted to take into account the various acuity levels of the patients to ensure that comparisons are reasonable. Since this project began, twenty five percent of providers with high ER utilizing patients have moved to the lowest category.

[4] *The Kaiser Family Foundation, Characteristics of Frequent Emergency Department Users, October 2007*

Members. The member component of the project focuses on identifying high utilizing members and educating them on the appropriate use of ER services. The project now concentrates on members with four or more ER visits in a quarter. Those identified are referred to our Member Services unit for intervention.

*During the course of the project the threshold of ER visits qualifying for intervention has been lowered from six visits or less to four visits or less in a quarter. This accounts for the tremendous increase in the volume of contacts. Initial contact letters are sent to all identified members.

*Figure 30: Intervention: SoonerCare Choice Members for SFY2006 - 2008**



Source: SoonerCare Operations

Figure 31: ER Project: Method of Intervention Contact & Referrals to Care Management for SFY2006 - 2008

Number of Contacts	2006	2007	2008
Letter	3,065	6,603	6,114
Telephone	1,509	1,492	1,269
Total	4,574	8,095	7,383
Number Referred to Care Management	19	14	5

Source: SoonerCare Operations

This project continues to evolve as more information is analyzed. Beginning in 2007, emphasis has been placed on addressing members with 30 or more visits to the emergency room in three consecutive quarters. Deemed "super users," this group receives face-to-face intervention from a two person team, one from Care Management and one from Member Services. If the member is unable to meet, a phone intervention is conducted.

The member's health history is reviewed, including mental health, general health and psycho-social health. Education is provided to the member and community resources identified during the initial contact and the member continues to receive Care Management coordination services to ensure the member is monitored and services are accessed appropriately.

Figure 32: ER Utilization Intervention -- "Super Users" -- for SFY2007 & SFY2008

SFY	Number Identified	Face-to-Face Interviews	Phone Interviews	No Contact Due to Loss of Eligibility	Unable to Reach
2007	36	18	7	4	7
2008	46	16	12	8	9

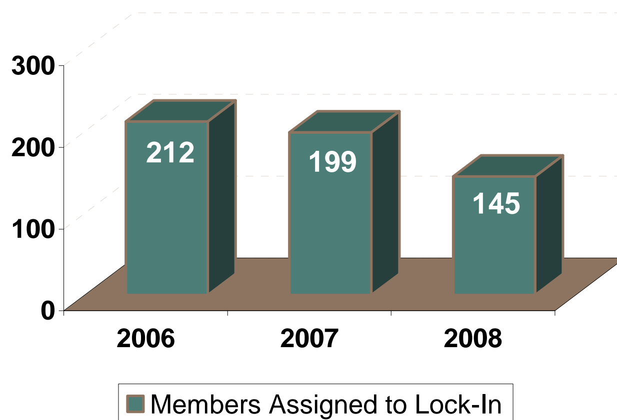
Source: OHCA Medical Operations Division

Objective: To educate members on the use of pharmacy services and monitor their behavior through the lock-in program.

Output: Average Number of SoonerCare members assigned to the Lock-In Program

No target is set for this program.

Figure 33: SoonerCare Members Assigned to the Lock-In Program for SFY2006 - 2008



Source: OHCA Program Integrity; Oklahoma University College of Pharmacy

What does this report? The purpose of this indicator is to track and trend the number of members locked into a specific pharmacy due to misuse of services.

What do we compare our performance to? Due to the changes that impact the Lock-In program, projections are not attempted at this time.

SFY2007 is the first full year of data with the current contractor. In January 2006, OHCA contracted with the Oklahoma University College of Pharmacy to manage the Lock-In program. This coincided with the implementation of the Medicare Part D pharmacy benefit. At that time, all members eligible for Medicare and also qualifying for SoonerCare (dual eligibles) were required to receive their medication through Part D. This requires that dual eligibles be removed from the pharmacy benefit, and therefore, the Lock-In program.

Has OHCA set a target for this measure? No target is set for this program.

Why report this measure? The SoonerCare pharmacy benefit is designed to ensure that members have access to the medications they need for health maintenance. The Pharmacy Lock-In program is a system to monitor members who have inappropriately used pharmacy services. Identified members are “locked-in” to one pharmacy to structure their access to pharmacy benefits. Members remain in the program until their behavior becomes consistent with acceptable standards.

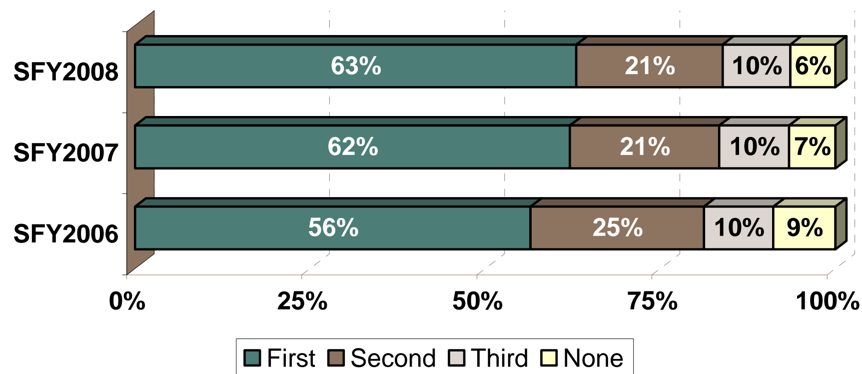
The significant decrease between SFY2007 and SFY2008 can be attributed to members losing eligibility during their lock-in term.

Objective: To increase the number of pregnant women seeking medical care before delivery.

Outcome: Percent of SoonerCare members seeking prenatal care - *Target / 90%*
Output: Number of births to SoonerCare members - *Estimate / None*
Output: Number of Members seeking prenatal care

- First Trimester - *Benchmark / 90%*
- Second Trimester - *Benchmark / None*
- Third Trimester - *Benchmark / None*

Figure 34: SoonerCare Members Who Sought Prenatal Care -- By Trimester -- for SFY2006 - 2008



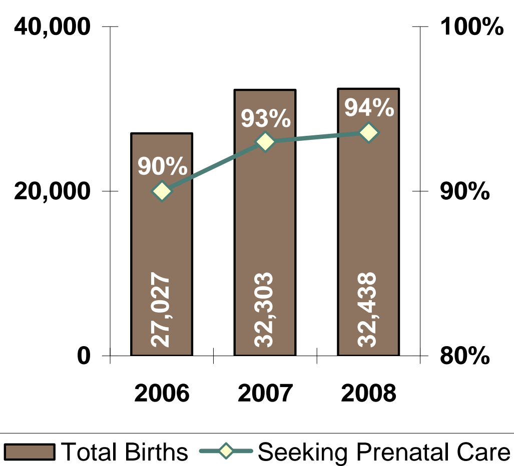
Source: OHCA's MMIS

What does this report? The purpose of these measures is to track the number and percent of births in which the mother sought prenatal care before delivery. The percentages are disaggregated by trimester in which care was first accessed.

What do we compare our performance to? National Vital Statistics Reports released in December 2007 indicated that the national average of pregnant women seeking prenatal care was 89.9 percent and the average for Oklahoma women seeking prenatal care was 77.3 percent.

Has OHCA set a target for these measures? The Healthy People 2010 campaign has set a goal that 90 percent of expectant mothers receive prenatal care in the first trimester of pregnancy.

Figure 35: Total Births to SoonerCare Members and Percent Seeking Prenatal Care for SFY2006 - 2008



Source: OHCA's MMIS; the national and Oklahoma average were obtained from National Vital Statistics Reports Vol. 56, No. 6, December 5, 2007 (based on 2005 data)

Why report these measures? A child's health begins well before birth and prenatal care can make a difference. According to the Department of Health and Human Services, Health and Resource Services Administration (HRSA), babies born to mothers who have not received prenatal care are three times more likely to be born at a low birth weight and five times more likely to die.[5]

Prenatal care allows a health care professional the opportunity to educate expectant women on such issues as diet and nutrition, exercise and immunizations. They can provide important information including nutrition for newborns as well as diagnose health-compromising conditions and help them prepare for the challenges, both physical and emotional, of caring for a baby.

What is OHCA doing that might impact these measures? OHCA initiated a partnership with OSDH to develop a statewide Perinatal Task Force to research and make recommendations for provision of optimal health care for mothers and newborns. Results included a benefit expansion to include an ultrasound during the first trimester.

Effective May 1, 2007, SoonerCare benefits expanded to provide perinatal dental care to women who are pregnant or have recently delivered. The benefit provides for basic dental care including examinations and cleanings. Medical data suggests a link between poor oral health and low birth weight and preterm deliveries. As of August 2006,153 pregnant or post-partum women have been received perinatal dental services (www.okhca.org/Research/Statistics and Data/Perinatal Dental Fast Facts).

[5]*A Healthy Start: Begin Before Baby's Born, US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau.*

Goal #4
Member Benefits

Goal #4
Member Benefits

To ensure that programs and services respond to the needs of members by providing necessary medical benefits to our members.

SoonerCare Health Plan

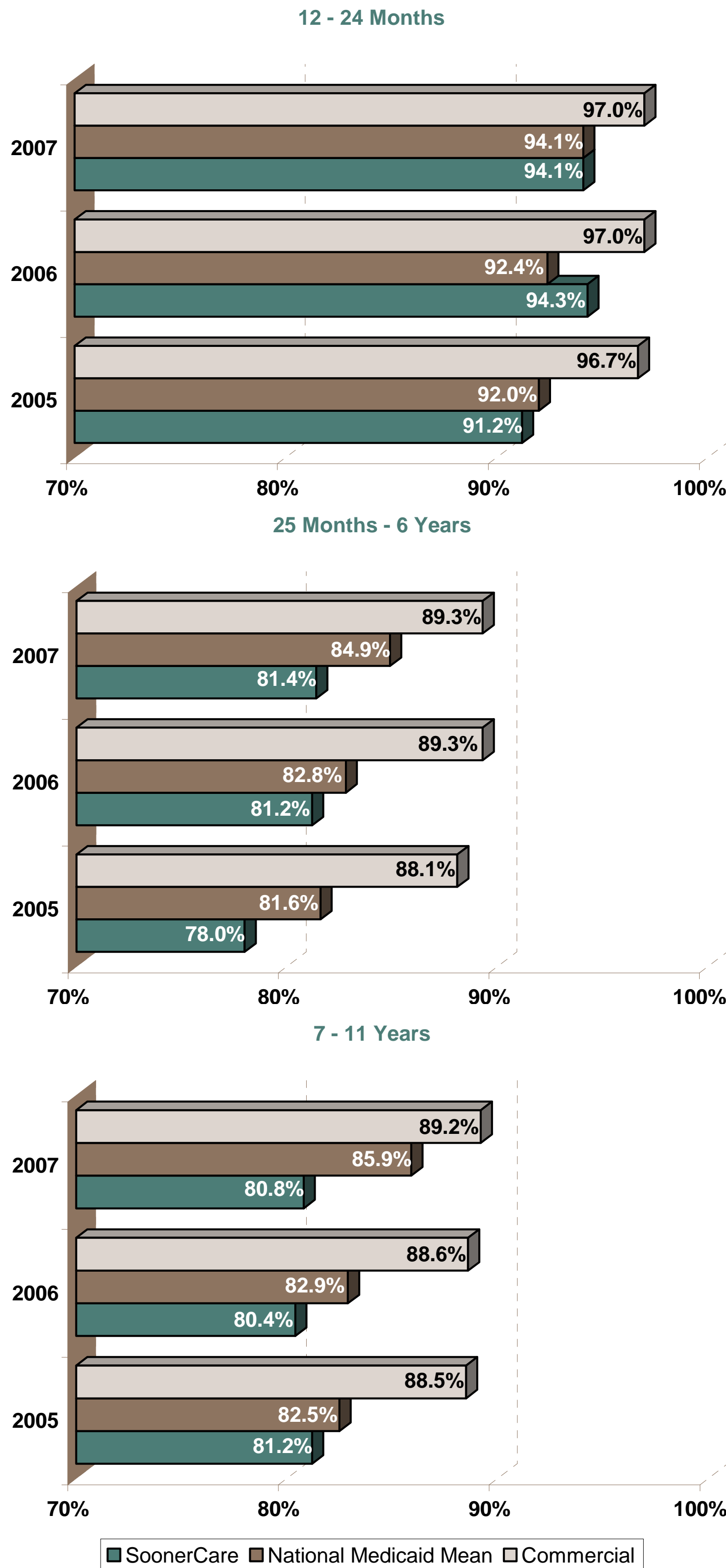
SoonerCare is a federally funded, state administered health plan. As such, federal law requires that some services be available to members, others are optional and some services do not qualify for federal funds. Fortunately for our members, these laws were written in such a manner as to give states some flexibility to design a program that addresses the unique needs of their individual populations.

OHCA strives to sculpt benefit packages that will be most valuable to Oklahomans while remaining within the federal and state frameworks and funding limits.

The value of health insurance can be measured in many ways. For example, costs, quality, and level of administration may be measured to help determine the value of health insurance. However, offering the benefits that members actually need is essential to promote a healthy population.

The following measures take a look at several categories of care available to SoonerCare members and how they are being utilized.

Figure 36: SoonerCare Children's Health Care Use for Calendar Year 2005 - 2007



Source: OHCA's MMIS

Objective: To strive for SoonerCare members to have Health Care Use that meets or exceeds the national Medicaid standards.

Outcome: SoonerCare Children's Health Care Use:

- 12 - 24 Months
- 25 Months - 6 Years
- 7 - 11 Years

Target / To meet or exceed the national benchmark

What does this report? This measure reports the percentage of children enrolled in SoonerCare who accessed primary care services, broken out by age groups. Data is based on HEDIS criteria which is calculated on the calendar year. For more information on HEDIS see page 40.

What do we compare our performance to? The National Medicaid Mean and Commercial Insurance Mean, calculated based on HEDIS criteria, are also reported for the same periods.

Has OHCA set a target for this measure? The target is to meet or exceed the national benchmark.

Why report this measure? Addressing medical needs early is vital to healthy living. Accessing primary care services at the onset of symptoms and attending follow up appointments increases the likelihood of preventing an illness from worsening and provides an opportunity to identify other health issues that may have gone untreated. This is especially true for children since some medical issues can impact their growth and future health status.

There have been significant opportunities and challenges in the matter of covering children through Medicaid funded services in Oklahoma in the past two years. The Oklahoma legislature enacted Cover All Kids in 2006, raising the income qualification for children from 185 percent to 300 percent of the federal poverty level (FPL). Due to federal considerations, the current plan is to increase the household income limit to 250 percent of the FPL. There has been a delay of several months at the federal level and our request has not yet been approved. For the time being, the SCHIP program has been federally funded at the current level through March of 2009. See page 23 for more information on SCHIP.

Objective: To strive for SoonerCare members to have Health Care Use that meets or exceeds the national Medicaid mean.

For a complete discussion, see Adult Health Care Use measures reported on page 47.

Figure 37: Adult Health Care Use for Calendar Year 2007

Adult Health Care Use - Calendar Year 2007 (See page 47 for more information.)	
Adults age 20 - 44 years	
SoonerCare	75.6%
National Medicaid Mean	78.2%
Commercial Insurance	93.1%
Adults age 45 - 64 years	
SoonerCare	85.2%
National Medicaid Mean	81.4%
Commercial Insurance	94.8%

Source: OHCA MMIS

Adult Health Care Use (Recap)

OHCA measures the effectiveness of benefits provided by looking at adult members' use of ambulatory care. Ambulatory care provides members with access to preventive care and intervention in medical conditions at an early stage.

In today's fast-paced society it is more critical than ever for people to utilize preventive and early intervention medical services. Adults must consider the ramifications should their health status decline. The cost of missing work or ending up in the emergency room can cause even more stress on the individual and the family.

This data also addresses the issue of adults taking responsibility for their health care. Therefore, Adult Health Care Use is also reported in Agency Goal 3. See data on page 47 for more information related to these measures.

Objective: To partner with others to reduce the number of Oklahomans without access to medical coverage.

For a complete discussion, see the Appeals measures reported on page 29.

Figure 38: Appeals for SFY2008

Appeals - SFY2008
(See page 29 for more information.)

The percent of the SoonerCare population filing appeals remains less than 1/4 of 1%.

The number of members filing appeals has remained fairly consistent: 46, up from 42 in SFY2006.

The percent of OHCA decisions overturned during the appeals process has dropped from 10% in SFY2006 to 4% in SFY2008.

Source: OHCA MMIS

Appeals (Recap)

The number of member appeals is an indirect measure of how well SoonerCare benefits are meeting members' needs. SoonerCare members have the right to appeal decisions made concerning their care. OHCA strives to ensure that benefits available meet members' needs while working within federal and state regulations and available resources.

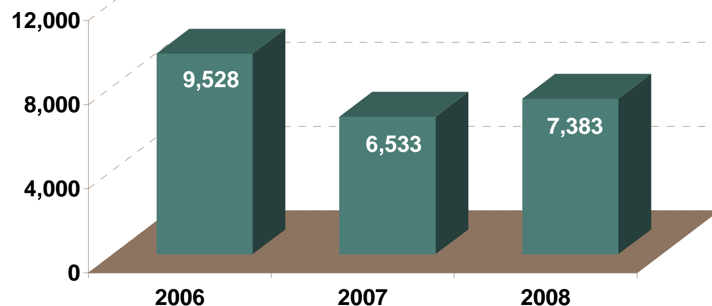
Because these measures also address member satisfaction, they are reported under Agency Goal 2. See page 29 for performance measures and further information.

Objective: To ensure that long-term care members are correctly placed in the appropriate level of care facilities.

Output: Level of Care / Long-Term Care Service Entry (PASRR) Reviews Processed - *Estimate / > 7,000*

What does this report? This measure reports the number of Pre-Admission Screening and Resident Reviews (PASRR) that were processed during the periods SFY2006 - 2008.

Figure 39: Level of Care Reviews Processed for SFY2006 - 2008



Source: OHCA Opportunities for Living Life Division

The federal government requires that a Pre-Admission Screening and Resident Review (PASRR) be administered to each individual entering a long-term care facility, this includes transfers from other facilities. The purpose of the screening is to ensure that long-term care patients with a possible developmental disability (DD) or mental retardation (MR) and/or mental illness (MI) are placed in facilities capable of providing the appropriate level of care for their identified needs.

What do we compare our performance to? The number of reviews performed every year can be compared to previous years' numbers as an indication of rising or falling populations utilizing these services.

Has OHCA set a target for this measure? No external target has been identified for this measure. Due to a change in policy, the method of estimating reviews has changed from a specific number based on a five year average to a range (>7,000).

During SFY2006 providers were educated on OHCA policy which requires submission of PASRR screening documentation within ten days of admission to a facility. Providers were notified that services rendered within ten days of OHCA's receipt of the documentation would be reimbursed. Any service dates preceding that would not be compensable.

Prior to implementation of the systems edit to execute this policy, providers were given a 30 day grace period to catch up their records. An influx of forms occurred at that time. It is believed that submissions will level off as providers become more accustomed to the policy's requirements.

Why report this measure? Tracking the number of reviews performed during the fiscal year allows the agency to measure nursing home utilization trends and the performance of the agency in fulfilling federal and state requirements.

Objective: To strive for Oklahoma's SoonerCare children to meet or exceed the national Medicaid average for EPSDT well-child visits.

For a complete discussion, see Adult Health Care Use measures reported on page 41.

Figure 40: Well-Child Visits for Calendar Years 2006 & 2007

Well-Child Visits
(See page 41 for more information.)

Between Calendar Years 2006 and 2007, Well-Child Visits for children experienced little change except in the Adolescent category which increased by 2.7 percent.

	2006	2007
First Fifteen Months	96.5%	96.8%
3 - 6 Year Olds	56.7%	57.1%
Adolescents	25.9%	28.6%

Source: OHCA MMIS

Well-Child Visits (Recap)

Preventive care is an essential element in children's coverage. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, also called Child Health Check-ups, are imperative to Oklahoma's children. Covering services such as vision and hearing screening and dental services, Child Health Check-ups increase the chances of a healthy childhood and adulthood.

Because these measures also address members' personal responsibilities, they are reported under Agency Goal 3. See page 41 for performance measures and further information.

Objective: To partner with other child serving organizations in the state to strive for Oklahoma's children to meet the federal immunization goal of 90 percent compliance.

For a complete discussion, see the Immunization Rate measure reported on page 44.

Figure 41: Immunization Rates

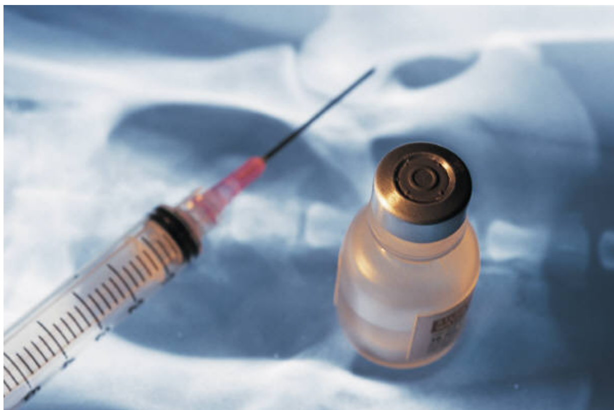
Immunization Rates for Oklahoma Children
(See page 44 for more information.)

Between Calendar Years 2002 and 2006, Oklahoma's immunization rate increased 10.4% (70% to 80.4%). For 2007, this rate remains steady at 80.1% equal to the national average.

Oklahoma falls 13.1 percentage points behind the highest state rate, New Hampshire (93.2%) and 13.4 percentage points above the lowest, Nevada (66.7%).

Source: Center for Disease Control, National Immunization Program http://www.cdc.gov/vaccines/stats-surv/nis/tables/07/tab03_antigen_state.xls

Immunization (Recap)



Immunizations are one of the most effective preventive care tools available. Not only will vaccinations protect this generation, it will help future ones as well by slowing the spread of many diseases.

To see if your family is up to date on immunizations go to the Center for Disease Control and Prevention (CDC) website at www.cdc.gov/vaccines. For your information, the 0 - 6 year olds recommended vaccines schedule is presented on page 59.

Because this measure also address members' personal responsibilities, results are reported under Agency Goal 3. See page 44 for the performance measure and further information.

Objective: To assist members' ability to attend health care appointments by providing transportation through SoonerRide.
Output: Number of SoonerRide Trips Made - *Estimate / 680,000*
Efficiency: Cost per One-Way Trip - *Estimate / $38.00*

What does this report? The measures report the number of SoonerRide trips made (one way) for SoonerCare members and the average cost per trip for SFY2006 - 2008.

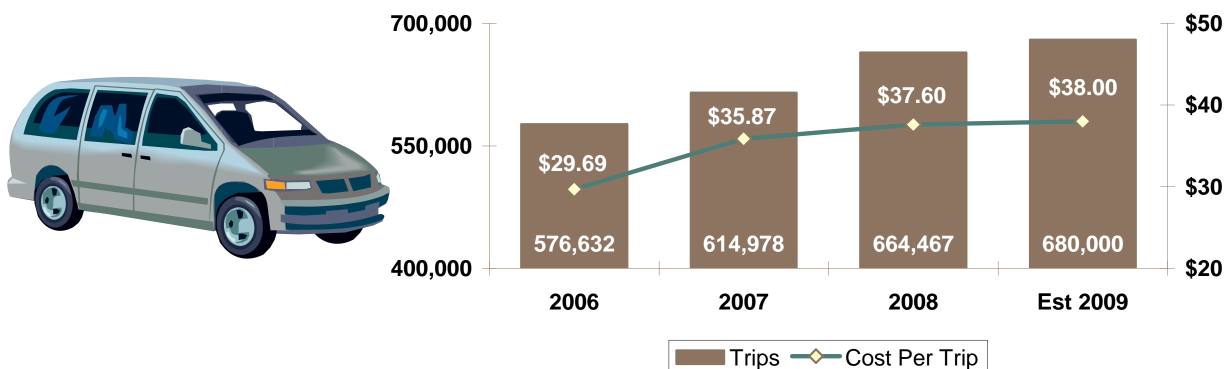
What do we compare our performance to? These measures are compared year-to-year to track developing trends and provide information about utilization.

Has OHCA set a target for these measures? No external targets have been identified for these measures. Estimates for SFY2009 are provided to indicate expectations for the coming year.

Why report these measures? Lack of adequate transportation has been cited as one of the obstacles to accessing medical services for low-income individuals. SoonerCare offers a non-emergency transportation benefit, SoonerRide, to ensure that members have the ability to get to scheduled health care appointments and back home in a safe, reliable manner. Members can schedule drop-off and pick-up services to and from qualifying medical appointments.

The SoonerRide benefit is being used more and more, up 36.5 percent from SFY2005.

Figure 42: SoonerRide Trips and Cost Per Trip for SFY2006 - 2008



Source: OHCA SoonerRide Division and LogistiCare Solutions, LLC (contracted provider)

FMAP Rate & Medical Inflation Rate

Oklahoma partners with the federal government to offer health care coverage to our members. For each state dollar Oklahoma spends on program costs, the federal government matches with approximately two dollars. The Federal Medical Assistance Percentage (FMAP) is calculated based on the State's per capita income.

For your information, the FMAP rate for 2006 through 2009 is reported. This represents the percent of cost paid by the federal government for medical services accessed by our members. The Region 6 FMAP rate represents the average for the other four states included in our region as defined by CMS. Those states are Arkansas, Louisiana, New Mexico and Texas.

Figure 43: Federal Financial Participation: FMAP Rate for Federal Fiscal Years 2006 - 2009 and Current Medical Inflation Rate for Calendar Years 2006 & 2007

Year*	Oklahoma	Region 6	Medical Inflation
2006	67.91%	68.84%	4.0%
2007	68.14%	68.94%	4.4%
2008	67.10%	69.25%	N/A
2009	65.90%	68.61%	N/A

* The FMAP Rate is reported by federal fiscal year running October 1 - September 30; Medical Inflation is reported by calendar year.

Source: 2009 FMAP Rate - Federal Register, November 28, 2007, Volume 72, Number 228, Pgs 67304 - 67306, wais.access.gpo.gov.
Source: Medical Inflation Rate - US Department of Labor, Bureau of Labor Statistics, Consumer Price Index at www.bls.gov.

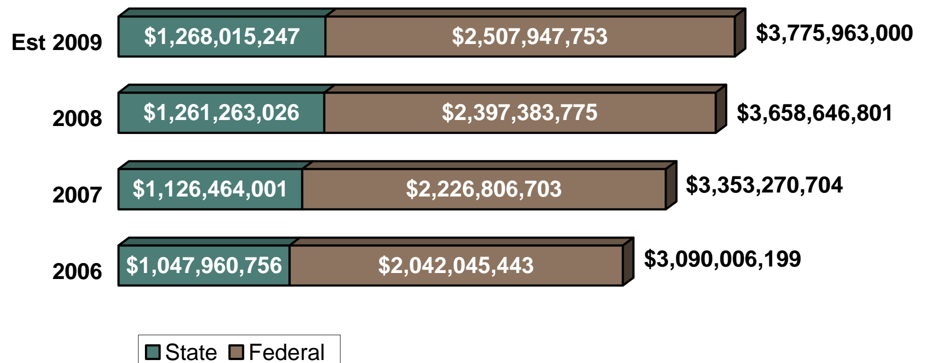
Also provided is the most recent national Medical Inflation Rate available, calendar year 2007.

Cost Measures for SoonerCare

Input: Total Cost of Services - Estimate / See Figure 44
Input: Oklahoma Cost of Services - Estimate / See Figure 44

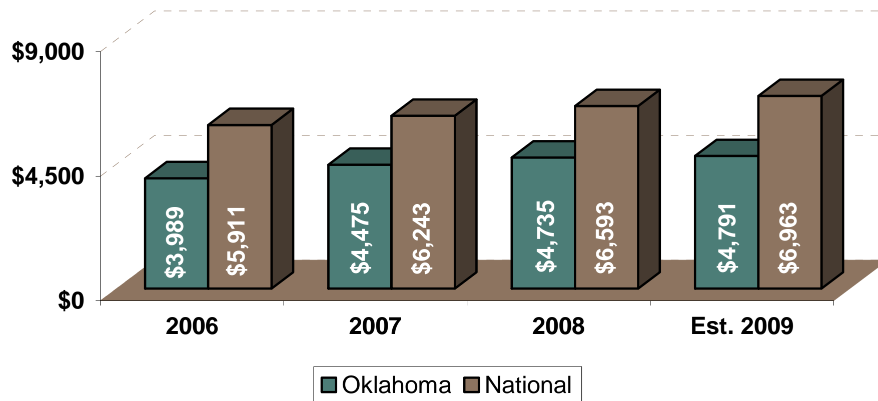
What does this report? These measures report disaggregated information on the cost of services provided to SoonerCare members and allow the user to see the changes in cost to both the state and the federal government and the average cost per member accessing services.

Figure 44: SoonerCare Program Costs for SFY2006 - 2008



Source: OHCA Financial Services Division

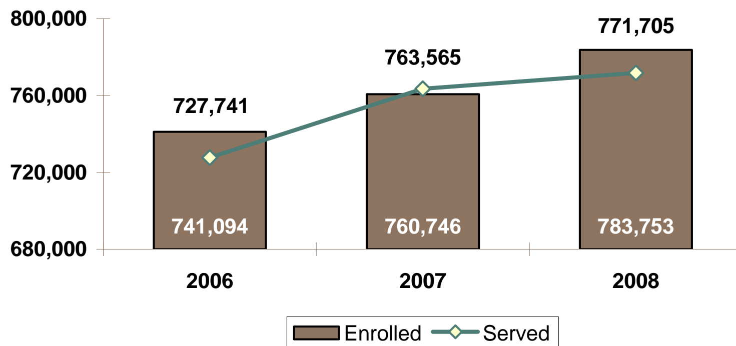
*Figure 45: SoonerCare Program Cost Per Member Served for SFY2006 - 2008**



Source: OHCS MMIS and Financial Services Division; National number is estimated based on data obtained from CMS.

*It should be noted that cost per member served is calculated based on OHCA's reporting to CMS in order to ensure comparability of the data with the numbers reported at the national level. The difference between OHCA's financial reports and data reported to CMS is that drug rebate and collections are deducted for federal reporting purposes.

Figure 46: SoonerCare Members Enrolled and Served for SFY2006 - 2008



Source: OHCA MMIS and Financial Services Division

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Goal #5 Responsible Purchasing

Goal #5 Responsible Purchasing

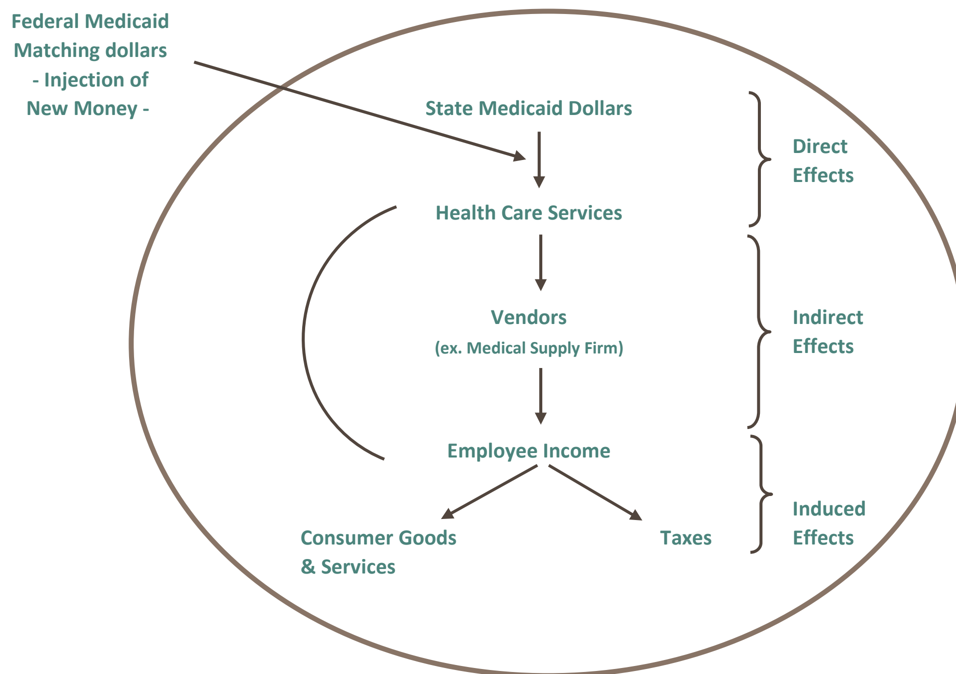
To purchase the best value health care for members by paying appropriate rates and exploring all available valid options for program financing to ensure access to medical services by our members.

Health Care Spending and the Economy

Growth in health care expenditures outpaces most other categories in the United States. Health care spending has grown at an average yearly rate of ten percent since the 1960s.[5] A study from the Kaiser Family Foundation indicates that in the past forty years, health care spending has grown between 1.3 percent and 3.1 percent faster than the overall economy. Per capita national health care expenditures increased 77 percent between 1995 and 2005.[6] "In 2006, over $2.1 trillion was spent on health care in the United States. Those expenditures are expected to increase to nearly $4.3 trillion by 2017."[5] This highlights two issues when considering Medicaid funded spending in Oklahoma.

First, state funds spent for public health care take up a significant portion of the scarce resources available. The Oklahoma Office of State Finance reports that 16 percent of the state's budget is dedicated to Health related expenditures, surpassed only by Education at 53 percent. SFY2008 budget appropriations slate 11 percent of the state's budget to OHCA, the third highest falling after common education (36 per-

Figure 47: Flow of Medicaid Dollars Through a State Economy: An Example



Source: The role of Medicaid in State Economies: A Look at the Research, Kaiser commission on Medicaid and the Uninsured Policy Brief, April 2004.

cent) and higher education (15 percent). For more information on Oklahoma's state budget, see www.ok.gov/okaa/index.html.

Conversely, Medicaid plays an equally significant role in supporting the economic status of our state, bringing in federal dollars at approximately $2 for every $1 contributed by the state. Medicaid's structure and the substantial amount of spending associated with it, results in a program of considerable importance to the state's economy by financing jobs, income and overall economic activity. The above chart (Figure 47), gives a graphic image of the impact of Medicaid on a state's economy.

Oklahoma contributed data to an economic impact study conducted by the Kaiser Commission on Medicaid and the Uninsured released in 2004. Based on 2002 expenditures, SoonerCare contributed to the employment of 90,366 jobs and supported income of $1.98 billion. The total fiscal impact reported $76.5 million in state income and consumption taxes.[7]

[5] *CoveringTheUninsured.org – Fact Sheet: National Spending on Health Care, www.CoveringTheUninsured.org/factsheets/National Spending on Health Care*
[6] *The Henry J. Kaiser Family Foundation, Heath Care Costs - A Primer, Key Information on Health Care Costs and Their Impact, August 2007, www.kff.org/insurance/*
[7] *Kaiser Commission on Medicaid and the Uninsured, The Role of Medicaid in State Economies: A Look at the Research, April 2004, www.kff.org/Medicaid/ .*

Fiscal Responsibility, Strong Provider Base & Maintaining Members' Choice

Part of a successful health care plan is ensuring that there are enough providers offering quality services to meet the needs of members. Federal Medicaid law requires that "provider reimbursement rates be consistent with efficiency, economy and quality of care and be adequate to enlist enough providers so that services are available to Medicaid enrollees to the same extent they are available to the general population." The challenge is balancing citizens' expectations for efficient use of resources with providers' need to cover expenses, maintain quality staff and keep up with current medical practices and equipment.

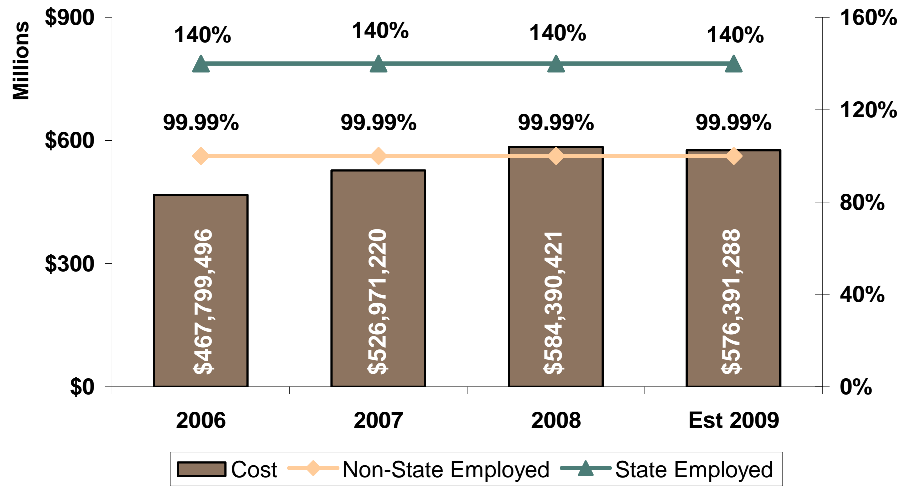
OHCA maintains competitive provider rates with the Medicare fee schedule, as well as other applicable industry standards, to make sure access to medical services is available to SoonerCare members. Our goal is to ensure reasonable reimbursement to providers, as appropriated funds allow, keeping in mind rising health care costs, technological advances and best practices.

Objective: To reimburse providers, when applicable Medicare rates are available, at 100 percent of Medicare rates.

Input: Cost of Physicians & Other Practitioners Services - *Estimate / See Figure 48*

Outcome: Reimbursement as a Percent of Medicare Rates - *Target / 100%*

Figure 48: Cost of Physicians / Other Providers and Rate of Reimbursement Compared to Medicare Rates for SFY2006 - 2008



Source: OHCA Financial Services Division

What does this report? These measures track the cost of medical services provided to members by physicians, laboratories and radiologists, dentists, home health care providers, ambulatory clinics, and other practitioners, as well as the cost of medical supplies. Also tracked are these costs as a percentage of Medicare rates.

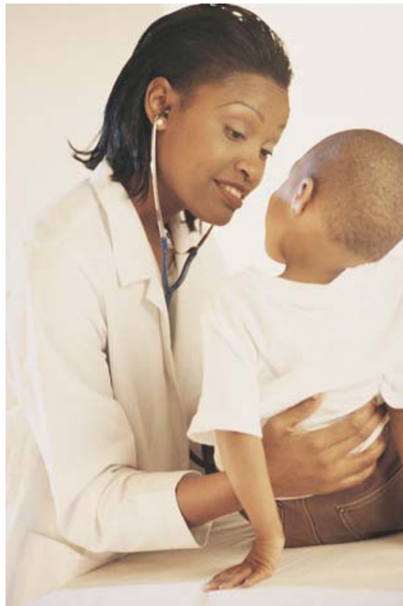
During SFY2005, state employed physicians comprised of those employed by the Colleges of Medicine at Oklahoma University and Oklahoma State University, received a rate increase to 140 percent of Medicare rates. The Universities pay the state matching funds for costs above the regular SoonerCare reimbursement rates.

What do we compare our performance to? Costs are reported over time to allow for trend analysis. The reimbursement rates are compared to Medicare rates as a benchmark.

Has OHCA set a target for this measure? In the past, Medicaid funded services were reimbursed at a low rate that discouraged providers participation in SoonerCare. For several years, OHCA requested state resources to reimburse SoonerCare providers at 100 percent of Medicare rates. In SFY2005, the funding was granted and OHCA began reimbursing providers at the 100 percent of Medicare rates. The only exception is Laboratory fees which are paid based on a CMS mandated schedule. Currently, the mandated reimbursement rate is 95 percent of the Medicare rate. OHCA is working towards increasing this percentage to 100 percent.

Why report these measures? In both the private and public sector, the majority of health care services are provided by physicians and hospitals. As an insurer, it is vital that members have a medical home to seek health care services, advice and education. Consequently, it is critical to reimburse providers at a rate in which they are able to maintain quality service delivery, technical expertise and current best practices.

What is OHCA doing that might impact these measures? The agency is currently transitioning to the "medical home" model of reimbursement in the partially capitated care management (PCCM) plan. In this model, providers receive a small capitated payment for care management services provided for SoonerCare members in their care. This fee varies based on the characteristics of the type of SoonerCare patients they agree to serve, the types of services offered, and quality initiatives undertaken by the provider. In return, the provider is able to bill fee-for-service for care given to the members that previously would have been considered part of the capitated payment.



In the "medical home" model, providers' reimbursement is better aligned with the services provided. Providers are not required to provide specific services in return for a capitated fee which may or may not be sufficient to cover costs. Nor do they receive payment for services not performed. OHCA anticipates that this will improve the cost/benefit ratio for providers and facilitate members getting in to see their physicians appropriately.

OHCA has requested additional funds in SFY2010 for several issues that could affect physicians and other providers, including provider rate increases, implementation of the medical home model, and adding adult therapy to benefits provided for specific medical cases.

Objective: To reimburse hospital providers a reasonable percentage of reported costs.
Input: Cost of Hospital Services - *Estimate / See Figure 49*
Outcome: Reimbursement as a Percent of Hospitals' Cost - *Target / 100%*

What does this report? This measure reports the cost of providing hospital services to SoonerCare members as well as the percentage reimbursed of hospitals' costs. (Hospital reimbursement percentages are based on federally required cost reports hospitals must provide.)

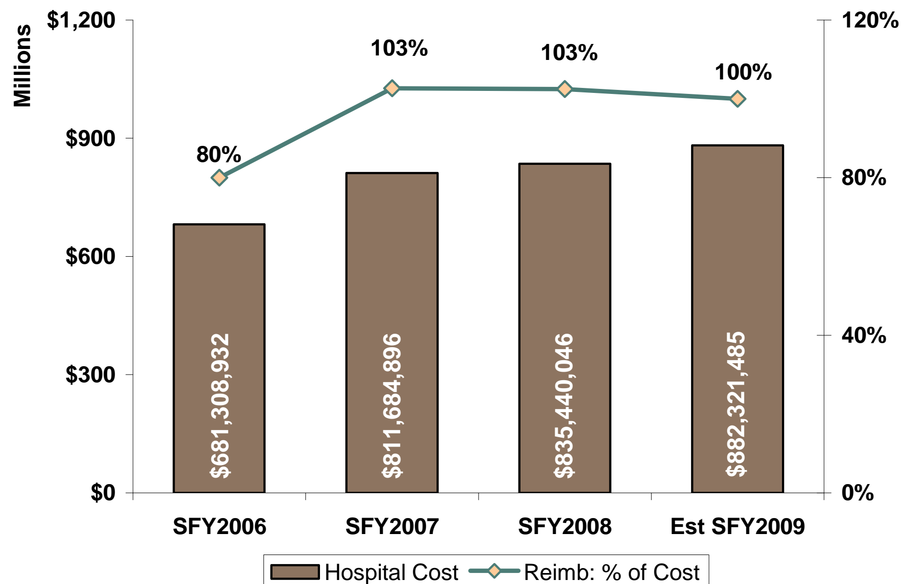
What do we compare our performance to? The cost of providing hospital services and the percentage of cost reimbursed is reported over time to allow for trend analysis.

Has OHCA set a target for this measure? OHCA compares costs over time and uses trends analysis to support projections of future costs. OHCA's target is to pay 100 percent of hospitals' costs.

Why report these measures? Hospitals are a critical component of the state's health care safety net. In today's environment of ever-increasing medical costs it is a struggle for hospitals to provide medical services to a wide range of Oklahomans with diverse medical needs while covering costs and remaining in compliance with state and federal regulations. OHCA tracks these measures to report our contribution to the health care of our members and the health care industry.

What is OHCA doing that might impact these measures? OHCA has requested additional funding through the SFY2010 state budget process to increase inpatient and outpatient hospital rates. With the increasing cost of services, this is necessary in order to maintain reimbursement at 100 percent of hospitals' costs.

Figure 49: Hospital Costs and Percent of Cost Reimbursed for SFY2006 - 2008



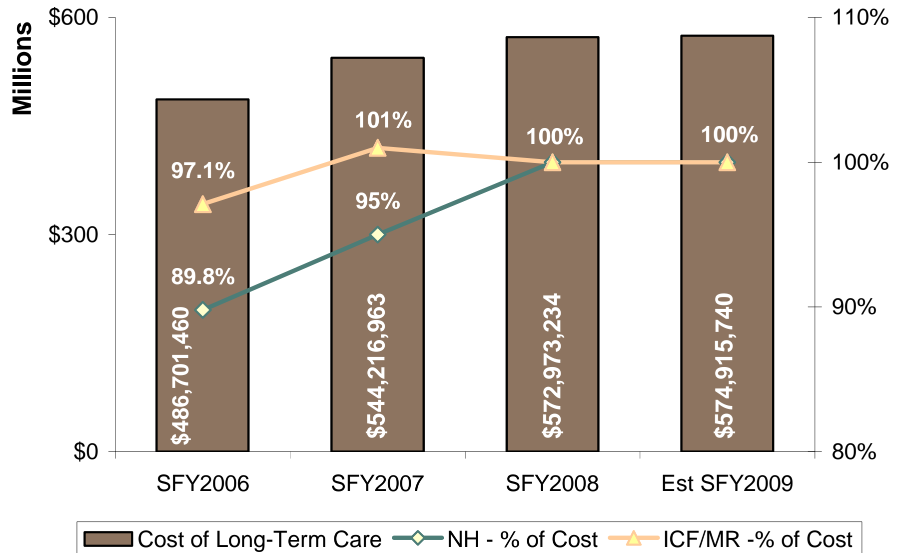
Source: OHCA Financial Services Division

Objective: To reimburse long-term care facilities a reasonable percentage of costs.
Input: Cost of Long-Term Care - *Estimate / See Figure 50*
Outcome: Reimbursement as a Percent of Nursing Homes' Cost - *Target / 100%*
Outcome: Reimbursement as a Percent of ICF/MRs' Cost - *Target / 100%*

What does this report? This measure reports the cost of long-term care services to SoonerCare members as well as the percentage of reimbursed long-term care facilities' costs based on audited cost reports.

Facilities are required to report audited cost after the end of the fiscal year. Therefore, audited reimbursement data is only available through SFY2007. Information received following the issuance of the report may result in slight changes to historical data to accurately reflect percent of costs reimbursed.

Figure 50: Cost of Long-Term Care and Percent of Cost Reimbursed for SFY2006 - 2008



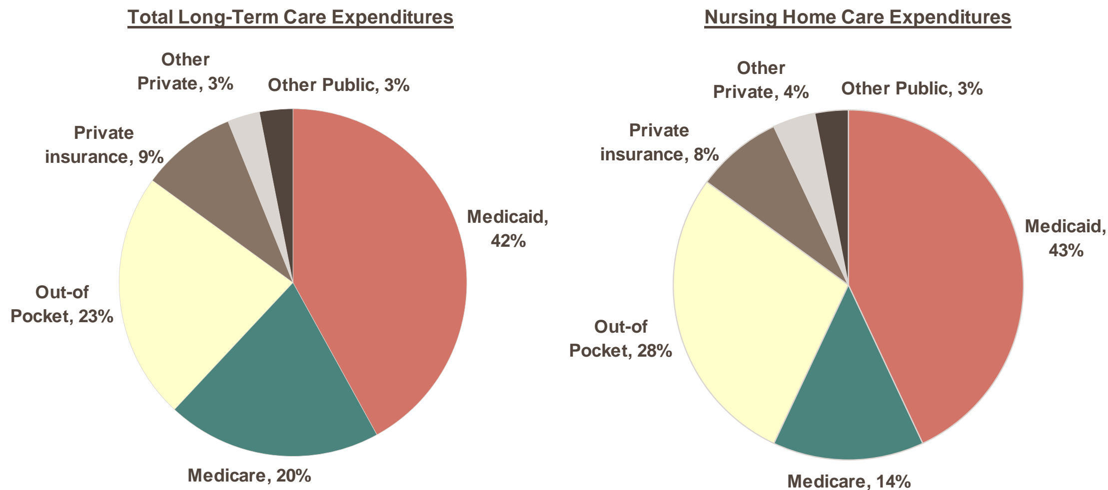
Source: OHCA Financial Services Division

What do we compare our performance to? OHCA compares costs over time and uses trends analysis to support projections of future costs. OHCA's target is to pay 100 percent of long-term care facilities' audited costs.

Has OHCA set a target for this measure? OHCA estimates future costs based on expected changes in growth and utilization. OHCA's target is to pay 100 percent of long-term care facilities' audited costs.

Why report these measures? Long term care issues remain at the forefront of health care discussions as Oklahoma mirrors the national aging population. Medicaid serves as the primary long-term care payer, financing 42 percent of the nation's spending on long-term care services.[8]

Figure 51: Medicaid Expenditures for Total Long-Term Care & Nursing Homes



Source: The Kaiser Commission on Medicaid and the Uninsured, Long-Term Services and Supports: The Future Role and Challenges for Medicaid, September 2007

Because life expectancies for typical long-term care users (chronically ill, disabled, elderly, etc.) have increased over the years, individuals are accessing services for longer periods of time. Indications are that use of paid long-term care services will more than double between 2000 and 2040.[8]

According to the US Census Bureau, the 2000 census estimated that 13.2 percent of Oklahoma's population falls into the 65 and older age group. By 2030, that segment of the population is projected to grow to 19.4 percent.[9]

In SFY2008, the number of Aged, Blind and Disabled made up about 21 percent of the population, but account for approximately 58 percent of program costs.[10]

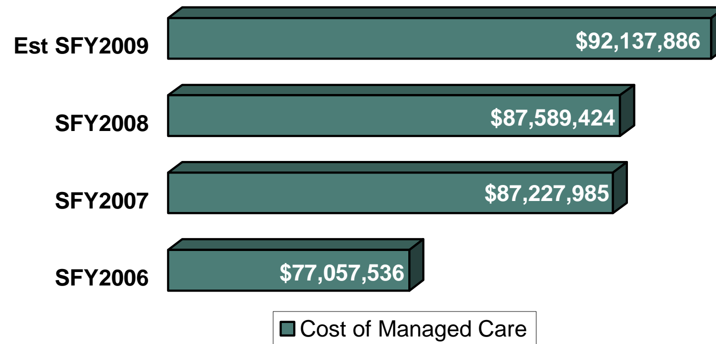
What is OHCA doing that might impact these measures? OHCA has requested additional funding in the SFY2010 state budget request process to ensure the ability to reimburse long-term care facilities at 100 percent of audited costs.

[8] *The Kaiser Commission on Medicaid and the Uninsured, Long-Term Services and Supports: The Future Role and Challenges for Medicaid, September 2007.*
[9] *US Census Bureau, Population Division, Interim State Population Projections, 2005. Internet Release Date: April 21, 2005.*
[10] *Oklahoma Health Care Authority, SFY2007 Annual Report, July 2006 through June 2007.*

Objective: To appropriately reimburse providers within state and federal regulations.
Input: Cost of Managed Care - *Estimate / See Figure 52*

What does this report? This measure reports the cost of providing managed care services to SoonerCare Choice members. The managed care expenditures represent the capitation payments made to providers.

Figure 52: Cost of Managed Care Services for SFY2006 - 2008



Source: OHCA Financial Services Division

What do we compare our performance to? OHCA compares costs over time and uses trends analysis to support projections of future costs.

Has OHCA set a target for this measure? OHCA does not set a target for this measure, but estimates future costs based on expected changes in growth and utilization.

Why report this measure? Currently, SoonerCare Choice operates as a partially capitated primary care case management program (PCCM) meaning that the primary care provider receives a capitated payment for each SoonerCare member on his/her panel. In return, the physician provides care management services and a fixed set of basic health care services. Qualifying noncapitated services are reimbursed on a fee-for-service basis.

In the future, OHCA will be instituting a medical home model in which providers receive a small capitated payment for care management services provided for their panel of SoonerCare members. This fee varies based on the characteristics of the member panel taken on, the types of services offered, and quality initiatives undertaken by the provider. In return, the provider is able to bill fee-for-service for care given to the members that previously would have been considered part of the capitated payment.

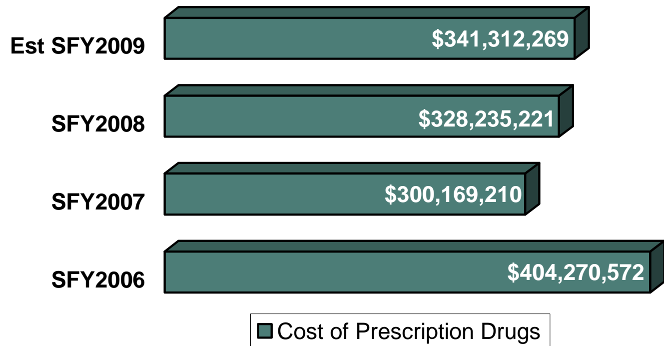
In the medical home model, providers' reimbursement is better aligned with the services provided. Providers are not required to provide specific services in return for a capitated fee which may or may not be sufficient to cover costs. Nor do they receive payment for services not performed. OHCA anticipates that this will improve the cost/benefit ratio for providers and facilitate members getting in to see their physicians appropriately.

Objective: To appropriately reimburse providers within state and federal regulations.
Input: Cost of Prescription Drugs - *Estimate* / See Figure 53*

What does this report? This measure reports the cost of providing prescription drugs to qualifying members.

What do we compare our performance to? OHCA compares costs over time and uses trend analysis to support projections of future costs.

Figure 53: Cost of Prescription Drugs for SFY2006 - 2008*



Source: OHCA Financial Services Division

*Several major events have impacted prescription drug spending on behalf of SoonerCare members and makes year-to-year comparison misleading. In January 2006, OHCA ceased to pay for prescription drugs for dual eligible members (eligible for Medicare and Medicaid funding) due to the implementation of Medicare Part D. This decreased prescription drug expenditures.

Conversely, the state is required to pay the federal government for savings realized from the change, labeled the Medicare Part D "clawback." The estimated savings is based on a federally mandated formula. So, while program spending for prescription drugs has decreased, those resources are still being expended, though not reflected in program costs.

Has OHCA set a target for this measure? OHCA does not set a target for this measure, but estimates future costs based on expected changes in growth and utilization.

Why report this measure? Medication plays a vital role in recovery, controlling chronic diseases and overall health maintenance. Medicare Part D

and the Deficit Reduction Act (DRA) have had a significant impact on Medicaid prescription drug programs around the country.

CMS has developed a new methodology for calculating federal reimbursement for medication by using the average manufacturer price versus the lowest price of three drug pricing lists. Pharmacists have expressed concern that they will be forced out of business or will have to stop providing Medicaid services. Initially the new methodology was to be implemented in January of 2007, but an injunction has delayed implementation until the court reviews the statute and regulations.

What is OHCA doing that might impact these measures? OHCA has requested additional funding for SFY2010 to add payment for Medication Management Therapy and iron supplements for pregnant women.

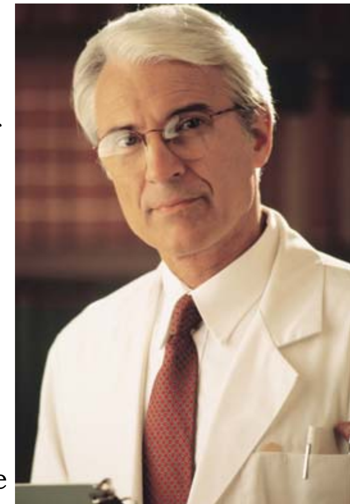
Objective: To appropriately reimburse providers within state and federal regulations.
Input: Cost of Behavioral Health Services - *Estimate / See Figure 54*

What does this report? This measure reports the cost of behavioral health services paid on behalf of SoonerCare members.

What do we compare our performance to? OHCA compares costs over time and uses trends analysis to support projections of future costs.

Has OHCA set a target for this measure? OHCA does not set a target for this measure, but estimates future costs based on expected changes in growth and utilization.

Why report this measure? Mental health issues impact more than the individual involved. Families, the health care system and ultimately the economy are also affected through loss of productivity, increased medical expenses and other costs such as those related to the legal system.

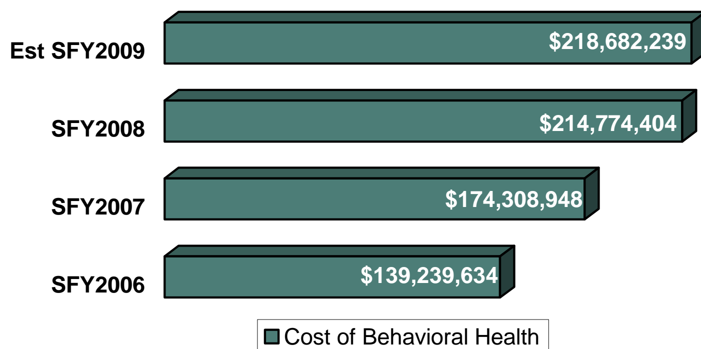


According to the 2007 National Survey of Drug Use and Health Report[11], 24.3 million (10.9 percent) adults age 18 and older in the United States reported serious psychological distress during the year. The highest prevalence was reported in the 18 to 25 year old age range.

Nationally, 5.4 million adults reported having no treatment or counseling for mental health problems. Of these, 43.2 percent reported cost as the barrier to getting needed assistance.

Among the nation's youth aged 12 to 17, 8.2 percent reported at least one major depressive episode in the last year. Of these children, 35.5 percent reported illicit drug use.

Figure 54: Cost of Behavioral Health Services for SFY2006 - 2008



Source: OHCA Financial Services Division

Nationally, 38.9 percent of youths aged 12 to 17 received some form of treatment by talking with a medical doctor or other professional and / or prescription medication.

What is OHCA doing that might impact these

measures? Oklahoma's mental health services public delivery system is undergoing transformation. State agencies responsible for behavioral health services, OHCA, Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), Oklahoma Department of Human Services, Oklahoma State Department of Health, Oklahoma Department of Corrections, and Oklahoma Office of Juvenile Affairs, are partnering with adult and youth consumers and their families as well as the provider community to improve the accessibility and quality of services available in our state.

OHCA has requested additional funding in SFY2010 to cover expenditures related to the ongoing Behavioral Health Collaborative.

Single Payer System. OHCA and ODMHSAS are working together to create a single payer system that will allow behavioral health providers to submit claims for public funds to one place - OHCA's MMIS system - regardless of the source of payment for the services. The MMIS will identify and reimburse from the correct fund reducing the administrative burden on providers. This system is still under development.

Application Process. OHCA and ODMHSAS have been working with consumers and providers to develop an application process that will increase efficiency for providers and communities and decrease stress on individuals and families in crisis. The agencies are working to develop a standard application that will capture information needed by all potential providers and payers reducing the need for filling out multiple forms with the same information. Implementation on this process is anticipated for summer 2009.

Documentation Requirements. OHCA and ODMHSAS have also collaborated to revise both agencies' policies to align requirements for documentation to alleviate as much as possible the necessity of maintaining different documentation depending on the source of payment. This process is ongoing.

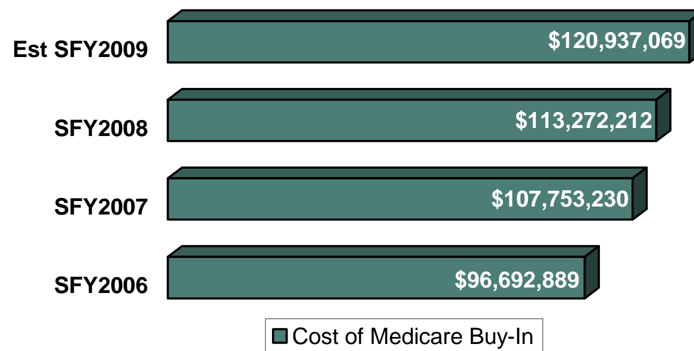
ODMHSAS Transformation State Incentive Grant. The state agencies, consumers and providers are working together to transform delivery services. A Governor's Transformation Advisory Board has been convened to oversee the progress. Serving on the board are elected officials, several state agency directors and commissioners, advocacy groups, providers and consumers.

Studies have been focused on several areas including consumer involvement, workforce development, children and adult services and the criminal justice systems. This $15 million, five year grant was awarded in 2005 and efforts are ongoing. More information on this grant can be found at www.okinnovationcenter.org.

[11]Substance Abuse and Mental Health Services Administration, Office of Applied Studies (2008). *Results from the 2007 National Survey on Drug Use and Health: National Findings* (NSDUH Series H-34, DHHS Publication No. SMA 08-4343). Rockville, MD.

Objective: To appropriately reimburse providers within state and federal regulations.
Input: Cost of Medicare Buy-In - *Estimate / See Figure 55*

Figure 55: Cost of Medicare Buy-In for SFY2006 - 2008



Source: OHCA Financial Services Division

What does this report? This measure reports the amount paid for members qualifying for both Medicare and Medicaid health care services. This category of service pays for qualifying members' Medicare premiums for hospital and / or physician benefits. These dollars reflect payments made to assist with Medicare out-of-pocket expenses. Any other costs incurred on behalf of dual eligibles are reported in the appropriate expenditure category.

What do we compare our performance to? OHCA compares costs over time and uses trends analysis to support projections of future costs.

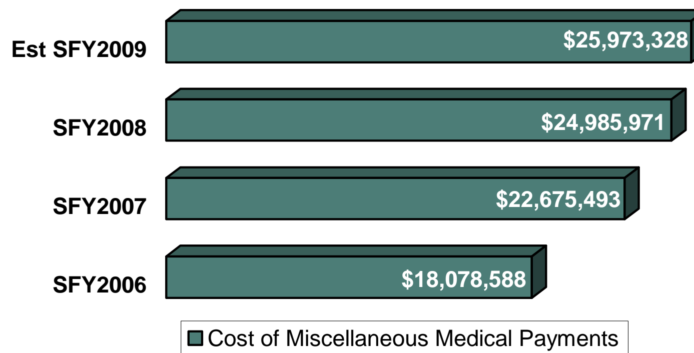
Has OHCA set a target for this measure? OHCA does not set a target for this measure but estimates future costs based on expected changes in growth and utilization.

Why report this measure? This benefit is designed to assist qualifying low-income Medicare beneficiaries in paying the out-of-pocket costs incurred in accessing Medicare compensable services. This population is identified as dual eligibles and typically includes disabled children and adults and individuals age 65 or older.

On January 1 of each year, CMS increases premium amounts for Medicare which requires additional state dollars to fund Oklahoma's part of the payments. These potential increases must be taken into consideration when projecting future funding needs. OHCA has submitted a budget request in order to cover increases in premium amounts for the fiscal year.

Objective: To appropriately reimburse providers within state and federal regulations.
Input: Cost of Miscellaneous Medical Payments - *Estimate* / *See Figure 56*

Figure 56: Cost of Miscellaneous Medical Payments for SFY2006 - 2008



Source: OHCA Financial Services Division

What does this report? This measure reports the amount of spending associated with miscellaneous medical payments not included in other categories of service.

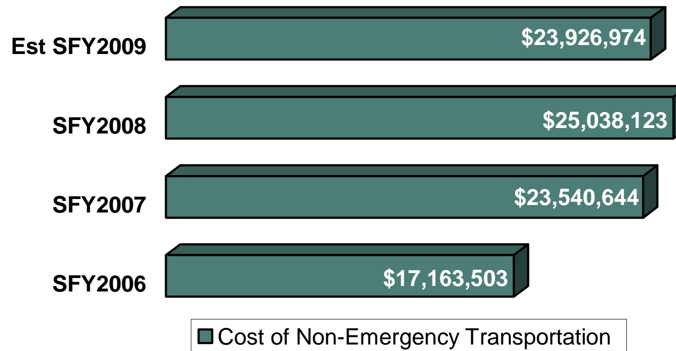
What do we compare our performance to? OHCA compares costs over time and uses trends analysis to support projections of future costs.

Has OHCA set a target for this measure? OHCA does not set a target for this measure, but estimates future costs based on expected changes in growth and utilization.

Why report this measure? This measure tracks the funds expended for such costs as emergency transportation and room and board expenses for members who travel out-of-state to obtain medical services not available in Oklahoma.

Objective: To appropriately reimburse providers within state and federal regulations.
Input: Cost of Non-Emergency Transportation - *Estimate / See Figure 57*

Figure 57: Cost of Non-Emergency Transportation Services for SFY2006 - 2008



Source: OHCA Financial Services Division

What does this report? This measure reports the cost of non-emergency transportation paid on behalf of SoonerCare members.

What do we compare our performance to? OHCA compares costs over time and uses trends analysis to support projections of future costs.

Has OHCA set a target for this measure? OHCA does not set a target for this measure, but estimates future costs based on expected changes in growth and utilization.

Why report this measure? Lack of transportation can often be a barrier to accessing medical services, especially in rural locations. OHCA has contracted with LogistiCare Solutions, LLP to coordinate SoonerRide, non-emergency transportation for SoonerCare members. Members can schedule transportation to qualifying medical appointments. Rides are scheduled at least three days in advance; except in cases where same day or next day appointments are necessary due to onset of illness.

The anticipated decrease between SFY2008 and SFY2009 is due to a reduction on our rate with the transportation contract. Also, we anticipate an impact from the disenrollment of members due to new state and federal citizenship verification requirements.

Goal #6 Administration

Goal #6 Administration

To foster excellence in the design and administration of OHCA programs.

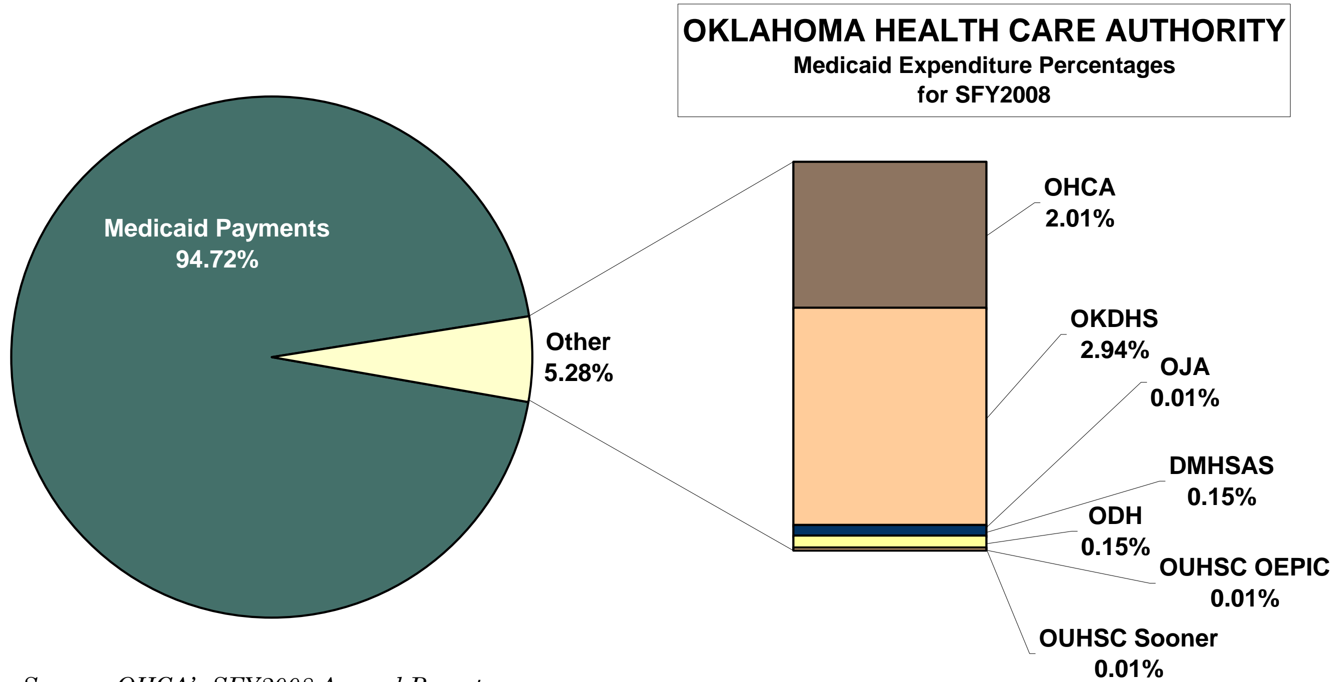
As like most government agencies, OHCA's state and federal resources are scarce. Limited resources, Oklahoma's poor health rating, and the continuing rise of cost of health care makes government administration a critical role of the Oklahoma Health Care Authority. OHCA is monitored by many different stakeholders including CMS, the State of Oklahoma, public officials, the health care industry, taxpayers / consumers and the media. Government administration ensures that public service objectives are met in the most cost effective manner.

OHCA is required to follow complex federal regulations and extensive state requirements while responding to the rising cost of health care, evolving technology and the medical need of our members. All these often conflicting obligations make administering Medicaid funded services challenging.

Two legislative actions have had a significant impact on the operations of the agency; the federal Deficit Reduction Act (2005) and the state Medicaid Reform Act (2006). These acts have created opportunities to stretch our resources for the good of our citizens.

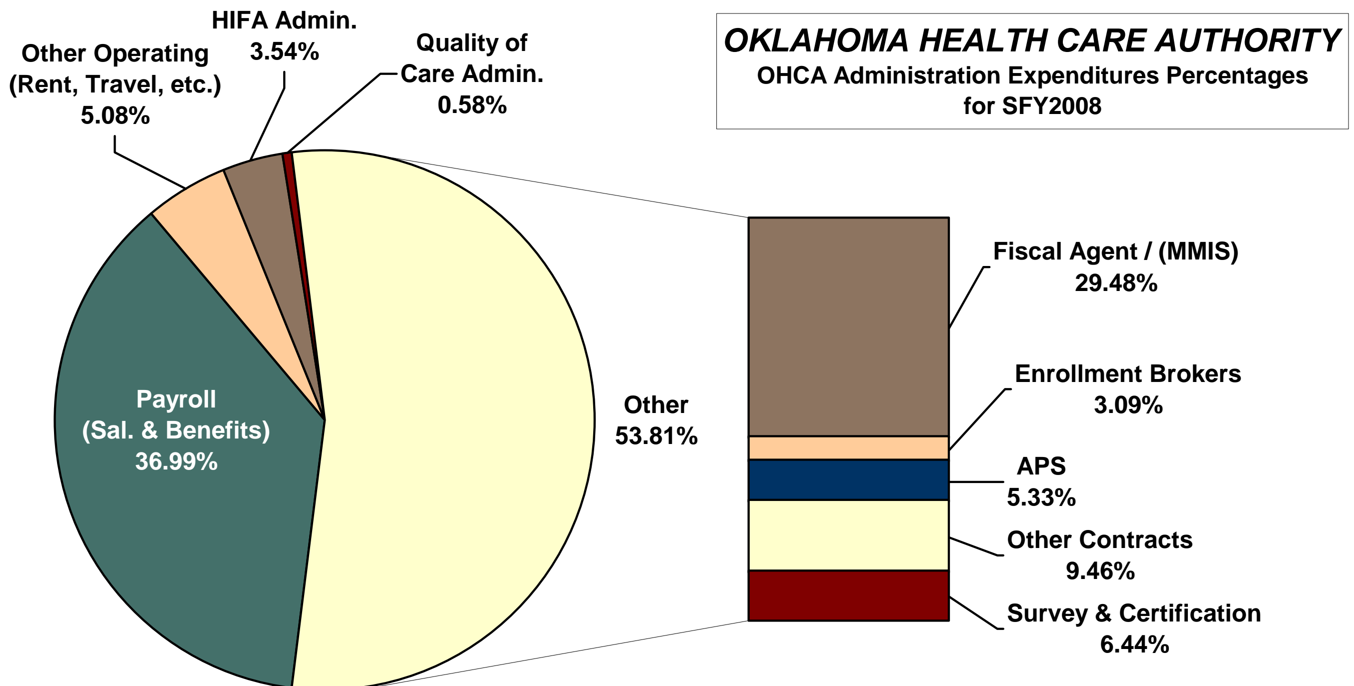
The following measures provide an overview of some of the administrative operations of the agency in order to provide a basis to evaluate OHCA administrative performance.

Figure 58: OHCA Medicaid Expenditures for SFY2008



Source: OHCA's SFY2008 Annual Report

Figure 59: OHCA Administration Expenditures for SFY2008

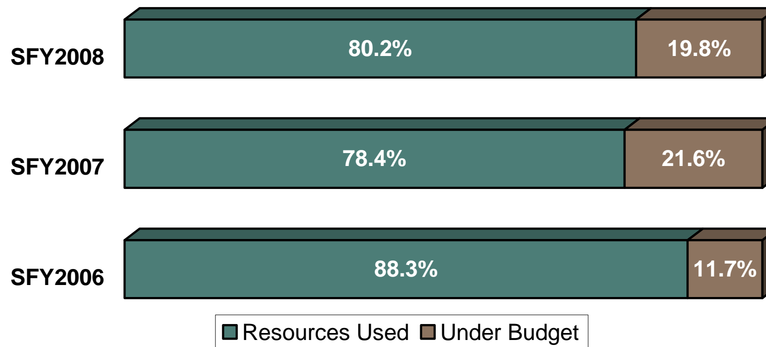


Source: OHCA's SFY2008 Annual Report

Objective: To consistently perform administrative responsibilities within funding budgeted.

Outcome: Percent of Time Administrative Costs Remain Within Budget - *Target* / 100%

Figure 60: Percent of Administration Budgeted Dollars Used for SFY2006 - 2008



Source: OHCA Financial Services Division

What does this report? These measures present the percentage of time the agency has maintained actual administrative expenses within the budgeted limits and how far below budget the actual expenses were for the last three state fiscal years. This information is presented as an indication of how well the agency has planned for the "business" of SoonerCare. The chart shows how much variance existed between projected administrative costs and actual amount spent.

What do we compare our performance to? OHCA compares current administrative expenditures to previous years in order to analyze trends and make projections for the future.

Has OHCA set a target for this measure? OHCA strives for administrative costs to remain within budget 100 percent of the time.

Why report these measures? OHCA has the responsibility to the citizens of Oklahoma to be good stewards of public funds. The prudent use of scarce resources is an indication of such stewardship. Agency staff uses current information and knowledge of the industry as well as the Strategic Plan to forecast and project resource needs.

Figure 61: Administration Costs Within Budget for SFY2006 - 2008

Outcome: Percent of Time Administrative Costs Remain Within Budget:

SFY2006 - SFY2008

100%

Source: OHCA Financial Services Division

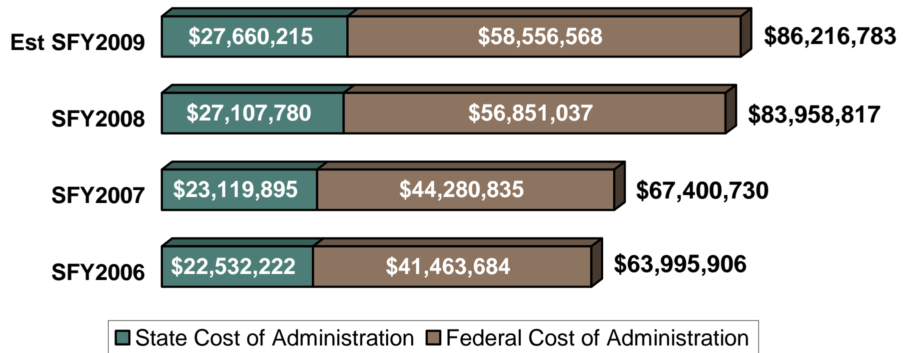
Several measures are used in this report to demonstrate the financial stewardship mentioned above. These measures are: percentage of budgeted administrative resources used, percentage of time administrative costs remained within budget, state and federal cost of administration and cost per member enrolled.

Cost Measures
Input: Cost of Administration - State & Federal - *Estimate / See Figure 62*
Efficiency: OHCA Cost of Administration per Member - State & Federal - *Estimate / See Figure 63*

What does this report: These measures report total resources invested in OHCA's administration and cost per member enrolled.

What do we compare our performance to? OHCA compares current expenditures to previous years to analyze trends and make projections for the future.

Figure 62: OHCA Cost of Administration: State & Federal for SFY2006 - 2008



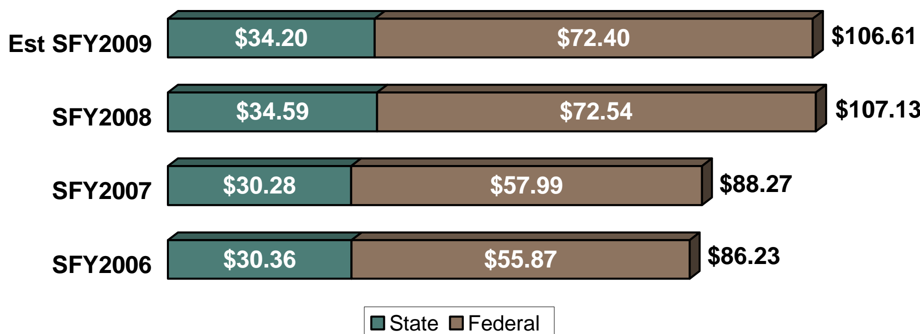
Source: OHCA Financial Services Division

Has OHCA set a target for this measure? OHCA does not set targets for cost measures.

Why report these measures? OHCA has the responsibility to be good stewards of public funds. The prudent use of scarce resources is an indication of such stewardship. Agency staff uses current information and knowledge of the industry as well as the Strategic Plan to forecast and project resource needs.

The significant increase between SFY2007 and SFY2008 is due to grant expenditures for the Money Follows the Person Grant (page 36), No Wrong Door Transformation Grant (page 21) and contracts and waiver development related to OHCA's disease management services. Normal operating expenditures remained consistent at about 1 percent of SoonerCare expenditures.

Figure 63: OHCA Cost of Administration Per Member: State & Federal for SFY2006 - 2008

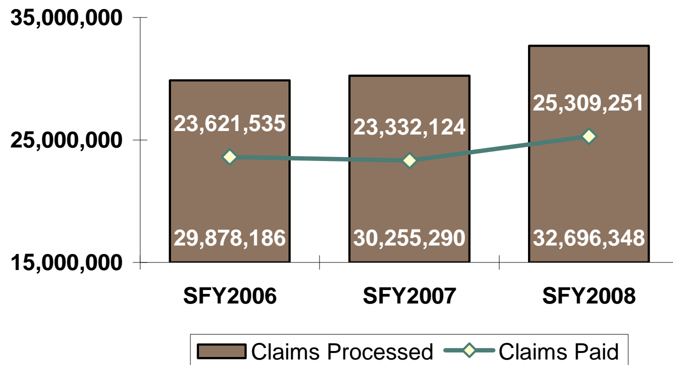


Source: OHCA Financial Services Division

Reported administrative measures relate to OHCA only and do not include expenses incurred by other agencies operating Medicaid funded functions, such as OKDHS and OJA.

Objective: To pay SoonerCare claims within an accuracy rate of at least 97 percent, considering policy and systems issues and member eligibility.
Output: Number of Claims Processed - *Estimate >35,000,000*
Output: Number of Claims Paid - *Estimate / >27,000,000*
Outcome: Payment Accuracy Measurement Rate - *Target / 97%*

Figure 64: Claims Processed / Paid for SFY2006 - 2008

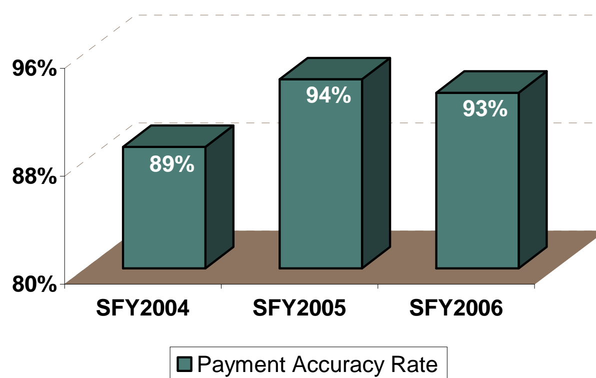


Source: OHCA MMIS

What does this report? These measures report the number of claims that are processed through the MMIS system and the number of those claims that were paid. The last measure reports the accuracy with which claims have been paid based on a comprehensive review process. As of the date of this report, the Payment Accuracy Measurement (PAM) rate for SFY2008 was not available.

*The agency is already gearing up for the next PERM review scheduled for SFY2009. Because this preparation has slowed the internal PERM process, results for the internal review are in the final phase, but have not yet been completed. Therefore, data is reported for SFY2004 - 2006.

*Figure 65: Payment Accuracy Measurement Rate for SFY2004 - 2006**



Source: OHCA Program Integrity Division

What do we compare our performance to? The results of the measures are compared to the agency's performance over time.

Has OHCA set a target for this measure? The agency does not set a target for claims processing and payment. OHCA estimates an increase in claims processing and payments due to the implementation of the medical home model of managed care. Slated to begin in January 2009, it is believed that claims submission will increase partially because of current under-reporting of encounter data . The target for the PAM rate is set at 97%.

Why report these measures? A significant amount of the state's health care costs are paid through the two million plus claims received every month. EDS, OHCA's fiscal agent, processes the incoming claims through the MMIS. In order for our providers to effectively care for their patients and operate their businesses, these claims must be handled in a timely and accurate manner. The reimbursement of legitimate and verifiable services is essential to Medicaid's federal partners and the taxpayers of Oklahoma. There are two functions related to payment accuracy that affect OHCA.

First, the internal PAM process was initiated as part of a three year federal grant working with nine other states and the federal government to devise a consistent, relevant process of measurement that would then be comparable from year-to-year and from state-to-state, eventually resulting in a national average reportable to Congress. The agency conducts this annual comprehensive review of claims payment for validation of three specific elements: processing of claims, documentation of services and their medical necessity and member eligibility. This process has been maintained consistently since its inception.

At the federal level, CMS developed what became known as the Payment Error Rate Measurement (PERM) legislation. Although the PAM grant data was used in the development of the legislation, it veered from the direction anticipated by the states. Originally, it was believed that the PAM (or PERM) function would be performed by the states themselves in compliance with federal regulations. The federal government has instead contracted with outside resources to review the states in a three year rotation.

OHCA was chosen for external review in the first year of the rotation, federal fiscal year 2006 (October 2005 through September 2006). Results from federal PERM review were released August, 2008. Oklahoma was found to have a 2.51 percent error rate. The national error rate will not be released until results are published to Congress in November, 2008.

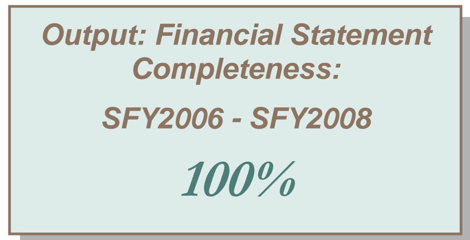
Objective: To accurately forecast, based upon available information, and subsequently report agency revenues in a timely manner.
Output: Financial Statement Completeness - *Target / 100%*

What does this report? This measure indicates whether OHCA has reported the financial status of the agency in a timely manner. Tracking this measure allows the agency to monitor its use of resources and to adjust expectations in a timely manner.

What do we compare our performance to? The result of the measure is compared to the agency's performance over time.

Has OHCA set a target for this measure? OHCA aims for financial statement completeness 100% of the time.

Figure 66: Financial Statement Completeness for SFY2006 - 2008



Source: OHCA Financial Services Division / OHCA Board Minutes

Why report this measure? The careful review of processes and reporting regarding financial statements is critical. The importance of this was heightened by the various private industry scandals which have caused every business sector, including governments, to carefully review their procedures. In order to accurately respond to changing dynamics, the agency must timely report on its financial status, including revenue and appropriately adjust expectations when making decisions.

OHCA reports to the Board on the financial status of the agency on a monthly basis. This includes discussion of budgeted versus actual revenue and expenditures and the potential impact on the agency of emerging and/or ongoing issues.

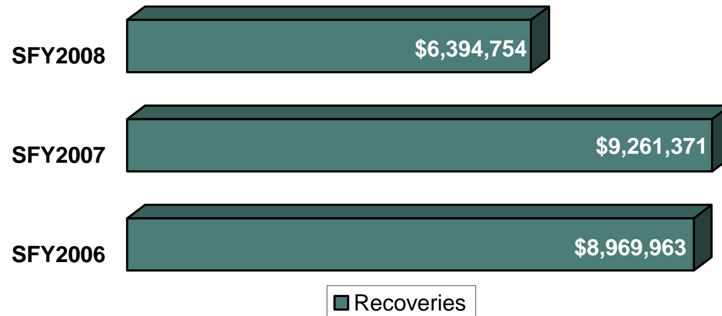
The financial statements are reviewed in depth by the Audit and Finance Committee of the Board. Financial statement information can be found in the OHCA's Annual Report, available on the web at www.okhca.org/research/reports.

Objective: To maintain and/or increase program and payment integrity efforts which may result in recoveries.

Output: Payment Integrity Recoveries - *Estimate / > $9,000,000*

What does this report? This measure tracks the amount of funds recouped due to inappropriately paid claims identified through post-payment reviews. Tracking payment integrity recoveries allows the agency to identify potential areas of errors or abuse, potential areas of needed provider training and unclear policy or procedures. The amount reported includes reviews conducted by Audit Management, Surveillance and Utilization Review and those conducted by the agency's peer review organization, APS.

Figure 67: Payment Integrity Recoveries for SFY2006 - 2008



Source: OHCA Program Integrity Division

What do we compare our performance to? The result of the measure can be compared to the payment integrity recoveries over time for trend analysis.

The decline in recoveries is due to the fact that many reviews conducted in SFY2008 were follow ups of previous audits. The scope of audits performed for the first time typically review longer periods, i.e. a review conducted on a newly identified billing error may look back over a three year period. Follow ups are usually much shorter, perhaps six months. Additionally, most providers will have adjusted their billing procedures to correct the issue.

Has OHCA set a target for this measure? OHCA does not attempt to set a target for payment integrity recoveries.

Why report this measure? Program Integrity has become one of the driving forces shaping administration of government in all forms. Audit and review functions, internal controls monitoring and prepayment edits are critical to preventing and detecting erroneous claims payment and identifying suspected fraud and abuse.

What might impact these measures? The complexity of Medicaid regulations, the significant dollars involved and the impact on federal and state budgets create an environment susceptible to errors, fraud and abuse. Payment integrity recoveries are the dollars identified through the audit and review function as inappropriately claimed and paid. Aside from the PERM function, the

agency is continuously monitoring claims payment through data mining, technical audits and incoming recommendations by citizens, members and providers.

Through the Deficit Reduction Act 2005, the federal government has recently assigned significant resources to program integrity including such activities as the Medicaid Integrity Program (MIP) and the State Program Integrity Assessment program (SPIA). There is a corresponding strain on the resources of OHCA to comply with the various mandates and scrutiny.

Medicaid Integrity Program (MIP). National concern about potential fraud and abuse taking place in Medicaid has prompted the federal government to create the Medicaid Integrity Group (MIG) with the responsibility of overseeing MIP. The MIP has been charged with reviewing state Medicaid programs, providers and members and to provide technical assistance and training to states.

OHCA was chosen for review for federal fiscal year 2007. The review scrutinized the agency's provider audit and SURS functions and provider enrollment. The report released in July 2008 indicated that (1) the agency should institute procedures to notify the Department of Health and Human Services, Office of Inspector General when adverse actions are taken against a provider for criminal or quality issues, and (2) that Disclosure of Ownership requirement should be added to the contract with our fiscal agent, EDS. Both of these issues have been addressed.

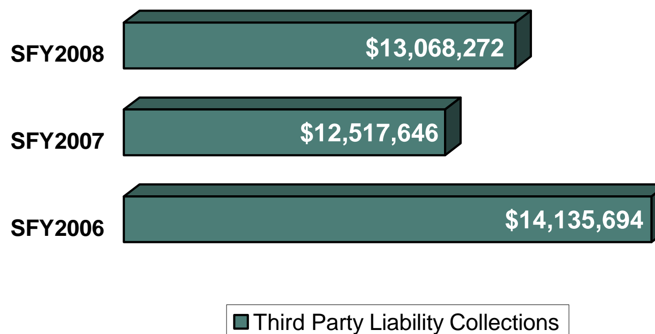
The report also pointed out noteworthy practices of the agency including the Quality Assurance Committee (see page 28), the internal PERM process (see page 91) and the provider re-enrollment process which requires providers to re-enroll every three years.

State Program Integrity Assessment (SPIA). The MIG has also created SPIA to collect standardized, national data on State Medicaid program integrity efforts for the purposes of program evaluation. The MIG intends to use the data to develop profiles for each state to determine areas needing federal support and to develop performance measures to assess the States' performance in an ongoing manner.

The first data collection deadline for SPIA is October 6, 2008. The agency is in the process of completing the collection and verification of required data and will file the information timely.

Objective: To actively pursue all third party liability payers, rebates and fees and recover or collect funds due to the SoonerCare and federal Medicare program.
Output: Third Party Liability Collections - *Estimate / $14.9 million*

Figure 68: Third Party Liability Collections for SFY2006 - 2008



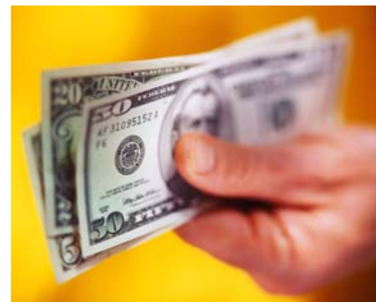
Source: OHCA Financial Services Division

What does this report? This measure reports the amount collected from third parties responsible for medical payments before Medicaid reimbursement is allowable.

What do we compare our performance to? The result of the measure is compared to previous years' data to identify trends.

Has OHCA set a target for this measure? OHCA does not attempt to set a target for third party liability collections.

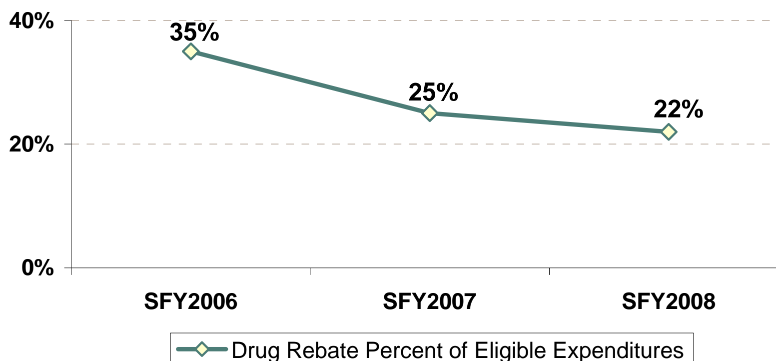
Why report this measure? Federal regulations require that Medicaid be the payer of last resort. All other payment sources must be utilized before Medicaid funding is available. OHCA consistently seeks reimbursement from third party payers such as insurance providers.



Objective: To actively pursue all third party liability payers, rebates and fees and recover or collect funds due to the SoonerCare and federal Medicare program.

Output: Drug Rebate as a Percent of Rebate Eligible Expenditures - *Estimate / > 20%*

Figure 69: Drug Rebates as a Percent of Rebate Eligible Expenditures for SFY2006 - 2008



Source: OHCA SoonerCare Operations Division

What does this report? The above percentage reflects a comparison of the rebate dollars earned to the amount expended on drugs eligible for rebate. In the past, this percentage has hovered around 20 - 21 percent. The difference between drugs eligible for rebate and Prescription Drugs category of service expenditures is due to physician administered drugs which are claimed on and recorded as physician expenditures. The drugs may be eligible for rebate and would be included in the Rebate Eligible Expenditures.

What do we compare our performance to? The result of the measure is compared to previous years' data to identify trends.

Has OHCA set a target for this measure? OHCA does not attempt to set a target for rebate collections.

Why report this measure? Ensuring that appropriate drugs are available and obtaining them at the lowest cost to taxpayers is a priority for both the federal and state Medicaid entities. The Medicaid Prescription Drug Rebate Program was enacted in 1990, granting the Medicaid program "most-favored customer" status and requiring drug manufacturers sell their drugs to Medicaid at the "best price" available to any other purchaser.

The significant dip in the percentage between SFY2006 and SFY2007 is attributable to the implementation of the Medicare Part D and the lag time between expenditures and rebate collection. It is considered an anomaly and it is anticipated that the agency will continue to see about a 20 percent rebate percentage in the future.

Objective: To train and educate SoonerCare providers, both on an "as-needed" basis and proactive basis, through group and/or individual training and other communication.

Output: Number of Provider Trainings - *No benchmarks*
- Seminars/Workshops & Attendees
- Onsite Training
- Written Communication

Figure 70: Provider Training for SFY2006 - 2008

Provider Training	SFY2006	SFY2007*	SFY2008
Seminars / Workshops	155	100	85
Attendees	7,282	7,215	8,590
On-Site Training	4,684	5,112	3,961
Written Communication	525,092	1,647,384	1,745,865

Source: OHCA SoonerCare Operations & APS, Inc.

What does this report? The number of educational opportunities offered to the providers and the number of providers who participate in and/or receive training information are reported through this measure.

*Numbers have been restated from those reported in SFY2007 to correctly reflect types of training. *(Previously reported numbers were: Seminars/ Workshops - 153, Attendees - 8,306, On-Site Training - 4,021.)*

Educational opportunities are offered in a variety of ways including seminars, workshops, regional group training, on-site trainings, global messages/banners and provider letters.

- The seminars, workshops, and regional group trainings cover topics that range from claims processing procedures to new or changing policies and may include any topic relevant to the SoonerCare plan, its members and providers. These events offer a forum for information dissemination and discussion.

- On-site trainings may be requested by the provider or may be initiated by OHCA staff as a quality monitoring and training tool.

- Global messages/banners are messages providers receive when they log onto the secure provider website. The messages may target particular provider types or may be sent to all depending on the information. These messages notify the provider of important changes or updates that concern their provider type.

- Provider Letters are sent out to all providers or may be limited to a specific provider type(s). These letters notify the providers of new policy, changes in existing policy or clarification of policies and procedures.

What do we compare our performance to? The results of the onsite trainings and workshops can be compared to the agency's performance over time. However, comparing global messages and provider letters may be misleading due to the arbitrary nature of policy and procedures issues that may arise during the period.

Has OHCA set a target for these measures? There are no targets set for these numbers, because of the different variables that are involved. The numbers are impacted by issues that surface during the year, new programs, new policies, number of providers enrolled, and amount of staffing available.

Why report these measures? During SFY2008, OHCA contracted with over 25,000 providers from all across the state. Ensuring providers have current information on relevant issues, policies, and procedures is critical to the quality of services received by our members and accurate reimbursement of our providers.

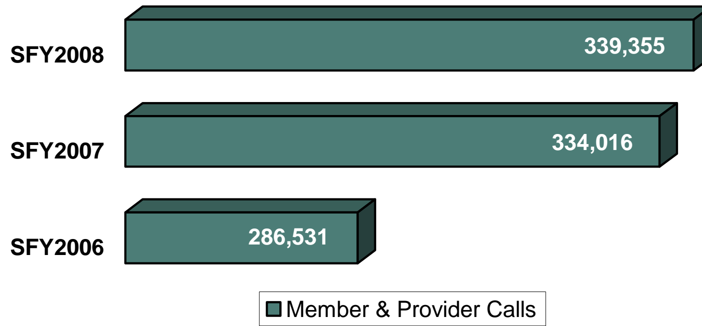
One of the most effective ways to reduce claims errors is to educate providers on agency policy, emerging issues and appropriate billing procedures.

The significant increase in written communication between SFY2006 and SFY2007 is attributed to increased utilization of global messages and provider letters, many of them sent to all providers. These trends continued through SFY2008.

Objective: To ensure members and providers have access to assistance through Member and Provider Services

Output: Number of Member and Provider Calls - Estimate / > 350,000

Figure 71: Member & Provider Calls for SFY2006 - 2008



Source: OHCA Call Tracking Integration System

What does this report? This measure tracks calls taken by our fiscal agent, EDS, and OHCA Provider Services and Member Services. EDS serves as the first line of contact in regard to claims and is responsible for answering basic questions about claims processing. More complex calls come to the agency through the call tree directed to either Provider or Member Services where an OHCA service representative is available to research and answer questions.

What do we compare our performance to? The results of the measure is compared to the agency's performance over time to ensure resources are appropriately utilized and that members, providers and the public have easy access to information from OHCA.

Has OHCA set a target for this measure? OHCA does not set a target for number of calls taken.

Why report this measure? As a state agency and public service organization it is important that we are available to SoonerCare members and providers. This measure illustrates to the taxpayers of Oklahoma that we are available and responsive to information requests received from our members and providers.

Acronym	Name	Description
ABD	Aged, Blind and Disabled	Medicaid eligibility category
AHRQ	Agency for Healthcare Research and Quality	Healthcare research and quality component of the federal Department of Health and Human Services.
APS	APS Healthcare	OHCA's contracted peer review organization.
CAHPS®	Consumer Assessment of Healthcare Providers and Systems	Previously known as Consumer Assessment of Health Plans Study; a consumer survey process developed and administered by the Agency for Healthcare Research and Quality (AHRQ).
CDC	Center for Disease Control and Prevention	Component of the Department of Health and Human Services; works toward prevention and control of infectious and chronic diseases, injuries, workplace hazards, disabilities, and environmental health threats.
CMS	Centers for Medicare and Medicaid Services	Division of the federal agency, Department of Health and Human Services, responsible for oversight of state Medicaid programs.
CNA	Certified Nurse Aide	Health care professional responsible for providing direct care services to residents in long-term care facilities, including direct patient care, nutrition, observation and documentation.
CPS	Current Population Survey	Survey conducted by the US Census Bureau to collect demographic data including information on the uninsured in the United States.
DD	Developmental Disability	Acronym used to denote a developmental disability diagnosis.
DRA	Deficit Reduction Act of 2005	Federal law enacted in 2005 for the purpose of reducing federal government spending related to entitlement programs.
DUR	Drug Utilization Review	A board of pharmaceutical professionals who meet monthly to advice OHCA on appropriate and optimal use of medications.
EDS	Electronic Data Systems Corporation	OHCA's contracted fiscal agent.
eNB1	Electronic Newborn System	New online enrollment system for newborns allowing hospitals to enter newborn enrollment information while still in the hospital.
EPSDT	Early and Periodic Screening, Diagnosis and Treatment	Comprehensive and preventive health services for children under the age of 21 including vision, hearing, dental and other basic health care services.
ER	Emergency Room	Acronym used to indicate the emergency room of hospitals.
ESI	Employer Sponsored Insurance	Acronym used with the Insure Oklahoma Plan to identify the program partnering small businesses, the state and employees and their spouses to make health insurance more affordable.
FMAP	Federal Medical Assistance Percentage	Percentage used to determine the amount of federal matching funds to be paid for state expenditures attributable to Medicaid compensable services.

Acronym	Name	Description
FOE	Focus on Excellence	New OHCA initiative to encourage excellence in nursing home care by reviewing and rating participating nursing homes on quality measures.
FPL	Federal Poverty Level	Federal poverty threshold measures issued by the Department of Health and Human Services to be used for administrative purposes such as determining financial eligibility for federal programs.
HCBS	Home and Community Based Services	Health and personal care provided in a community setting to long-term care members who might otherwise require nursing home services.
HEDIS®	Health Plan Employers Data and Information Set	A set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans; this set has been modified to be used for the collection of Medicaid data.
HMP	Health Management Program	OHCA's disease management program.
HRSA	Health and Resource Services Administration	Agency in the US Department of Health and Human Services responsible for improving access to health care services for people who are uninsured, isolated or medically vulnerable.
ICF/MR	Intermediate Care Facility for the Mentally Retarded	Acronym used to indicate facilities designed to serve nursing facility members diagnosed with mental disabilities.
IP	Individual Plan	Acronym used with the Insure Oklahoma Plan to identify the program available to individuals employed by businesses that do not qualify for ESI, who are self-employed or unemployed.
KPMG LLC	KPMG LLC	Public accounting / auditing firm.
MAC	Medical Advisory Committee	Committee of professionals, consumers and advocates who advise the OHCA on Medicaid medical issues.
MFP	Money Follows the Person	Grant received by the OHCA administered by CMS being utilized to develop a self-directed care program for long-term care members.
MRA	Medicaid Reform Act of 2006	Oklahoma law enacted in 2006 to reform the state's Medicaid program.
MI	Mentally Ill	Acronym used to denote a mental illness diagnosis.
MIG	Medicaid Integrity Group	Division created by CMS to oversee the program integrity efforts of state Medicaid programs.
MIP	Medicaid Integrity Program	Program created by CMS to review state Medicaid programs, providers and members and to provider technical assistance and training to states regarding program integrity efforts.
MMIS	Medicaid Management Information System	Electronic claims processing system for the Medicaid program.

Acronym	Name	Description
MR	Mentally Retarded	Acronym used to denote a mental retardation diagnosis.
NCM	Nurse Care Manager	Nurses providing intervention services in the agency's HealthCare Management Program.
NCQA	National Committee for Quality Assurance	Non-profit organization providing information on the quality of managed care health plans; the Centers for Medicare and Medicaid Services partnered with the NCQA to adapt HEDIS® data to Medicaid funded programs.
NIP	National Immunization Program	Partners with the National Center for Health Statistics of the Center for Disease Control and Prevention to conduct the National Immunization Survey.
NWD	No Wrong Door	New online enrollment system under development funded through a transformation grant that will allow potential members to enroll online from any computer at anytime.
OKDHS	Oklahoma Dept of Human Services	State agency primarily responsible for reviewing and maintaining eligibility data for the ***SoonerCare*** program.
ODMHSAS	Oklahoma Dept of Mental Health and Substance Abuse Services	State agency responsible for most publicly funded mental health services in Oklahoma.
O-EPIC	Oklahoma Employer / Employee Partnership For Insurance Coverage	Former name of the Insure Oklahoma Plan that partnered small business employers, the state, and employees and their spouses to make health insurance more affordable. Now referred to as Insure Oklahoma ESI.
OHCA	Oklahoma Health Care Authority	The state agency responsible for purchasing state and federally funded health care and studying / recommending strategies for optimizing the accessibility of quality health care.
OSDH	Oklahoma State Dept of Health	State agency participating in health programs.
OSEEGIB	Oklahoma State and Education Employees Group Insurance Board	State agency responsible for the legal trust which adminsters group health insurance for employees, dependents of state agencies, school districts and other governmental units.
OSU	Oklahoma State University	Refers to Oklahoma State University.
OU	Oklahoma University	Refers to University of Oklahoma.
OUHSC	OU Health Sciences Center	University of Oklahoma's Colleges of Health.
PAM	Payment Accuracy Measurement	Acronym for the measurement developed for the purpose of calculating accurate payment of claims through appropriate processing and determination of medical necessity.
PASRR	Pre-Admission Screening and Resident Review	A review required by the federal government that screens enrollees entering a nursing home for developmental disabilities or mental retardation and / or mental illness to ensure appropriate placement.

Acronym	Name	Description
PCA	Personal Care Aide	Individuals providing personal daily living services to long-term care members living in the community who might otherwise require nursing home services.
PCCM	Primary Care Case Management	A partially capitated insurance plan in which primary care providers serve as care managers for patients in return for a fee; SoonerCare Choice is a PCCM plan.
PCP	Primary Care Provider	Provider serving as a member's medical home providing basic medical services and assisting members with navigation of other medically necessary services.
PERM	Payment Error Rate Measurement	Acronym to denote the measurement rate to be calculated by the Centers for Medicare and Medicaid Services to indicate performance in paying claims appropriately and ensuring medical necessity criteria applied and documented appropriately.
PI	Program Integrity	Ensuring that a program is operating effectively and efficiently within applicable policy and procedures and performing control functions designed to detect fraud, waste and abuse. OHCA's Policy, Planning and Integrity Division is responsible for this function and includes provider audits, utilization reviews of services and internal processes and procedures reviews.
QAC	Quality Assurance Committee	Committee of representatives integral to the operations of SoonerCare responsible for reviewing and making recommendations on issues relevant to the quality of health care delivered, operations and administration of the program.
QISMC	Quality Improvement System for Managed Care	The Centers for Medicare and Medicaid Services (CMS) recommended standards for Medicaid funded programs. This quality initiative has been discontinued by CMS. OHCA has replaced this with a similarly structured review.
S&C	Survey & Certification	Quality and safety reviews of nursing facilities; requirement of the federal government and performed by OSDH for Oklahoma.
SAI	State Auditor and Inspector	State agency responsible for auditing other state programs and agencies.
SAS	Statement of Accounting Standards	Rules of financial accounting promulgated by the Financial Accounting Standards Board for the purpose of creating standard accounting practices across industries.
SCHIP	State Children's Health Insurance Program	Legislation enacted in 1997 allowing state Medicaid programs to offer health insurance to children with a higher poverty level than the primary Medicaid criteria in order to cover more children that would otherwise be uninsured.
SFY	State Fiscal Year	The accounting cycle as adopted by the state; Oklahoma's state fiscal year runs July to June.

Acronym	Name	Description
SPIA	State Payment Integrity Assessment	Program by CMS to collect standardized, national data on State Medicaid program integrity efforts.
TANF	Temporary Assistance for Needy Families	Category of individuals qualifying for public assistance which requires low income enrollees to meet specific work criteria to receive financial assistance for a limited period of time.
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982	Federal law enacted in 1982 giving states the option to cover children who have physical or mental disabilities qualifying for institutional care but because of parent's income, do not qualify for Medicaid.

Goal # 1 ~ Eligibility	Performance Measure		2004	2005	2006
To provide and improve health care access to the underserved and vulnerable populations of Oklahoma	Outcome	% of Oklahomans Enrolled	19.1%	19.5%	20.6%
	Output	# of Unduplicated Enrollees	670,797	696,743	742,152
	Output	% of Change in Enrollment	3.4%	3.9%	6.5%
	Input	Total State Cost	$794,080,422	$917,462,526	$1,070,492,978
	Input	Total Cost	$2,705,057,665	$2,863,476,393	$3,154,002,105
	Efficiency	Total State Cost Per Member Enrolled	$1,184	$1,317	$1,444
	Efficiency	Total Cost Per Member Enrolled	$4,033	$4,110	$4,256

2007	2008	*2009 (Est)*	*2010 (Est)*	*2011 (Est)*
21.1%	21.9%	*22.7%*	*23.2%*	*23.7%*
763,565	797,556	*833,446*	*857,373*	*882,237*
2.9%	4.5%	*4.5%*	*2.9%*	*2.9%*
$1,149,583,896	$1,288,370,806	*$1,295,675,462*	*$1,463,027,404*	*$1,467,353,730*
$3,420,671,434	$3,742,605,618	*$3,862,179,783*	*$4,161,744,067*	*$4,246,262,170*
$1,506	$1,615	*$1,602*	*$1,780*	*$1,743*
$4,496	$4,693	*$4,634*	*$4,854*	*$4,813*

Goal # 2 ~ Satisfaction & Quality

To protect and improve member health and satisfaction, as well as ensure quality, with programs, services and care

	Performance Measure	2004	2005	2006
Outcome	Ratio of Appeals Filed to Members	1/4 of 1%	1/4 of 1%	1/4 of 1%
Output	# of Member Appeals Filed	42	35	42
Outcome	% of OHCA's Decisions Overturned in the Appeals Process	21%	43%	10%
Customer Survey (CAHPS ®) Results				
Outcome	Rating of Health Plan	Not Available		65.5%
Outcome	Rating of Health Care	Not Available		68.7%
Outcome	Rating of Personal Doctor	Not Available		77.0%
Outcome	Rating of Specialist	Not Available		72.8%
Outcome	Customer Service	Not Available		82.6%
Outcome	Courteous/Helpful Office Staff	Not Available		82.0%
Outcome	How Well Doctors Communicate	Not Available		79.6%
Outcome	Getting Care Quickly	Not Available		64.9%
Outcome	Getting Needed Care	Not Available		80.1%
Choice Quality Scores				
Outcome	Quality Assessment	0.99	1.00	1.00
Outcome	Enrollee Rights	1.00	1.00	1.00
Outcome	Health Service Management	0.99	0.99	0.99
Outcome	Delegation	1.00	1.00	1.00
Input	Cost of QISMC Review	$307,951	$189,448	$203,024
Efficiency	Cost per SoonerCare Choice Member	$0.68	$0.35	$0.37
[1] Restated to Correctly report Cost of QISMC Review and Cost per SoonerCare Choice Member				
Survey & Certification				
Input	Cost of S&C Contract	$5,238,148	$5,282,549	$5,551,738
Output	# of Surveys Conducted	Not Available	710	770
Efficiency	Cost Per Survey	Not Available	$7,440	$7,210
Output	% of Quality of Care Fee Collected	100%	100%	100%
Output	# of Involuntary Provider Contract Terminations	61	20	25

* Restated to correctly reflect total number of providers terminated.

2007	2008	2009 (Est)	2010 (Est)	2011 (Est)
1/4 of 1%	1/4 of 1%	*1/4 of 1%*	*1/4 of 1%*	*1/4 of 1%*
45	46	*<40*	*<40*	*<40*
7%	4%	*<10%*	*<10%*	*<10%*
Not Applicable	62.1%	*70.7& (Benchmark)*		
Not Applicable	60.6%	*66.3% (Benchmark)*		
Not Applicable	75.1%	*65.1% (Benchmark)*		
Not Applicable	68.8%	*75.1% (Benchmark)*		
Not Applicable	78.1%	*79.0% (Benchmark)*		
Not Applicable	83.1%	*86.4% (Benchmark)*		
Not Applicable	80.4%	*86.8% (Benchmark)*		
Not Applicable	77.1%	*79.6% (Benchmark)*		
Not Applicable	72.8%	*75.5% (Benchmark)*		
1.00	1.00	*1.00*	*1.00*	*1.00*
1.00	1.00	*1.00*	*1.00*	*1.00*
1.00	1.00	*1.00*	*1.00*	*1.00*
1.00	1.00	*1.00*	*1.00*	*1.00*
$ 178,953 [1]	$178,958	*$190,531*	*$190,531*	*$190,531*
$ 0.32 [1]	$0.32	*$0.34*	*$0.34*	*$0.34*
$6,291,593	$6,154,327	*$6,561,000*	*$6,889,050*	*$7,233,503*
785	719	*Not Available*		
8,015	8,560	*Not Available*		
100%	100%	*100%*	*100%*	*100%*
34*	22	*<32*	*<32*	*<32*

Goal # 3 ~ Personal Responsibilities	Performance Measure		2004	2005	2006
To promote members' personal responsibilities for their health services utilization, behaviors and outcomes	Outcome	% of Children Accessing Well-Child Visits/EPSDT			
		First 15 months	91.6%	95.2%	96.5%
		3 to 6 years	48.6%	54.7%	56.7%
		Adolescents	23.8%	25.9%	25.9%
	Outcome	Immunization Rate	72.1%	75.7%	80.4%
	Outcome	Adults' Health Care Use - Preventive/Ambulatory Care			
		20 to 44 years	71.6%	72.0%	74.9%
		45 to 64 years	81.8%	82.8%	84.2%
	Outcome	ER Visits Per 1,000 Visits			
		TANF	66.1	70	70
		ABD	70.0	48	47
		Total Population	73.9	63	63
	Output	# of Members Identified for Intervention	656	2,044	4,563
	Outcome	Intervention Rate	100%	100%	95%
	Output	Contact Intervention			
		Letter	452	1,005	3,065
		Call/ER Education & Other Services	198	1,015	1,509
		Call/Care Management Referral	6	24	19
	Output	Average # of Members in Pharmacy Lock-In	179	369	212
	Outcome	% of Members Seeking Prenatal Care	Not Available	Not Available	90%
	Output	# of Births	Not Available	Not Available	27,027
	Output	# of Members Seeking Prenatal Care			
		First Trimester	Not Available	Not Available	56%
		Second Trimester	Not Available	Not Available	25%
		Third Trimester	Not Available	Not Available	10%
		None	Not Available	Not Available	9%

2007	2008	*2009 (Est)*	*2010 (Est)*	*2011 (Est)*
96.8%	*95.0% (Benchmark)*			
57.1%	*63.3% (Benchmark)*			
28.6%	*40.6% (Benchmark)*			
80.1%	*90% (Target)*			
75.6%	*76.4% (Benchmark)*			
85.2%	*81.4% (Benchmark)*			
70	*Not Available*			
48	*Not Available*			
64	*Not Available*			
6,730	6,723	*Not Available*		
96%	91%	*Not Available*		
6,603	6,114	*Not Available*		
1,492	1,269	*Not Available*		
14	5	*Not Available*		
199	145	*Not Available*		
93%	94%	*90% (Target)*		
32,303	32,438	*Not Available*		
62%	63%	*90% (Target)*		
21%	21%	*Not Available*		
10%	10%	*Not Available*		
7%	6%	*Not Available*		

Goal # 4 ~ Member Benefits	Performance Measure		2004	2005	2006
To ensure that programs and services respond to the needs of members by providing necessary medical benefits to our members	Outcome	Children's Health Care Use			
		12 to 24 months	91.4%	91.2%	94.3%
		25 months to 6 years	78.2%	78.0%	81.2%
		7 to 11 years	77.3%	81.2%	80.4%
	See Adult Health Care Use under Goal # 3				
	See Appeals Data under Goal # 2				
	Output	# of PASRR Reviews Performed	5,596	6,219	9,528
	See Well-Child Visits under Goal # 3				
	See Immunization Rate under Goal # 3				
	Comparative	Medical Inflation	4.4%	4.2%	4.0%
	Other Info	Oklahoma FMAP	73.19%	70.18%	67.91%
	Comparative	Region 6 FMAP	73.29%	70.24%	68.84%
	Input	State Cost of Service	$766,913,013	$899,943,763	$1,047,960,756
	Input	Total Cost of Service	$2,639,871,399	$2,087,288,146	$3,090,006,199
	Efficiency	Total Cost Per ***SoonerCare*** Member Served	$3,817	$3,926	$3,989
	Efficiency	Average Cost Per Enrollee - Nationwide	$5,300	$5,597	$5,911

2007	2008	2009 (Est)	2010 (Est)	2011 (Est)
94.1%	*92.4% (Benchmark)*			
81.4%	*82.8% (Benchmark)*			
80.8%	*82.9% (Benchmark)*			
6,533	7,383	*Not Available*		
4.4%	4.4%	*Not Available*		
68.14%	67.10%	65.90%	64.43%	*Not Available*
68.94%	69.25%	68.61%	67.62%	*Not Available*
$1,126,464,001	$1,261,263,026	*$1,268,015,247*	*$1,434,152,602*	*$1,437,221,343*
$3,353,270,704	$3,658,646,801	*$3,775,963,000*	*$4,072,556,000*	*$4,154,007,120*
$4,475	$4,735	*$4,791*	*$5,085*	*$5,062*
$6,243	$6,593	*$6,963*	*$7,354*	*$7,767*

Goal # 5 ~ Provider Reimbursement	Performance Measure		2004	2005	2006
To purchase the best value health care for members by paying appropriate rates and exploring all available valid options for program financing to ensure access to medical services by our members	Input	Cost of Physicians/Other Providers Services	$229,856,738	$343,365,122	$467,799,496
	Outcome	Reimb as a % of Medicare Rates - State Employed Physicians	Not Available	140%	140%
	Outcome	Reimb as a % of Medicare Rates - Other Physicians / Providers	Not Available	89.23%	99.99%
	Input	Cost of Hospital Services	$384,210,619	$459,572,258	$681,308,932
	Outcome	Reimbursement as a % of Hospital Costs	83%	81%	80%
	Input	Cost of Nursing Homes / ICF/MR	$319,336,196	$496,768,830	$486,701,460
	Outcome	Reimbursement as a % of Nursing Home Costs	95.3%	93.8%	89.8%
	Outcome	Reimbursement as a % of ICF/MR Costs	104.9%	99.0%	97.1%
	Input	Cost of Managed Care Services	$274,946,082	$71,122,507	$77,057,536
	Input	Prescription Drug Services	$355,209,786	$475,606,181	$404,270,572
	Input	Behavioral Health Services	$118,318,453	$134,225,035	$139,239,634
	Input	Medicare Buy-In	$69,240,600	$81,269,288	$96,692,889
	Input	Cost of Misc Medical Payments	$6,731,296	$9,576,685	$18,078,588
	Input	Cost of Non-Emergency Transportation	Not Available	$15,118,558	$17,163,503

2007	2008	2009 (Est)	2010 (Est)	2011 (Est)
$526,971,220	$584,390,421	$576,391,288	$675,680,119	$718,247,966
140%	140%	140%	140%	140%
99.99%	100.00%	100.00%	99.99%	99.99%
$811,684,896	$835,440,046	$882,321,485	$947,176,463	$988,852,227
103%	103%	100%	100%	100%
$544,216,963	$572,973,234	$574,915,740	$638,767,362	$638,767,362
100%	100%	100 % (Target)		
100%	100%	100 % (Target)		
$87,227,985	$87,589,424	$92,137,886	$94,164,733	$94,164,733
$300,169,210	$328,235,221	$341,312,269	$363,178,245	$385,332,118
$174,308,948	$214,774,404	$218,682,239	$228,523,823	$238,807,395
$107,753,230	$113,272,212	$120,937,069	$130,757,075	$130,757,075
$22,675,493	$24,985,971	$25,973,328	$27,142,124	$28,363,520
$23,540,644	$25,038,123	$23,926,974	$30,867,408	$32,565,115

Goal # 6 ~ Administration

To foster excellence in the design and administration of the SoonerCare program

Performance Measure		2004	2005	2006
Outcome	% of Time Administration Costs Remain Within Budget	100%	100%	100%
Input	State Cost of Administration	$27,167,409	$17,518,763	$22,532,222
Input	Total Cost of Administration	$65,186,266	$56,188,247	$63,995,906
Efficiency	State Cost Per Member Enrolled	$40.50	$28.08	$30.36
Efficiency	Total Cost Per Member Enrolled	$97.18	$80.64	$86.35
Output	# of Claims Processed	26,015,408	29,251,991	29,878,186
Output	# of Claims Paid	18,138,886	22,678,837	23,621,535
Outcome	Payment Accuracy Measurement	89%	94%	93%
Output	Financial Statement Completeness	100%	100%	100%
Output	Payment Integrity Recoveries	$1,796,655	$7,374,259	$8,969,963
Output	Third Party Liabilities Collections	$5,901,207	$8,488,397	$14,135,694
Output	Drug Rebate as a % of Pharmacy Expenditures	20%	21%	35%
Output	Provider Training			
	Seminars / Workshops	Not Available	Not Available	155*
	Attendees	Not Available	Not Available	7,282
	On-Site Training	Not Available	Not Available	4,684*
	Written Communication	Not Available	Not Available	525,092
* Restated to correctly reflect training c	* Restated to correctly reflect training category.			

2007	2008	2009 (Est)	2010 (Est)	2011 (Est
100%	100%	*100 % (Target)*		
$23,119,895	$27,107,780	*$27,660,215*	*$28,874,802*	*$30,132,387*
$67,400,730	$83,958,817	*$86,216,783*	*$89,188,067*	*$92,255,050*
$30.28	$34.59	*$34.20*	*$35.13*	*$35.78*
$88.27	$107.12	*$106.61*	*$108.52*	*$109.55*
30,255,290	32,696,348	*>35,000,000*	*>35,000,000*	*>35,000,000*
23,332,124	25,309,251	*>27,000,000*	*>27,000,000*	*>27,000,000*
97% (Target)				
100%	100%	*100 % (Target)*		
$9,261,371	$6,394,754	*$9,000,000*	*$9,000,000*	*$9,000,000*
$12,517,646	$13,068,272	*$14,900,000*	*$14,900,000*	*$14,900,000*
25%	22%	*>20%*	*>20%*	*>20%*
100*	85	*Not Available*		
7,215*	8,590	*Not Available*		
5,112*	3,961	*Not Available*		
1,647,384	1,745,865	*Not Available*		