A History in Brief...

Oklahoma Health Care Authority

September 2005

A History in Brief ...

Oklahoma Health Care Authority

Since its creation by the State Legislature in 1993, the Oklahoma Health Care Authority has implemented extensive reforms to promote efficient use of state funds while retaining the flexibility to adapt to the ever-changing health care industry.

Medicaid provides health care for many of Oklahoma's most vulnerable populations: children, the uninsured, and the aged, blind and disabled. In 2004, Medicaid covered 47 percent of the births in Oklahoma and funded 76 percent of Oklahoma's total bed days in facilities providing long-term care.

Meeting the needs of a growing number of uninsured Oklahomans

The rising health care costs that have driven recent changes in Oklahoma's Medicaid program are nothing new. The escalating growth of medical services is what led to the creation of the Oklahoma Health Care Authority in the first place.

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

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

In an effort to avoid additional, dramatic cuts in services and reductions in eligible populations, the governor and legislature placed health care reform near the top of their agendas. From 1992 through 1993, Oklahoma's leadership formed two broad-based citizens' committees, the Task Force on Medicaid and Welfare Reform

and the Commission on Oklahoma Health Care. These groups were directed to study access and cost-containment problems within the existing system and to propose meaningful reforms.

As a result of their recommendations, the Oklahoma Health Care Authority was established by the legislature in 1993. In addition, their recommendations were the catalyst for Oklahoma to begin the transition of its traditional fee-for-service Medicaid program to a coordinated system of managed care – focusing on primary care, prevention and increased access.

The decision for Oklahoma to move its Medicaid program from a fee-for-service to a managed care delivery system is not unique. To date, 47 states have implemented some form of managed care delivery systems in their Medicaid programs. The Centers for Medicare & Medicaid Services (CMS), for example, has documented remarkable growth in enrollment in Medicaid managed care nationwide from 9.53 percent in 1991 to 59.11 percent in 2003. Commercial health plans also have embraced managed care. According to the Agency for Healthcare Research and Quality, more than half of all Americans who have health insurance are enrolled in some kind of managed care plan.

Changing Medicaid's health care delivery system

In 1993, two bills were passed that enabled the state of Oklahoma to transition its fee-for-service Medicaid program to a managed care delivery system. House Bill 1573 and Senate Bill 76 put in motion a significant transition of health care delivery under Oklahoma's Medicaid program.

HB 1573 enacted the Oklahoma Health Care Authority Act, which established the OHCA as an executive agency with the mandate to:

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

SB 76, also known as the Oklahoma Medicaid Health Care Options Act, mandated the conversion of the Oklahoma Medicaid program from fee-for-service to a

statewide, comprehensive system of managed health care delivery. It was designed to allow for prepaid, fully capitated health plan arrangements as well as primary care case management systems in areas that could not support the fully capitated approach.

Under the legislation, specific timelines were established that identified specific benchmarks for the OHCA to meet in terms of the Medicaid populations being transitioned to the managed care delivery system. A phase-in approach began July 1, 1995, with the recipients who were categorically related to Aid to Families with Dependent Children (AFDC) – now known as Temporary Aid for Needy Families (TANF). As monthly re-determinations were completed for eligibility, individuals were transitioned to managed care. The entire AFDC/TANF population was enrolled by July 1, 1996.

The Aged, Blind and Disabled (ABD) populations were scheduled to enter the managed care delivery system July 1, 1997, under SB 76. However, it was mutually decided by the legislature, the OHCA and other involved individuals that it would be beneficial to modify the transition date. This postponement to an effective date of July 1, 1999, was designed to provide the OHCA additional time to conduct further research and analysis of the special health care needs of the populations and the health care delivery systems in place to serve them.

Refining a workable structure for managed care

A significant amount of work had to be accomplished before the OHCA could begin administrating Oklahoma's Medicaid program in 1995. Before Oklahoma could transition its Medicaid program to one of managed care, the state had to request a waiver from the federal Centers for Medicare & Medicaid Services (CMS).

States apply for waivers of Medicaid rules to test innovative approaches to benefits, services, eligibility, program payments and service delivery. State demonstration projects are frequently aimed at saving money or extending Medicaid coverage to additional low-income and uninsured people. The federal government currently grants two kinds of Medicaid managed care waivers: Section 1915(b) "Freedom of Choice" waivers and Section 1115(a) "Research and Demonstration" waivers.

Section 1915(b) waivers permit states to require beneficiaries to enroll in managed care plans. To receive such a waiver, states must prove that these plans have the capacity to serve Medicaid beneficiaries who will be enrolled in the program. Freedom of

choice waivers are intended to improve beneficiary access to care through enrollment in a guaranteed provider network that operates in a cost-efficient manner and to facilitate the monitoring of beneficiary quality of care. They frequently place beneficiaries in delivery systems in which there is greater emphasis on health education and preventive medicine.

Section 1115(a) demonstrations allow states to test new approaches to benefits, services, eligibility, program payments and service delivery, often on a statewide basis. These approaches are frequently aimed at saving money to allow states to extend Medicaid coverage to additional low-income and uninsured people. Research and demonstration waivers can normally be granted for up to five years at a time. This permits states to try out a far greater range of policies than would otherwise be permissible in ordinary freedom of choice waiver programs.

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

SoonerCare Plus was a fully capitated Managed Care Organization (MCO) program that was implemented July 1, 1995, under a 1915(b) waiver. Under ***SoonerCare Plus***, the OHCA contracted directly with MCOs (also commonly referred to as Health Maintenance Organizations, or HMOs) to provide all medically necessary services to recipients residing in Oklahoma City, Tulsa, Lawton and the counties immediately surrounding these urban centers.

Benefits under ***SoonerCare Plus*** included office visits, hospital care, emergency room services, specialty care, prescription drugs and immunizations. “Plus” referred to the enhanced benefit package created through the removal of limitations of hospital days, prescriptions and office visits for adults, all of which were present under the traditional fee-for-service program. Beneficiaries who took part in ***SoonerCare Plus*** were given the opportunity to choose a health plan and a primary care provider (PCP) who would be responsible for coordinating most of each beneficiary’s health care, including a majority of specialty care and referrals.

This focus on the role of the PCP featured largely in the OHCA's new orientation toward providing a "medical home" for beneficiaries, who had traditionally navigated a fragmented health care delivery system through the use of Yellow Pages and numerous phone calls to determine if providers took Medicaid as payment for services.

It was through CMS's approval of Oklahoma's 1115(a) waiver that the OHCA was able to implement ***SoonerCare Choice*** – the initial statewide rural model – on Oct. 1, 1996. ***SoonerCare Choice*** was created as a Primary Care Provider/Case Management (PCP/CM) program, where the state contracted directly with primary care providers throughout the state to provide basic health care services. Qualified providers included physicians, physician assistants and nurse practitioners. The program was partially capitated in that providers were paid a monthly capitated rate for a fixed set of services, with noncapitated services remaining compensable on a fee-for-service basis.

Under the prepaid benefit package and responsibilities of the Primary Care Provider/Case Manager (PCP/CM), ***SoonerCare Choice*** participants received unlimited office visits for primary and preventive care; Early and Periodic Screening, Diagnosis and Treatment (EPSDT) visits, injections and immunizations; basic lab and X-ray services; basic family planning; case management; urgent care; and 24-hour access to care. Specialty referrals, hospitalizations or prescription services remained compensable under the fee-for-service schedule, with associated limitations still in place for adults. By July 1999, ***SoonerCare Choice*** had contracted with more than 500 providers offering primary health care services at 600 sites.

The word "choice" in the program name referred to the recipient's ability to change health care providers on a monthly basis. Recipients enrolled in ***SoonerCare Choice*** were not "locked in" with the PCP/CM like their counterparts in the ***SoonerCare Plus*** delivery system. As a result, providers could be added in rural areas of Oklahoma on a continuous basis – especially in areas of the state that had been historically underserved or limited on the types of available providers. Allowing the recipients to move among providers also gave them greater choice in terms of selecting a medical home for themselves and their family.

The ***SoonerCare*** programs grew steadily over the years. By 2003, enrollment in both programs had grown to more than 333,760 members. This growth was attributed to the Legislature's mandate to expand Medicaid eligibility to include children from birth to age 18 and pregnant women at 185 percent of the Federal Poverty Level as well as the inclusion of the Aged, Blind and Disabled populations into the ***SoonerCare*** delivery systems, including the provision of prescription medications.

Continuing to enhance and promote *SoonerCare*

In late 2003, one of the health maintenance organizations active in ***SoonerCare Plus*** decided to pull out of the state Medicaid program. The HMO's withdrawal would have left ***SoonerCare Plus*** members in some parts of the state with insufficient choice of health care providers. In an effort to rectify that problem and increase efficiency throughout the ***SoonerCare*** program, the OHCA board decided to end all of its HMO contracts as of Dec. 31 and switch all members to the other managed care system, ***SoonerCare Choice***.

As of Jan. 1, 2004, about 189,000 people were transferred into a temporary but enhanced fee-for-service program, and by April 1, all were moved to ***SoonerCare Choice***, joining the approximately 160,000 other people already served by that program. As of July 2004, ***SoonerCare Choice*** had contracted with 1,144 primary care providers (including physician assistants and nurse practitioners), who served almost 360,000 members.

SoonerCare Choice recipients may select a primary care provider from a comprehensive statewide list. If a recipient fails to make a choice of provider, ***SoonerCare Choice*** aligns them with the closest appropriate provider. Family members may enroll with different types of providers during this process. Should parents/guardians wish to coordinate their children's care through a single provider, it can be achieved through one phone call to the ***SoonerCare*** Help Line. The change normally takes effect within 15 to 45 days, with effective dates always occurring on the first of the month.

SoonerCare also used the transition period in 2004 to identify almost 900 members with complex or exceptional health care needs and offer those beneficiaries care management services.

The ***SoonerCare*** program also offers a Nurse Advice Line that is available toll-free to recipients 24 hours a day, seven days a week. This service was initiated with the statewide implementation of the ***SoonerCare Choice*** program Oct. 1, 1996, in an effort to reduce unnecessary emergency room utilization and provide an additional way to have their medical questions answered in a timely manner.

At the same time beneficiaries were being transferred into the ***Choice*** program, the OHCA conducted an extensive recruitment campaign to bring providers into the network. Staff conducted onsite meetings with providers and

contacted hundreds of physicians, most of whom had been under contract to the managed care plans, about joining the ***SoonerCare*** network. In Oklahoma City, 80 percent of those providers joined ***SoonerCare*** during the initial campaign, as did 75 percent of the Tulsa providers and 96 percent of those in Lawton. Even more providers chose to enter the network later. The OHCA also recruited about 480 specialists as fee-for-service providers.

Providing care for Oklahoma's uninsured children

Based on 2000-2001 state data, the Kaiser Family Foundation reported Oklahoma's uninsured population to be more than 630,000, or 19 percent of the state population. In early 1997, Oklahoma held the inauspicious title of being ranked third in the nation in its uninsured rates for children. By 2003, the ranking was slightly improved, with the state moving to ninth – despite the fact that 22 percent of Oklahoma children were uninsured. In addition, the uninsured rates are further exacerbated by the disappointing participation rate of children who have access to health care services under Medicaid but are not enrolled.

No one is certain why Oklahoma had such a low participation rate in its Medicaid program. However, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 may have played a significant role – not only in Oklahoma, but throughout the entire nation. The PRWORA replaced the Aid to Families with Dependent Children (AFDC) program with the Temporary Aid for Needy Families (TANF) program. Unlike AFDC and Medicaid, TANF is not an entitlement program, and states are not under any federal obligation to provide cash assistance to poor families. In other words, Medicaid and its eligibility were "de-linked" from cash assistance.

One of the major components of the PRWORA was the institution of a five-year time limit on TANF benefits. Medicaid benefits, however, are not subject to this restriction. The immediate result of this "de-linking" of TANF and Medicaid was the decline in the number of Medicaid recipients – with TANF recipients assuming that when their cash assistance terminated, they were no longer eligible for Medicaid benefits.

This unfortunate phenomenon resulted in the federal government taking immediate action by setting aside $500 million specifically to help states with the outreach and administrative

costs of de-linking welfare and Medicaid. Rather than being a lump-sum block grant, states could receive an enhanced federal match of 90 percent for specific outreach, educational and eligibility computer system activities targeting those who were eligible for Medicaid but not participating. In spite of the availability of additional resources, it was difficult for states to access the enhanced funding due to the significant restrictions and rules placed on its use. The problem was compounded by the Sept. 30, 1999, sunset on the availability of the funds.

The substandard ranking of Oklahoma in uninsured rates for children was in itself enough to focus public attention on the need for some decisive action by Oklahoma's policymakers. Recognizing the growing concern for the health and welfare of Oklahoma's children, the state legislature took action in 1997 by passing Senate Bill 639. This legislation initially made available increased access to health care services under Medicaid by expanding the income eligibility level to 185 percent of the Federal Poverty Level (FPL) for children and pregnant women.

The legislation was implemented Dec. 1, 1997, for children through age 14 and pregnant women. Children ages 15 through 17 were phased into the expansion effective Nov. 1, 1998. On Sept. 1, 2001, eligibility rules were expanded to include 18-year-olds, bringing about 6,000 additional Oklahomans to the Medicaid rolls.

Pursuing partnerships among state agencies

The state of Oklahoma recognized early on that providing health care coverage to needy children and pregnant women was not only good public policy, it had social significance. Further, it had the ability to positively affect the health and welfare of Oklahomans over the long term. Therefore, prior to the implementation of SB 639 on Dec. 1, 1997, a number of state agencies came together in an effort to assure the legislation would reach its full intent and potential. The agencies involved in the planning and development effort were the Oklahoma Health Care Authority, the Oklahoma Department of Human Services, the Oklahoma State Department of Health, the Oklahoma State Department of Education and the Oklahoma Commission on Children and Youth. These agencies laid the foundation for radical change in Medicaid eligibility and access to health care services for Oklahoma's uninsured children.

The intense collaboration effort of the state agencies resulted in modifications to

the computer eligibility system and the application for Medicaid. Focused training programs were developed and designed to reach all OKDHS county offices statewide. An aggressive outreach program was also developed in an effort to increase awareness of the expanded eligibility guidelines and decrease the stigma associated with assistance programs. Most importantly, many rules and policies were changed in order to simplify the application process and increase access to health care services under the ***SoonerCare*** programs.

Prior to the implementation of SB 639, Oklahoma's Medicaid application consisted of 17 detailed pages and took up to 45 days to process by the OKDHS county workers. Modifications to the eligibility rules such as the elimination of the asset test allowed Oklahoma to pare down its application to one page front and back and reduced its processing time to as little as 10 days, not to exceed a maximum of 20. The requirement for a face-to-face interview was removed, allowing the application to become a "mail-in" document. This modification to the application placed Oklahoma in the forefront of Medicaid outreach and access for recipients as well as eligibility reform.

Shortly after this rule was implemented, the state again took prompt action to reduce additional barriers to the application process. Income declaration replaced income verification during the eligibility process, which enabled prospective applicants to complete the necessary form without providing pay stubs or other forms of income verification. Information provided by applicants remains subject to verification, however. The state also changed the termination of Medicaid cases to a "re-determination" process at six months. This was designed to facilitate continuity of care and health care delivery. More recently, eligibility was extended to 12 months.

The outreach component of SB 639 has received national recognition by the Centers for Medicare & Medicaid Services, the National Governors' Association, the Children's Defense Fund and the Center for Budget Policy Priorities. This recognition came only after significant commitment and hard work on the part of the state partners who worked jointly on a marketing and outreach task force in the development and implementation of a comprehensive, statewide public awareness campaign. Dialogue focused on determining the priorities related to the production of materials as well as isolating individual agency responsibilities.

It was recognized early on that the campaign had to be carefully designed to not only increase the eligible population's

knowledge of the availability of programs, but to inspire them to take action and enroll. The challenge for Oklahoma continues to lie not within the direct marketing of SB 639, but rather in dealing with the complex elements associated with the "social marketing" of programs and services that require behavioral changes as well as individual action.

Though the state's efforts to communicate to the eligible populations have been mostly at the mass media level (newspaper, television, radio and theater promotion), significant emphasis has also been placed on local, community-based approaches. In 1998, the OHCA authorized $2.5 million to OKDHS to place 47 outreach workers statewide. These positions were filled by existing OKDHS employees who had demonstrated excellence and possessed a considerable aptitude in the medical programs. The outreach workers' focus was to coordinate and assist in the statewide outreach functions, but they were primarily charged with developing cooperative efforts at the community level to promote the ***SoonerCare*** programs. In addition, they were directed to maximize their outreach efforts by training other interested parties in taking applications and to provide education to community partners regarding the ***SoonerCare*** programs and the processes involved in enrollment.

The OHCA recognizes the significant need to maintain and coordinate the development of comprehensive, ongoing community-based outreach initiatives. However, with the sunset of the enhanced TANF dollars on Sept. 30, 1999, it became impossible for the OHCA to continue the OKDHS outreach worker approach. Other resources and initiatives were maximized such as the Oklahoma Institute on Child Advocacy's $726,000 Robert Wood-Johnson (RWJ) "Covering Kids" grant specifically designed for outreach to low-income, uninsured children. The OHCA also continues its communication and work with broad state and local coalitions to facilitate the identification and enrollment of Medicaid-eligible children.

Coming on board with Title XXI

(State Children's Health Insurance Program)

Shortly after the implementation of SB 639 in 1997, $24 billion in federal matching funds became available to states under Title XXI of the Social Security Act. These funds were earmarked to provide insurance to more than 5.8 million of the 10 million children nationwide who are uninsured. This program is a capped entitlement for states and is commonly known as the State Children's Health Insurance Program (SCHIP).

The purpose of SCHIP is to enable states to initiate and expand child health assistance to uninsured, low-income children. States can cover uninsured children by expanding Medicaid, creating or expanding separate state insurance programs, or both. Funds must be used to cover previously uninsured children and not to replace existing public or private coverage. In order to be eligible for funds, states must submit a State Child Health Plan to the Secretary of Health and Human Services and obtain approval.

In January 1998, Gov. Frank Keating designated the expanded Medicaid program as the vehicle for Oklahoma's Title XXI Plan and the Oklahoma Health Care Authority as the administering agency. Oklahoma's SCHIP plan was approved in May of the same year, providing an initial allotment of $102.3 million state and federal dollars. Oklahoma's access to these dollars came through an enhanced federal match rate of approximately 79 percent, with Oklahoma responsible for the remaining 21 percent. To illustrate the financial benefit to Oklahoma, it is worth noting that under the traditional Title XIX Medicaid program, direct health care delivery costs are matched at a rate of approximately 70 percent federal, 30 percent state.

Upon the approval of Oklahoma's SCHIP plan, it was necessary to determine which categories uninsured children would fall into under the rules and regulations established under Title XXI of the Social Security Act. For example, if a child was eligible under the old Title XIX standards, the state of Oklahoma could not receive the enhanced match rate available under SCHIP. In addition, those eligible under the new SCHIP standards but who had some form of insurance could not be counted under the enhanced SCHIP match rate.

Oklahoma had a great deal of work ahead of it to enroll the 200,000 children eligible under Oklahoma's Medicaid expansion. Of the 200,000, 105,000 children were identified as eligible for Medicaid under the old standards but not participating; 54,005 children were identified as eligible due to the expansion but were accounted for under the regular Title XIX match rate due to the presence of some form of health insurance; and 40,995 children were eligible due to the expansion and could be accounted for under the enhanced Title XXI (SCHIP) matching rates.

The OHCA has continued to carefully monitor its successes in enrollment. As a result of an aggressive outreach program, Oklahoma experienced a significant increase in the number of children covered by Medicaid. Since the implementation of the eligibility expansion programs, the number of children enrolled in Oklahoma Medicaid has more than doubled. In November 1997, 161,732 children were enrolled in standard Medicaid. As of January 2005, a total of 366,707 children were covered under Medicaid, which includes the expansion programs.

Increasing Oklahomans' access to health care

SoonerRide

In early 1999, the OHCA instituted a transportation brokerage system called SoonerRide to stabilize the budget process for the non-emergency transportation (NET) program under fee-for-service Medicaid and increase the program's accountability.

SoonerRide replaced a fee-for-service system of reimbursement for mileage paid to beneficiaries outside of the fully capitated ***SoonerCare Plus*** program. Broker systems for transportation are not unique, and many states use them to provide non-emergency transportation for their Medicaid beneficiaries.

The SoonerRide program began operating in Tulsa, McCurtain, Woodward, Muskogee, Cleveland, Tillman and Comanche counties on June 1, 1999. It was expanded two months later to include Choctaw, Pushmataha and Atoka counties. Nineteen additional counties were added Sept. 1, 1999. They included Adair, Sequoyah, Cherokee, Leflore, Latimer, Haskell, Pittsburg, McIntosh, Beckham, Greer, Harmon, Jackson, Kiowa, Cotton, Stephens, Jefferson, Custer, Roger Mills and Washita.

The expansion of SoonerRide into the balance of the state was completed in 2000. In State Fiscal Year 2004, almost 55,000 beneficiaries from across Oklahoma used the SoonerRide services for more than 418,000 transports.

OHCA awarded the 2003-2004 NET contract to LogistiCare Solutions, LLC, headquartered in Atlanta, Ga. The contract will run from Aug. 1, 2003, through June 30, 2004, with three subsequent one-year renewal options. Estimated contract value over the three years is more than $20 million.

Similar to a managed health care delivery system, LogistiCare is reimbursed by the OHCA on a per-member-per-month (PM/PM) capitated basis. This means that a pre-determined, fixed rate is paid in advance for each eligible beneficiary listed on the roster issued by the OHCA. Should beneficiaries become eligible after the issuance of the roster, transportation services are provided, but the OHCA reimburses LogistiCare for these individuals on a fee-for-service basis.

The OHCA's contract with LogistiCare is specifically to arrange for all non-emergency transportation for medical services. LogistiCare's scope of services includes Medicaid recipient eligibility verification and screening, trip scheduling

and routing. The company also subcontracts with and manages the performance of third-party local transportation companies that provide actual trip service. In that capacity, LogistiCare also performs provider billing verification and trip reimbursement, while ensuring overall quality assurance.

SoonerRide is available to beneficiaries in ***SoonerCare*** and nursing home residents in the Medicaid program needing non-emergency transportation. The benefit for nursing home residents is funded by legislative mandate through the Quality of Care fee.

To use SoonerRide, beneficiaries call a toll-free number to reach the LogistiCare reservation center. A customer service representative gathers the necessary information and provides an authorization number for the trip. When necessary, appointments are verified in order to best coordinate transportation to health care services.

In its contract with the OHCA, LogistiCare and all of its subcontracted transportation providers are required to have liability insurance, engage in driver training programs, ensure proper vehicle maintenance, and provide drug testing and driving history checks. Further, LogistiCare and its subcontracted transportation providers are required to perform criminal background checks for their drivers. All requirements of this nature are designed to ensure a high level of quality within the SoonerRide program. But most importantly, they are intended to guarantee the safety of the Medicaid beneficiaries served by the program.

School-based services

School health services play an important role in the health care of adolescents and children. Whether implemented for children with special needs under the Individuals with Disabilities Education Act (IDEA) or for routine preventive care, ongoing primary care and treatment in the form of a school-based or linked health clinic, school-centered programs are often able to provide medical care efficiently and easily without extended absences from school. The Medicaid program has long been supportive of school-centered health care as an effective method of providing access to essential medical care to eligible children.

There are, however, challenges in the collaboration between the Medicaid program and the schools. Federal Medicaid requirements are complex, and the implementation of Medicaid varies by state. Because many schools are unaccustomed to these requirements

and the complexity of operating in the "medical services world," understanding and negotiating Medicaid in order to receive reimbursement has often placed a considerable administrative burden on schools. This notwithstanding, most Oklahoma public schools are making the commitment to become Medicaid providers.

In State Fiscal Year 2004, the OHCA contracted with 252 school-based providers in 66 counties, compared with 173 schools in SFY 1998. The expansion in contracting is attributed to a number of important factors, such as the development of statewide training initiatives and provider manuals specific to schools. Further, the OHCA simplified the school-based contract and committed additional personnel to assist schools in their contracting effort. And finally, many smaller districts with limited resources have exercised ingenuity by entering into cooperative arrangements with other districts to secure a contract with the OHCA.

The consequence of this growth in school-based contracting is that more children are gaining access to services such as Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT). EPSDT benefits are a federally mandated set of comprehensive health services for children up to age 21. Under EPSDT, states must provide for physicals; screening for speech, behavioral health and substance abuse problems; vision and hearing exams; immunizations; nutritional reviews; lab tests; and dental services. These services are provided at intervals that meet reasonable standards of medical and dental practice. The program is designed to improve primary health benefits for children with emphasis on preventive care.

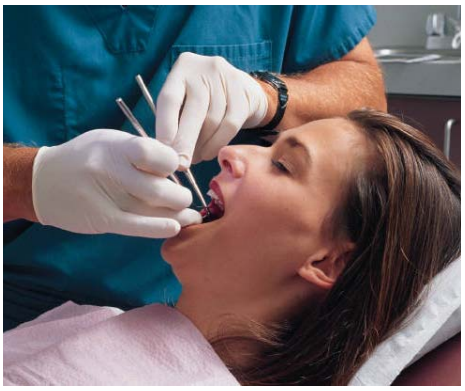
Increased outreach regarding the importance of EPSDT services coupled with an increase in health care provider education and school-based contracting are credited with increasing Oklahoma's compliance rate. Further, the OHCA is working closely with its providers to identify EPSDT screens that may be going undocumented. Once these are identified, it is anticipated that the rate will continue to increase.

Dental services

Though adult dental services are optional, the federal Medicaid statute requires that all states provide dental services to children eligible for Medicaid. In April 2005, OHCA held contracts with 465 dentists across Oklahoma.

In an effort to increase the participation of Oklahoma dentists in its Medicaid program, Oklahoma has worked closely with the Oklahoma Dental Association to secure additional funds for dental services. Further, beyond the financial aspect, the OHCA has worked jointly with dentists to address administrative issues related to participation in the Medicaid program, many of which have been

seen as a significant burden on day-to-day operations. For instance, the OHCA has made several changes aimed at reducing paperwork and the amount of prior authorizations required for the Medicaid fee-for-service dental program.



Presently, for Medicaid beneficiaries under age 21, routine dental care is a self- referral service. However, for beneficiaries age 21 or older, coverage is limited to emergency extractions and reconstructive dental surgery when medically necessary.

Implementing new programs for specific populations

Aged, Blind and Disabled and managed care

On July 1, 1999, the Oklahoma Health Care Authority began to fulfill its 1993 legislative mandate to transition people categorized as Aged, Blind and Disabled (ABD) from the fee-for-service Medicaid program to Oklahoma's Medicaid managed care program (***SoonerCare)***. When this new population was fully incorporated into ***SoonerCare***, Oklahoma became one of nearly 20 states that have instituted some form of managed care within their respective ABD populations.

It is important to note that there are specific exclusions in this population who are not enrolled in Oklahoma's Medicaid managed care programs. They include children who are in the custody of the state, people who are institutionalized, people who receive services through home and community-based waiver programs, and people who are dually eligible for Medicare and Medicaid.

In Oklahoma, the ABD population numbered more than 126,000 by January 2005. Of that number, almost 90 percent are adults. The population seems to be evenly distributed across urban and rural areas, although there seems to be slightly higher numbers of ABD beneficiaries residing in eastern and southeastern portions of the state. In terms of eligibility, the ABD population remains more static. In other words, the number of individuals gaining and losing eligibility under these categories does not fluctuate significantly from month to month.

They commonly use health care services with greater frequency due to the nature of their eligibility and, compared with the populations under Temporary Aid to Needy Families (TANF), are less mobile and are significantly more involved in their health care decision making.

Breast/cervical cancer screening

The Oklahoma Breast and Cervical Cancer Treatment Program went into effect Jan. 1, 2005, with eligible women receiving full Medicaid benefits through the OHCA for the duration of their cancer treatment.

Eligible women must be screened under the Breast and Cervical Cancer Early Detection Program (BCCEDP) and found to be in need of treatment for either breast or cervical cancer. The BCCEDP was established under Title XV of the Public Health Service Act. Women also must be younger than age 65 and have no creditable health insurance coverage or other available insurance providing breast or cervical cancer services, including Medicaid.

The BCCEDP grants are administered by the Oklahoma State Department of Health Chronic Disease Service, the Kaw Nation of Oklahoma and the Cherokee Nation. The three grantees work in collaboration with the OHCA to ensure that women who are found in need of treatment through their screening programs receive Medicaid services.

Women who do receive a diagnosis of cancer or a precancerous condition are enrolled in ***SoonerCare***. In addition to primary care and specialty referrals, they can receive care management services, transportation through SoonerRide and access to the ***SoonerCare*** Help Line and Nurse Advice Line. They can continue to receive services through ***SoonerCare*** until their provider determines they no longer need treatment for cancer.

Family planning waiver

Low-income, uninsured women and men who would not otherwise qualify for Medicaid became eligible to receive family planning services under a new program implemented April 1, 2005.

The program, SoonerPlan, pays for office visits and physical exams related to family planning, birth control information and supplies, laboratory tests related to family planning services (including pap smears and screening for sexually transmitted infections), pregnancy tests, and tubal ligations and vasectomies for those age 21 and older.

Additional eligibility requirements for the new program stipulate that the applicants be residents of Oklahoma who are age 19 or older and that they be U.S. citizens or qualified aliens.

They must have no health insurance coverage for family planning and not be eligible for regular Medicaid. They must also meet income guidelines.

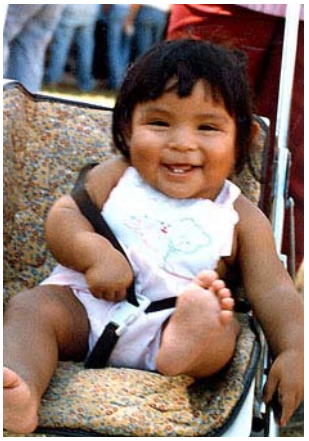
SoonerPlan services are available through any Medicaid provider who offers family planning services. Although additional medical services are not covered under SoonerPlan, the OHCA will provide referral information about where recipients may obtain needed medical services at their own expense.

The Family Planning Waiver is funded through a 90:10 federal match that will allow Medicaid to extend family planning services to about 50,000 Oklahomans.

SoonerCare and Native Americans

Native Americans have been included in ***SoonerCare*** since Oklahoma began managed care in 1995. However, they retain the option to self-refer to any Indian Health Service (IHS) facility, tribal health facility or urban Indian clinic (I/T/U) for services that are available onsite.

In July 2001, a new model was implemented that allows I/T/U providers to serve as primary care physicians (PCPs). I/T/U providers can provide culturally sensitive case management to Native American ***SoonerCare*** members. The I/T/U providers act as PCPs and make referrals and coordinate additional services such as specialty care and hospitalization when patients access care facilities that are not operated by tribes or the IHS.



In 2003, the OHCA joined with the Indian Health Services (IHS) and the Oklahoma City Area Inter-Tribal Health Board (IHB) to address Medicaid issues affecting tribal and IHS interests. The IHB is providing the resources for a contract employee to be placed at the OHCA to work specifically with Indian health issues.

For the month of January 2005, 67,008 people categorized as Native Americans were enrolled in Medicaid. Medicaid services provided to eligible Native Americans in IHS and tribal facilities result in a 100 percent federal match.

Finding new sources of funding

With the onset of an economic recession, unemployment numbers skyrocketed, sending Medicaid numbers soaring throughout the country. Health care costs jumped by double-digit rates, while incoming tax dollars steadily dwindled. States cut eligibility, provider reimbursement rates and benefits in efforts to stop the bleeding.

Finally, reacting to pressure from their constituents, Congress and President Bush passed the Jobs and Growth Tax Relief Reconciliation Act of 2003. Under the new law, Oklahoma began receiving a temporary increase in the amount of Medicaid federal matching funds for five calendar quarters, beginning April 1, 2003, and ending June 30, 2004. The increase for all eligible expenditures was approximately 2.95 percentage points over the normal federal share amount. While the new federal funds provided a temporary bandage, Oklahoma is looking for a more permanent fix.

State tax refund

In 2003, the Oklahoma Legislature approved Senate Bill 549, which allows taxpayers to voluntarily donate part of their state tax refund to the state Medicaid program. A check-off box for Medicaid was added to the state tax form beginning with the 2004 tax return. People receiving a refund have the option of donating $2 or more.

The donated funds can also be matched with federal funds, doubling the impact of the donation.

Tobacco tax

Oklahoma raised its excise tax from 23 cents to $1.03 per pack beginning Jan. 1, 2005. With nearly 400 million packs of cigarettes sold in Oklahoma each year, estimates suggest revenue could raise more than $215 million per year. Some of those revenues are earmarked for the Oklahoma Health Care Authority to pay for health care costs, such as increases in Medicaid provider rates.

Funds from the tobacco tax authorized the OHCA to offer two new programs starting in 2005.

TEFRA

Under Section 134 of the federal Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Public Law 97-248, states were granted a state plan option to make Medicaid benefits available to certain children with severe disabilities who would not ordinarily be eligible for Supplemental Security Income benefits because of their parent's income or resources.

Oklahoma implemented a TEFRA program on Oct. 1, 2005, to provide resources to families so children with special health care needs or disabilities could be cared for at home instead of in an institution.

To be eligible, a child must be younger than 19 years old, be a U.S. citizen or qualified alien, be a resident of Oklahoma, have a Social Security number, have a gross monthly income at or below 300 percent of the Supplemental Security Income (SSI) payment and countable resources at or below $2,000, and meet an institutional level of care. In addition, it must be appropriate and safe to provide care to the child at home, and the estimated cost of caring for the child at home cannot exceed the estimated cost of caring for the child in an institution.

Children qualifying for TEFRA receive the full scope of Medicaid services, such as inpatient and outpatient treatment, pharmacy, physical and occupational therapy, non-emergency transportation and participation in the Early and Periodic Screening, Diagnosis and Treatment program.

Premium Assistance Program

By the end of 2005, the OHCA hopes to have in place the Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC), a program to provide premium assistance for health care coverage to Oklahoma's low-income individuals and businesses.

The proposal was submitted to the Centers for Medicare & Medicaid Services under the Health Insurance Flexibility and Accountability Demonstration Initiative after Gov. Brad Henry and the Oklahoma Legislature authorized measures to increase access to affordable health care coverage.

Of an estimated 650,000 uninsured Oklahomans, nearly 75 percent are employed or are dependents of employed individuals. But the costs of providing health insurance have steadily escalated for both employers and their workers. In 2004, Oklahoma employers

reported a 16 percent increase in the cost of health insurance premiums. Since 2001, employees' share of premium payments has increased by more than 50 percent.

The O-EPIC program, authorized by the Oklahoma Health Care Recovery Act, will initially be open to all employers with 25 or fewer workers, including those that currently offer health insurance coverage. Premium assistance will at first be available for workers and spouses with household incomes at or below 185 percent of the Federal Poverty Level.

Participating employers and employees will be required to pay a portion of the premiums. Employees will also be responsible for any applicable deductibles and co-payments.

O-EPIC also includes a safety-net option for eligible workers and spouses whose employers are unable or unwilling to participate in the program. These individuals will be permitted to buy directly into a product offered by the state. O-EPIC also will offer assistance to disabled individuals through the Ticket to Work Incentives Improvement Act.

Oklahoma plans to devote an average of $50 million per year generated through the tobacco tax. It is expected the state's subsidy will be matched with approximately $100 million in federal funds. When O-EPIC is fully operational, the OHCA expects to enroll up to 70,000 Oklahomans.

Meeting the demands of changing technology

In State Fiscal Year 2003, the OHCA overhauled its Medicaid Management Information Systems (MMIS). Electronic Data Systems (EDS) of Plano, Texas, took over as the new fiscal agent. EDS, which has more than 30 years of experience in the public health industry, constructed one of the most advanced MMIS systems in the nation.

With the new system, the OHCA was able to provide several new services, including more efficient options to obtain eligibility and prior authorization information and more efficient methods for filing claims. Providers can submit batch claims using Electronic Data Exchange (EDI).

On Jan. 1, 2003, the OHCA brought up the fully functional secure site – Medicaid on the Web. The secure, multilevel Web site allows providers to receive communications directly from the OHCA, check beneficiary eligibility, submit claims and request and check the status of prior authorizations.

Preparing for the challenges of the future

The state is faced with the ongoing inflation of health care costs and swelling Medicaid enrollment, as well as an uninsured rate of 20.4 percent, one of the highest in the nation.

In 2005, the Legislature approved a plan to use about $63 million in taxes on gross production of oil and natural gas to boost Medicaid funding and pull an additional $137 million in federal matching funds. A task force has been formed to study possible reforms, and the Oklahoma Health Care Authority will continue to seek more cost-effective ways to deliver health care.

In our current economy, it is inevitable that expenses will continue to escalate. Health care and pharmaceuticals are profitable industries that keep heavily investing in new technologies, another factor in rising costs. However, that trend has led to a spiraling problem. As costs rise, the price of health insurance goes up. Higher premiums, co-pays and deductibles mean fewer people and employers can afford health insurance. These people drop out of the insured population, creating a greater pool of patients receiving uncompensated care from hospitals and physicians. The uncompensated care is cost-shifted, raising the price of health care delivery and insurance premiums – and the circle continues.

The federal/state Medicaid program is now 40 years old, and it is in many aspects still made up of policies that reflect its 1965 “welfare” program roots. Our challenge is to make substantive reforms at both the federal and state level to make it more manageable and responsive to publicly funded health care coverage.

Nationally, Medicaid has developed into two distinct and very different programs. Oklahoma's program also has both: one, an “insurance” model paying for health care for families with children (primarily children and a few very impoverished parents), those with total and permanent disabilities, and elderly adults; and two, the provision of long-term services for disabled and elderly individuals who require comprehensive supports including nursing, social, food and nutrition, recreation, and housing services. Both

at the national and state level, the long-term care services cover significantly fewer people but constitute a much greater share of the total Medicaid cost.

OHCA operates ***SoonerCare***, a purchaser of managed health services that is similar to commercial insurance programs. Pending federal approval, the O-EPIC (Oklahoma Employer/Employee Partnership for Insurance Coverage) program will be introduced in the near future. It will use public federal/state Medicaid funds to subsidize the employer and employee cost of purchasing commercial group health insurance policies, putting the qualified beneficiaries in the commercial insurance pool. At the same time, Medicaid continues to move toward a more commercial business model, providing care management to help curtail costs while providing appropriate care and also asking members to share the financial responsibility for their health care through modest premiums, co-insurance and/or deductibles. OHCA also provides a broad array of resources and services for people who need ongoing care and support because of disability, chronic illness, injury or age.

Meaningful reform of the Medicaid program at both the federal and state level should include two very important elements. First, it should continue to eliminate antiquated policies that are barriers to operating Medicaid much like commercial insurance products. The reformed program should assure access to primary and preventive care, care management and medically appropriate treatment and also encourage personal responsibility for health and health care choices. Second, a comprehensive program for meeting chronic health needs and other life supportive services for individuals who are elderly or disabled should be addressed as a separate and distinct program. This program should assure individuals the ability to sustain the functions and activities of daily living with the least invasive form of support and provide the beneficiary with the maximum range of choices with respect to independent versus congregate housing and service delivery.

BRF-10-05
This publication is authorized by the Oklahoma Health Care Authority in accordance with state and federal regulations. Cost of the printing was $106.80 for 1,200 copies. OHCA is in compliance with Title VI and Title VII of the 1964 Civil Rights Act and the Rehabilitation Act of 1973. Copies have been deposited with the Oklahoma Department of Libraries Clearinghouse. The Oklahoma Health Care Authority does not discriminate on the basis of race, color, national origin, sex, religion, age or disability in employment or the provision of services. For additional copies, call the OHCA Public Information Office at (405) 522-7130.