

# Oklahoma Health Care Authority



**Oklahomans are Counting on Us**

**Service Efforts and Accomplishments SFY2010**

July 2009—June 2010

The Oklahoma Health Care Authority (OHCA) is the primary entity in the state charged with purchasing state and federally funded health care coverage for low income Oklahomans. OHCA must assure that purchased health care meets acceptable standards of care and ensure that citizens who rely on state-purchased health care are served in a comprehensive and positive system.



The state fiscal year (SFY) 2010 Service Efforts and Accomplishments (SEA) Report describes key measures tracked by the agency to ensure agency efforts are consistent with the state mandated mission and the strategic goals and objectives set forth by OHCA's Board of Directors. The report is intended to provide the reader with the information needed to evaluate the agency's performance .

SFY2010 proved to be an eventful year. The following paragraphs touch on a few of the ups and downs as well as future concerns and opportunities the agency foresees.

In SFY2010, SoonerCare served 842,253 Oklahomans representing a 5.75 percent increase in enrollment from 2009. Insure Oklahoma, the state's health insurance subsidy program, also experienced significant growth. The employer sponsored insurance (ESI) program membership increased by 32 percent, with participating businesses growing by 16 percent. The Individual Plan (IP) membership increased by 75 percent. Much of the increase reflects the continually struggling national and Oklahoma economy. As the economy worsens, more Oklahomans are unable to afford health insurance through their employer or on their own.

Recent decisions regarding national health care may have a significant affect on enrollment in the coming years. OHCA is currently reviewing legislation to provide state officials with information as they consider Oklahoma's future health care needs.

Budget issues played a prominent role in 2010. When state revenue continued to come in below projections, the state had to make tough decisions regarding the budget. OHCA sought recommendations from stakeholders, including providers, and was initially able to make targeted cuts to achieve a balanced budget.

In December 2009, the board approved a 3.25 percent across the board provider rate cut after state appropriations continued to come in below expectations. OHCA faced the possibility of another 3.5 percent rate cut in March 2010, but the agency received supplemental funding from the state and was able to avoid those cuts. State revenues remain uncertain, leaving the agency's future budget concerns at the forefront of the decision-making process.

OHCA has been developing the Medicaid Electronic Health Records (EHR) incentive program for Oklahoma which is slated to kick off in January 2011. Through the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, eligible health care professionals and hospitals can qualify for Medicaid incentive payments when they adopt

## EXECUTIVE SUMMARY

certified EHR technology and use it in a meaningful way. The federal government will pay 100 percent of the provider incentive payments and 90 percent of administrative costs associated with the program.

To end the fiscal year, late spring 2010 unleashed some of the volatile weather for which Oklahoma is known. The massive rainstorm that hit central Oklahoma in May resulted in a collapsing roof and flooding throughout the agency's workplace. Storm damage forced the relocation of over 500 employees and contract staff. Much time and effort went into successfully ensuring SoonerCare members and providers continued to receive the services they needed during the transition.

The Oklahoma Living Choice Project (OLCP) promotes community living for people of all ages who have disabilities or long-term illnesses. In SFY2010, OHCA helped transition 65 members from nursing homes back into the community through OLCP: 37 persons with intellectual disabilities, 17 with physical disabilities, and 11 elderly.

At the request of the provider community and through collaboration with the Medical Advisory Task Force, OHCA implemented a patient-centered medical home primary care delivery system on January 1, 2009. This model ensures members have a primary care provider home. In SFY2010, the medical home program added 146 new medical homes for SoonerCare Choice members.

The SFY2010 Service Efforts and Accomplishments Report is intended to provide stakeholders with data about the performance of the agency in meeting its goals and objectives. It includes discussion about the issues mentioned above and others that impacted OHCA's efforts in SFY2010 or may do so in the future. If you have any questions or would like more information, please feel free to contact OHCA (see information below). The agency looks forward to working with you and other stakeholders to improve health care in Oklahoma.

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## PERFORMANCE HIGHLIGHTS

OHCA reports a few key indicators here to provide you with a concise overview of the agency's performance in the six agency goal areas. Further detail can be found in the goal sections referenced with the measures which include: descriptive information on exactly what a measure means, why it's important, explanatory information to offer context, and actions the agency has planned or taken that pertains to the measure or goal.

### Goal # 1: Eligibility Measures, page 19

**Outcome :** Percent of Oklahomans enrolled in SoonerCare & Insure Oklahoma

**Output:** Unduplicated Number of Members Enrolled in SoonerCare and Insure Oklahoma

**Outcome:** Percent of Change in Total Enrollment

Figure 1

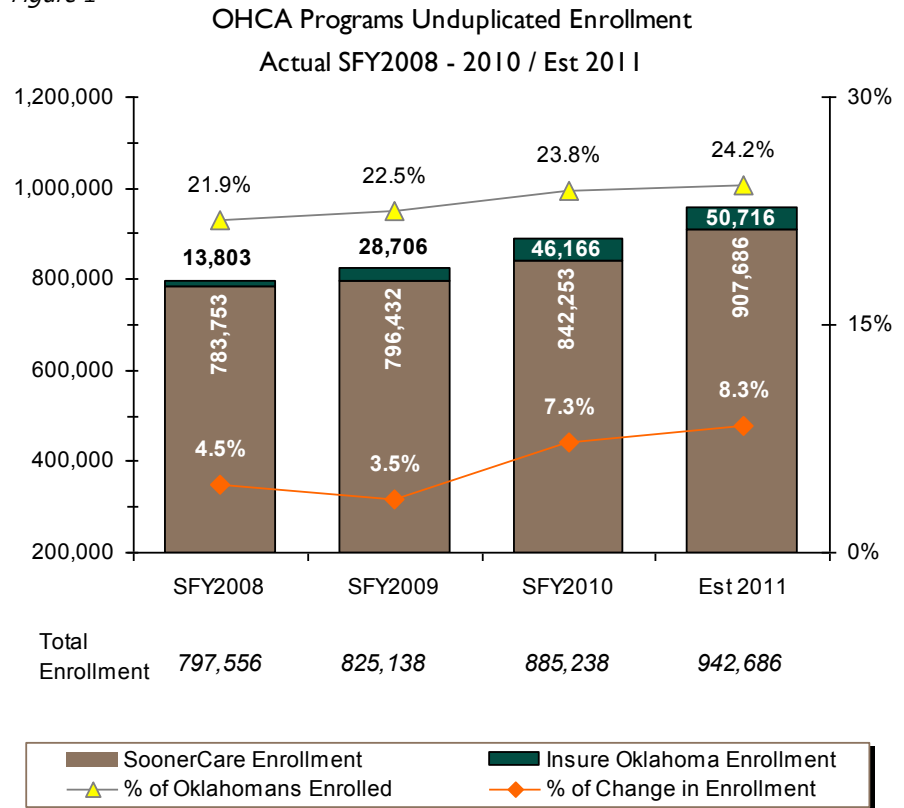
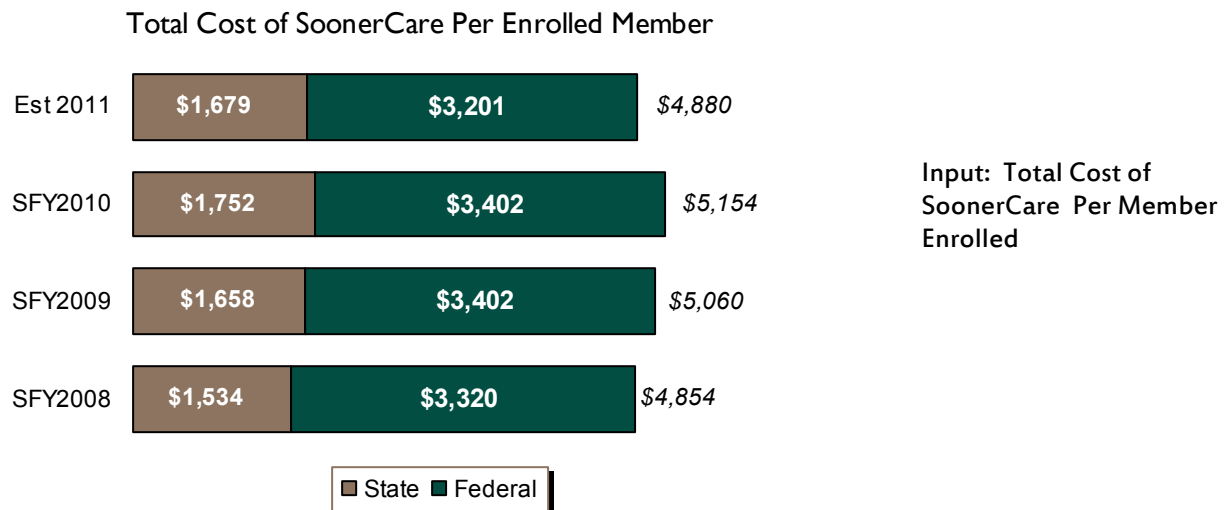
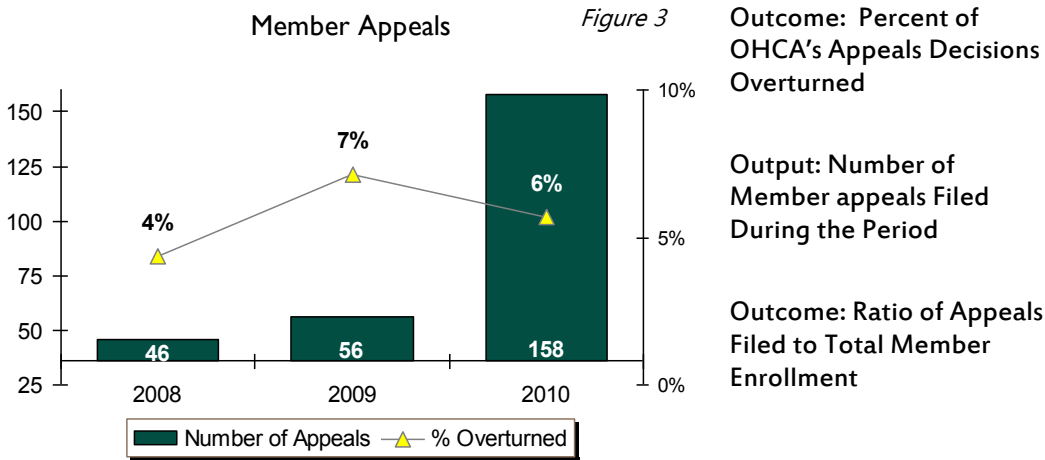


Figure 2



# PERFORMANCE HIGHLIGHTS

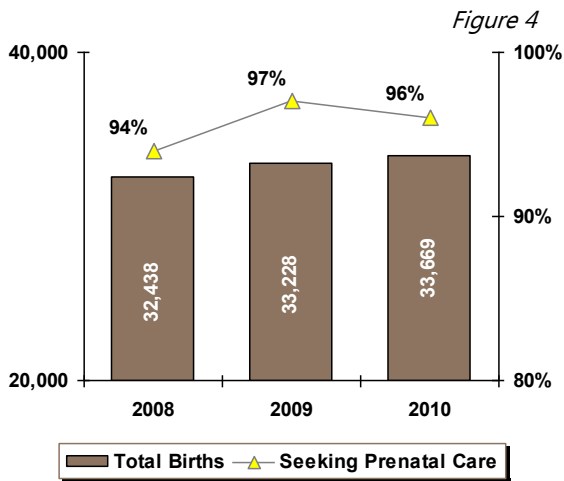
## Goal # 2: Satisfaction and Quality Measures, page 32



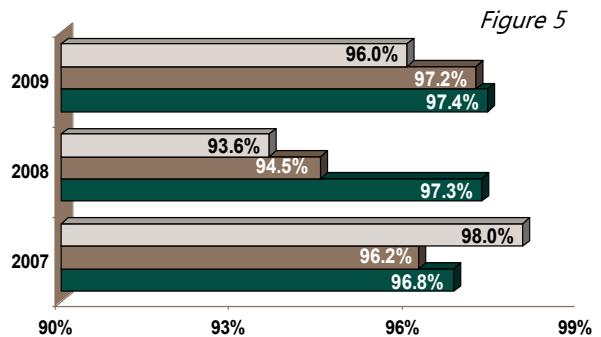
## Goal # 3: Member Personal Responsibility Measures, page 45

**Outcome: Members seeking prenatal care**      **Outcome: Well-Child Visits**  
**First Fifteen Months**  
**3-6 Years**  
**Adolescents**

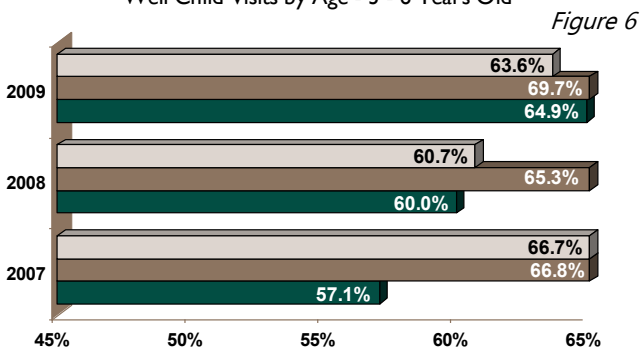
Total Births to SoonerCare Members / Percent seeking Prenatal Care for SFY2008-2010



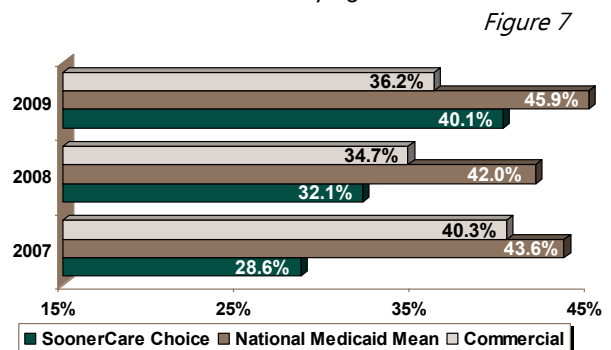
Well Child Visits by Age - First Fifteen Months



Well Child Visits by Age - 3 - 6 Years Old



Well Child Visits by Age - Adolescent



PERFORMANCE HIGHLIGHTS

Outcome: Percent of SoonerCare Members Seeking Prenatal Care

SoonerCare Members Who Sought Prenatal Care — By Trimester — SFY2008—2010

Figure 8

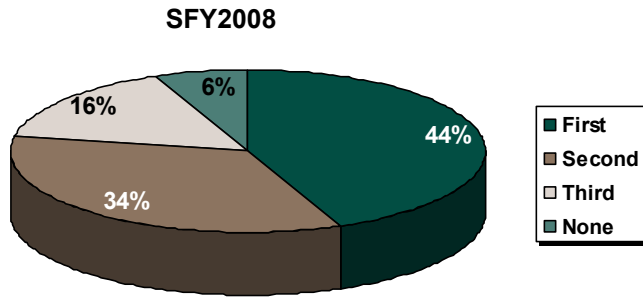


Figure 9

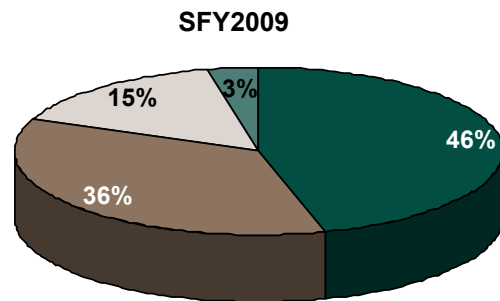
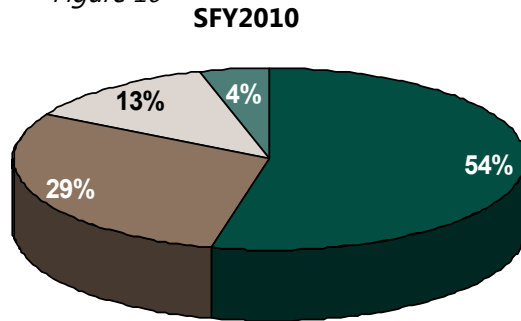


Figure 10



Goal # 4: Member Benefits Measures, page 61

Outcome: Adult Preventive / Ambulatory Care

20-44 Years

45-64 Years

Adults use of Preventive / Ambulatory Care by Age for Calendar Years 2007—2009

Figure 11

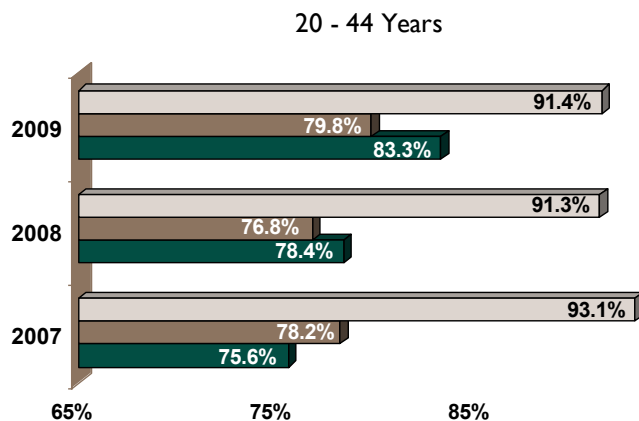
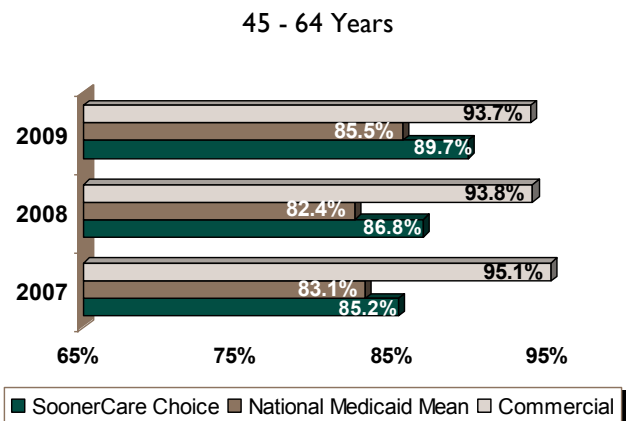


Figure 12

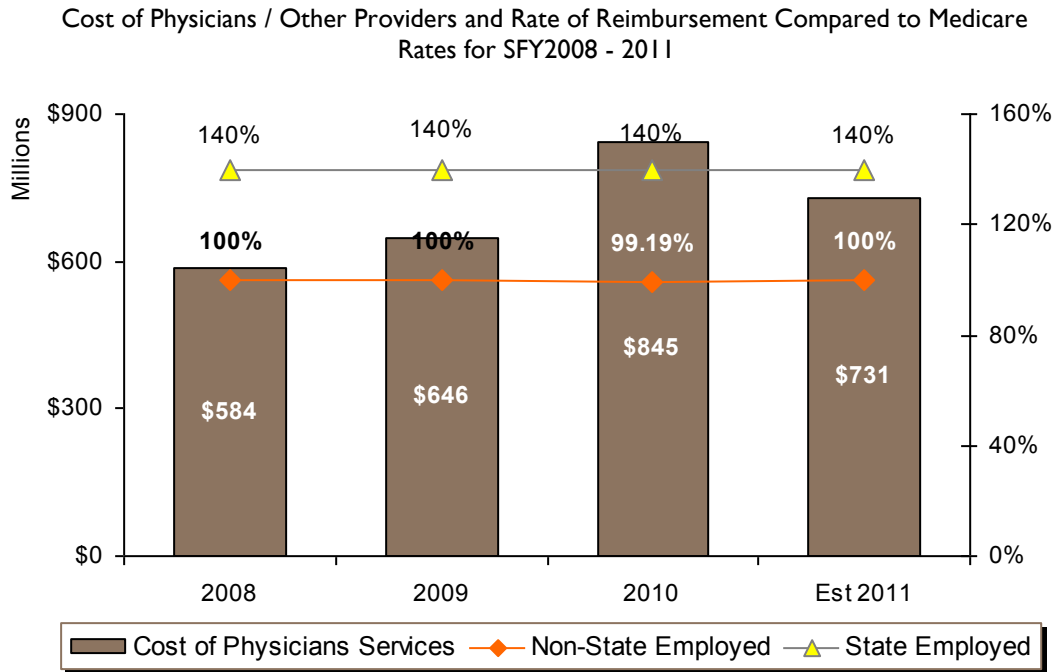


# PERFORMANCE HIGHLIGHTS

## Goal # 5: Responsible Financing / Purchasing Measures, page 73

### Outcome: Reimbursement as a Percentage of Medicare Rates

Figure 13



## Goal # 6: Administration Measures, page 87

Outcomes: Percent of Time Administration Costs Remain Within Budget

Output: Payment Integrity Recoveries

Output: Claims Processed and Paid

Output: Calls Answered - Providers & Members

Figure 14



Highlights—Administration Measures			
<b>Percent of Time Administration Costs Within Budget</b>			
SFY2008 - SFY2010 100%			
<b>Claims Processed / Claims Paid / Percent Paid</b>			
SFY2008	32,696,348	25,309,251	77.4%
SFY2009	36,706,138	28,428,254	77.4%
SFY2010	39,838,306	31,691,202	79.6%
<b>Payment Integrity Recoveries</b>		<b>Calls Answered Providers / Members</b>	
SFY2008	\$6,394,754	375,575	
SFY2009	\$3,988,042	415,157	



WELCOME TO OHCA’S 2010 SERVICE EFFORTS AND ACCOMPLISHMENTS REPORT

OHCA VISION

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

*Who might benefit from this report?*

CITIZENS

*Resource Providers*

CUSTOMERS

*Members and providers directly impacted by benefits and reimbursements*

POLICY MAKERS

*Officials responsible for allocating resources*

OHCA’S BOARD OF DIRECTORS & MANAGEMENT

*Leadership tracking our progress in meeting goals*

RESEARCHERS / OTHER HEALTH CARE ORGANIZATIONS / FEDERAL PARTNERS

*Entities comparing performance to benchmarks, targets, and other participants in medical care access*

**Purpose.** The Oklahoma Health Care Authority (OHCA) has the mission of ensuring that low income individuals have access to medical care. OHCA’s SoonerCare programs, including Insure Oklahoma, are critical in providing medical care to Oklahomans. The performance and administration of these programs must be examined and evaluated.

Stakeholders must have access to understandable and relevant performance data to make effective decisions as progress is made toward a healthier Oklahoma. This report describes key measures tracked by the agency to ensure OHCA’s efforts are consistent with our state mandated mission and the strategic goals and objectives set forth by OHCA’s Board of Directors.

OHCA hopes to equip the reader with information needed to assess its performance and ultimately play a strategic role in improving Oklahomans’ health.

**Content.** This report provides performance information on 100 percent of the agency’s operations. It covers three fiscal periods, State Fiscal Year (SFY) 2008, 2009, and 2010. Oklahoma’s fiscal period runs from July through June. Additional performance data dating back as far as SFY2005 can be found in the tables located at the end of this report.

The key performance measures reported are intended to provide data about the resources OHCA has been allocated (inputs), the work done (outputs), and the success in meeting objectives (outcomes). Resources expended will be

compared to those outcomes and outputs (efficiencies). Estimates of future performance, future targets, and comparative benchmarks have also been included. In addition to OHCA, other Oklahoma agencies accumulate administrative costs which are federally funded through Medicaid including the Oklahoma Department of Human Services (OKDHS) and the Office of Juvenile Affairs (OJA). Only OHCA’s administrative performance is discussed in this report.

## INTRODUCTION

**Layout.** Three layers of data are provided so users can seek out detail based on their degree of interest. The report is structured to show how the agency has performed in each of six goal areas.

*Performance Highlights* - For summary, results from a few key indicators for each of the six agency goals are reported to provide a slice of information regarding the agency's performance (pages 6-9).

*Detailed Performance Measures* - For in depth analysis, each agency goal is stated along with the objectives and performance measures related to it. Targets, estimates, and benchmarks are also reported. Narrative is included to provide context, explanatory information, and anticipated future events that may impact the goal area.

*Tables* - For quick review and trend analysis, the agency measures are reported by goal in a table format. Actual data is reported from SFY2008 through SFY2010. Budgeted data is reported for SFY2011 and estimated data is provided for SFY2012.

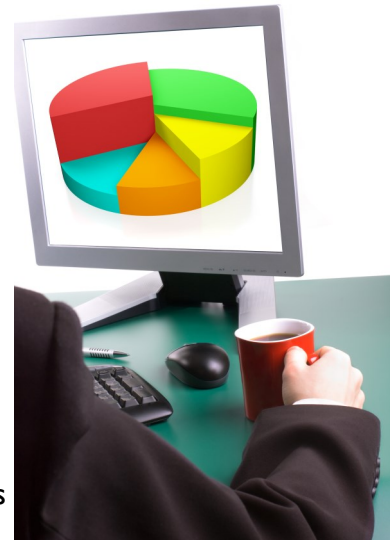
Some measures relate to more than one goal. The detailed results for these measures will be presented in the first goal in which it is reported. The measure will be referenced in the other goal section to which it relates along with the page number where the full detail can be found.

**Reliability.** The information included in this report is only as good as the data itself. Following are some of the accountability controls and oversight in place to monitor the integrity of the data. Where performance measures are reported, the source of the data will be reported as well. This will allow the user to gauge the reliability of the information.

*Medicaid Management Information System (MMIS).* The MMIS refers to the complex data processing system through which SoonerCare and Insure Oklahoma claims are paid. Much of the data reported in the performance measures come from the MMIS. The MMIS processed over 39 million claims in SFY2010.

*CMS Certification.* OHCA's MMIS system has been certified by the Centers for Medicare and Medicaid Services (CMS). CMS found it to be efficient, economical, and effective for the administration of funding. Because of the certification, OHCA receives a higher federal funding match rate for specific administrative expenditures.

*SAS 70 Audit.* Annually, the MMIS system undergoes an audit conducted by an independent audit firm. Policies and procedures designed to ensure accurate



payment of claims through the MMIS system are reviewed. It is an in depth evaluation and test of controls to ensure they are working as intended and performing effectively. In the 2009 SAS 70 audit, KPMG stated that controls were described fairly, were in place during the audit period, and are designed to provide reasonable assurance that control objectives can be achieved.

*Federal Accountability.* As the state agency designated to account for Medicaid funding, OHCA undergoes close federal scrutiny. The Centers for Medicare and Medicaid Services (CMS) is the federal entity responsible for OHCA’s oversight.

*CMS Reviews.* CMS reviews OHCA’s quarterly statements to ensure the “prudent use of program funds” and a “reasonable degree of assurance” that federal resources are used in accordance with the Social Security Act and Oklahoma’s State Plan. Additionally, OHCA is reviewed on an ad hoc basis to ensure appropriate application of policy and procedures related to federal funding.

*Medicaid Integrity Program Audit.* The Deficit Reduction Act of 2005 emphasized the need to ensure Medicaid funding is diligently monitored for fraud and abuse. The Medicaid Integrity Group (MIG) was created to identify various strategies to support and improve the states’ program integrity functions.

PROGRAM INTEGRITY AND ACCOUNTABILITY DEPARTMENT (PID)

PROVIDER AUDITS UNIT

*Reviews providers for appropriate reimbursement based on federal and state policy, medical necessity, and utilization.*

PAYMENT ERROR RATE MEASUREMENT UNIT

*Performs payment accuracy measurement functions (internal and external PERM processes) and reviews internal controls, operational effectiveness and efficiency.*

According to the federal guidelines, states will be reviewed once every three years on program integrity procedures such as provider and utilization audits and provider enrollment procedures. OHCA was reviewed in 2008 for the federal fiscal year (FFY) 2007 and will be reviewed again in early 2011. OHCA received a positive audit report for FFY2007 with two minor findings which have been corrected. The agency was also recognized in the report for three effective practices that impact program integrity.

*Payment Error Rate Measurement (PERM).* Oklahoma was one of the first states chosen for the federal Payment Error Rate Measurement (PERM) review. SoonerCare claims were reviewed for medical

necessity and payment accuracy. For FFY2009, OHCA’s error rate was 1.24 percent compared to the national average of 1.89 percent. The results are reported in the Goal 6 section, (page 91) which contains more information about the federal review.

*State Accountability.* OHCA is audited annually under the Single Audit Act. All state entities receiving federal funds are reviewed to ensure that the resources were spent according to the parameters under which they were granted. The State Auditor and Inspector (SAI) conducts

## INTRODUCTION

the review and the most recent Single Audit Report is available on their website at [www.sai.ok.gov](http://www.sai.ok.gov) under annual audits.

**Internal Accountability Controls.** OHCA's Program Integrity and Accountability Department (PID) is located in the Policy, Planning and Integrity Division. The PID staff works closely with other departments within the agency to ensure that program integrity is maintained.



Similar to the federal PERM review, which is performed every three years, the agency conducts an intensive internal review on an annual basis. For the SFY2010 internal review, the agency reports a 99 percent payment accuracy measurement (PAM) rate. Details on this measure can be found on page 91.

**Consistency.** The agency reports the same performance measures from year to year to provide consistent and reliable information over time. When the agency determines a more appropriate measure should be reported or a change in the method of calculation is needed, the change will be explained in the narrative and the impact of the change will be explained.

Due to the OHCA budget request being finalized before the release of this report, there may be a difference in numbers presented. It is noteworthy to mention that the two publications may be completed at different times. Performance data is released in the budget request due to the State in October. Any differences subsequently identified will be explained within this report.

**Public Forums.** To be sure OHCA stays in line with the expectations of its constituents, OHCA offers many forums to allow the public an opportunity to weigh in on the issues that matter to them.

**Annual Board Retreat.** Every year in August, the Board of Directors, agency management, and key personnel gather away from the office to focus on plans for the coming year. The meeting is open to the public and has had an increasing number of stakeholders outside of the agency attend the last several years. Attendees have included elected officials, other agencies' directors, commissioners and key staff members, providers and provider associations, and individuals and organizations representing members including Native American tribal representatives.

### OHCA BOARDS AND COMMITTEES

*Learn about OHCA Boards and Committees including meeting dates and agendas on our website at [www.okhca.org/about-us/boards-and-committees](http://www.okhca.org/about-us/boards-and-committees).*

The retreat offers information about national and local issues that are affecting health care and/or OHCA, updates on agency projects and programs, and an



open forum to discuss issues to be considered in current and future planning. The retreat coincides with the state budget process, allowing the agency to incorporate outcomes from the meeting into the upcoming budget request. Information about the upcoming retreat can be found on the OHCA website in July.

**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. The meetings are open to the public and are often attended by providers and advocacy groups who actively participate. Meeting dates are posted on the agency's public website at [www.okhca.org/about us/Medical Advisory Committee](http://www.okhca.org/about-us/Medical-Advisory-Committee).

**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/ Drug Utilization Review Board](http://www.okhca.org/about-us/Drug-Utilization-Review-Board).

**Advisory Committees and Task Forces.** In addition to public meetings, the agency has several task forces and committees in which the public advises the agency on targeted topics. More information on the following groups can be found on OHCA's website at [www.okhca.org/about us/boards and committees](http://www.okhca.org/about-us/boards-and-committees).

**Child Health Advisory Task Force.** OHCA, in collaboration with the Oklahoma State Department of Health (OSDH), established a Child Health Advisory Task Force to assist both agencies in developing improved benefits and services for Oklahoma's low income families. This ongoing committee advises OHCA and OSDH on children's health issues such as how to improve the quality/quantity

Feedback, please!

OHCA hopes this report will give you the right information to evaluate our performance. Let us know if we succeeded. If we did not, then we need your help! Please let us know what would make it better. Call or send your input to:



Performance & Reporting  
405.522.7525, [Marjorie.Snyder@okhca.org](mailto:Marjorie.Snyder@okhca.org)



## INTRODUCTION

of child health screenings and follow-up care, and how to identify better ways to address wide-spread children's health problems throughout the state. Information about the Child Health Advisory Task Force can be found at [www.okhca.org/about us/Child Health Advisory Task Force](http://www.okhca.org/about-us/Child-Health-Advisory-Task-Force).

*Perinatal Task Force.* This task force is composed of more than 20 agencies and organizations involved with perinatal care. It was developed to focus on issues concerning pregnant women covered by SoonerCare or other public health sources. The task force provides expertise regarding perinatal health care and makes recommendations regarding systemic modifications that may contribute to improving perinatal outcomes in Oklahoma. Information about the Perinatal Task Force can be found at [www.okhca.org/about us/Perinatal Task Force](http://www.okhca.org/about-us/Perinatal-Task-Force).

*Living Choice Advisory Committee.* This committee advises and assists OHCA and its partner agencies in the design, development, and implementation of the Living Choice program. The program serves nursing home level of care members in the community and the committee provides the consumer and family perspective. Along with representatives from the participating agencies and non-profit groups, membership includes persons of all ages with disabilities or long-term illnesses, and family members or advocacy groups representing them. Information about the Living Choice Advisory Committee can be found at [www.okhca.org/about us/Living Choice Advisory Committee](http://www.okhca.org/about-us/Living-Choice-Advisory-Committee).

*DME Advisory Council.* This new council began in January 2010 and provides input on OHCA policy and specific issues related to Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS). Members on the council include DME providers and stakeholders representing DME organizations. The council has been instrumental in making coverage and pricing suggestions during the budget crisis. More information is available at [www.okhca.org/providers/DME Advisory Council](http://www.okhca.org/providers/DME-Advisory-Council).

Next is more detailed information about the agency's mission, goals, and objectives, followed by OHCA's detailed performance information.



# 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.

## **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.

## **Goal # 2: Quality and Satisfaction**

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 high quality ratings for SoonerCare Choice, the Patient-Centered Medical Home model of primary care case management.
- 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.

## **Goal # 3: Member 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 GOALS AND OBJECTIVES

### **Goal # 4: Member 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/Early Periodic Screening, Diagnosis, and Treatment (EPSDT) well-child visits.
- To assist members' ability to attend health care appointments by providing transportation through SoonerRide.

### **Goal # 5: Responsible Financing / 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.

- 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 appropriately reimburse providers within state and federal regulations.

### **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

TO PROVIDE AND IMPROVE HEALTH CARE ACCESS TO THE UNDERSERVED AND VULNERABLE POPULATIONS OF OKLAHOMA.

### Oklahoma's Uninsured

Oklahoma continues to strive to decrease the number of residents without health insurance. However, with over 659,000 Oklahomans uninsured according to State Health Access Data Center (SHADAC) estimates, nearly 18.1% of the state's population lacks basic coverage versus the national average of 16.7%. The SHADAC report was released in September 2010 with 2009 data.

*Oklahoma's uninsured rate increased from 17.9 percent to 18.1 percent between 2005 and 2009.*

Source: State Health Access Data Assistance Center, [www.shadac.org](http://www.shadac.org)

Figure 15

### UNINSURED IN OKLAHOMA BY AGE

	2005	2009
< 19	11.0%	13.3%
19-64	24.5%	24.3%
65+	1.0%	0.7%
Total	17.9%	18.1%

Source: State Health Access Data Assistance Center, [www.shadac.org](http://www.shadac.org)

The Oklahoma Insurance Department attributes the relatively high rate of uninsured Oklahomans to an estimated cost of \$954 million each year in uncompensated care. When the uninsured seek care and cannot pay for it, the cost of their care is shifted to the state, providers, and consumers, thereby creating a "hidden tax" on medical services. Reducing the rate of uninsured Oklahomans would result in a substantial reduction in the cost of uncompensated care.

SHADAC reports that adults, aged 19-64, account for 79.6 percent of the uninsured. The typical uninsured Oklahoman is under 35 years old, earns a salary in the low to middle range, and has children. The Kaiser Commission on Medicaid and the Uninsured

characterizes the most common reasons given by the uninsured for not having health insurance as the high cost of purchasing an insurance plan and the lack of access to employer-sponsored coverage. The magnitude of these problems is expected to increase with the ongoing economic crisis, placing ever greater importance on OHCA's efforts to create avenues of access to health care.



## GOAL # 1: ELIGIBILITY

Federal law provides the state with guidelines as to whom OHCA may cover under SoonerCare, providing Medicaid funding only for qualifying, low-income children, pregnant women and the aged, blind, or disabled. According to the Department of Health and Human Services (HHS), parents of children enrolled in SoonerCare may qualify for benefits if their income is 37 percent or below the federal poverty level (\$6,996 for a family of four based on 2010 FPL). Currently, federal law prohibits childless adults from qualifying for Medicaid under any circumstances.



Accessibility to medical services is paramount to the overall health of Oklahomans. Oklahoma continues to make progress in reducing the number of uninsured citizens through innovative initiatives and improvements to existing programs. OHCA strives to implement methods to ensure those who are uninsured and eligible have access to public insurance. To this end, OHCA implemented the Online Enrollment program in the first quarter of SFY2011 and continues to expand and improve the highly acclaimed Insure Oklahoma program.

**Online Enrollment.** The goal of Online Enrollment is to eliminate barriers that might prevent potential members from applying for an OHCA program. Online Enrollment will also increase efficiency by streamlining the enrollment process. The heart of the program is a new online enrollment system that allows Oklahomans with internet access to apply any time or anywhere. A comprehensive rules engine uniformly applies policy and the applicant receives a real time eligibility decision when the application is submitted. Approved applicants select their Primary Care Provider at the time of application. The online system will eliminate the reliance on traditional, restrictive business hours and the typical 20-30 day lag in processing eligibility.

Online Enrollment became operational in September 2010. Phase I of implementation includes the SoonerCare and SoonerPlan populations, as well as the State Mental Health and Substance Abuse services population. Plans are to expand to Insure Oklahoma, the Aged, Blind, and Disabled, Breast and Cervical Cancer, and TANF populations in the future.



## GOAL # 1: ELIGIBILITY



**Insure Oklahoma.** Insure Oklahoma has two plans designed to assist qualifying low income, working Oklahomans in acquiring health insurance coverage.

The Employer Sponsored Insurance (ESI) plan is the state's premium assistance program that aims to make private health insurance affordable for both the employer and the employee. Started in 2006, it presently covers over 18,000 workers and their spouses through nearly 5,500 businesses representing all 77 counties in the state. Currently, employees and their spouses earning 200 percent or less of the federal poverty level (FPL) qualify for Insure Oklahoma if they work for a business with 99 or fewer employees.

Insure Oklahoma also has the Individual Plan (IP) that provides coverage to those who are self-employed, employed in small businesses that do not participate in the ESI plan, disabled in the Ticket-To-Work program, or unemployed individuals looking for work. The IP plan currently has over 13,000 members participating.

In SFY2011, ESI and IP will be expanded to offer coverage for dependent children of Insure Oklahoma members that are between 186 to 200 percent of the federal poverty level.

The growth in the program has been essential to providing a larger portion of Oklahoma's population with access to health insurance and medical care. But with the growth in enrollment comes growth in costs. Insure Oklahoma was designed to expand until the costs equaled the tobacco tax revenue dedicated to the program, and is currently estimated to hit the funding cap at approximately 35,000 individuals, not including students and children. With enrollment increasing rapidly, Insure Oklahoma will likely approach its limit in SFY2011. Other resources must be found in order for the program to cover more uninsured.

**Health Care in Oklahoma.** National legislation passed in 2010 includes potential changes that may affect the Medicaid program. OHCA continues to evaluate the impact this may have on SoonerCare enrollment.



## GOAL # 1: ELIGIBILITY

**OBJECTIVE** TO PARTNER WITH OTHERS TO REDUCE THE NUMBER OF OKLAHOMANS WITHOUT ACCESS TO MEDICAL COVERAGE.

Outcome:	<b>% Enrolled in SoonerCare &amp; Insure Oklahoma</b> <i>Estimated 2010 - 23.2%</i> 2011 Estimate - 24.2%
Output:	<b>Unduplicated SoonerCare Enrollment</b> <i>Estimated 2010 - 850,265</i> 2011 Estimate - 907,686
Output:	<b>Unduplicated Insure Oklahoma Enrollment (see note on page 23)</b> <i>Estimated 2010 - 35,000</i> 2011 Estimate - 50,716
Outcome:	<b>% Change in Total Enrollment</b> <i>Estimated 2010 - 3.9%</i> 2011 Estimate - 8.3%

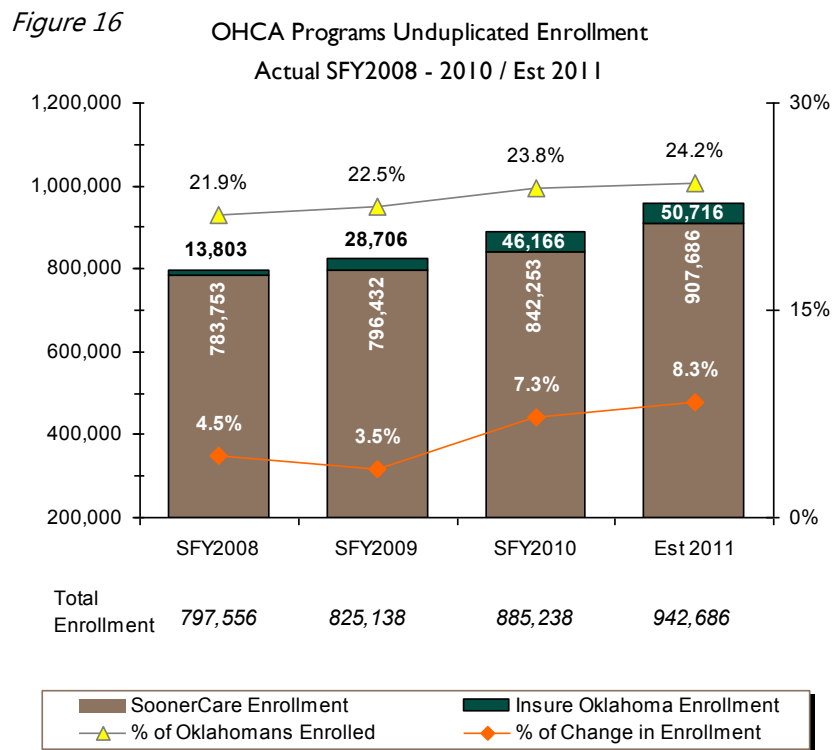
**What's being measured?**

These measures report the unduplicated number and percent of Oklahomans enrolled in SoonerCare and Insure Oklahoma (see note on page 25) and the percentage change from year to year.

**Why is this important?**

Access to and utilization of medical care are important factors in the health of Oklahomans. Access to affordable health insurance coverage, whether it be through private insurance, employer provided insurance or state provided programs, is critical.

The unduplicated enrollment in SoonerCare and Insure Oklahoma reflect the number of Oklahomans who had access to medical services through OHCA's programs. See the information beginning on page 27 to find out more about the demographics of SoonerCare and Insure Oklahoma populations.



Source: OHCA MMIS, US Census Bureau

## GOAL # 1: ELIGIBILITY

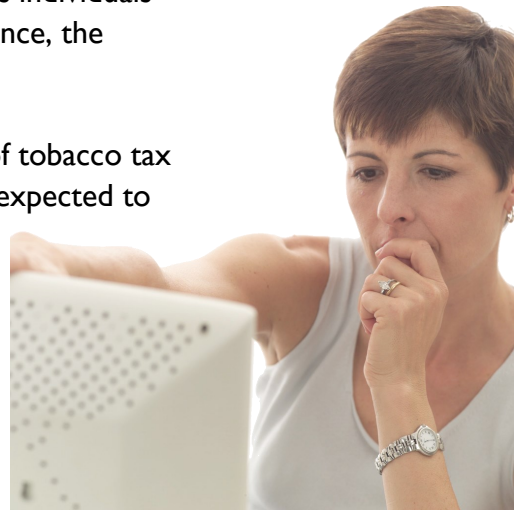
### What do the results mean?

The steadily increasing number of Oklahomans receiving medical coverage through OHCA suggests the difficulty many are having in finding affordable health care insurance in the private market or through employers.



Due to the counter-cyclical nature between public health programs and economic conditions, both SoonerCare and Insure Oklahoma continue to experience steady growth in enrollment. As individuals lose jobs, or employers opt out of offering health insurance, the demand for OHCA services increase.

The Insure Oklahoma plans are limited by the amount of tobacco tax revenue allotted by the state. The current provision is expected to cover approximately 35,000 individuals. At current enrollment rates, it is anticipated that the Insure Oklahoma plans will reach that cap during SFY2011.



\* Note: The enrollment number of 46,166 for Insure Oklahoma mentioned above includes all Oklahomans who were in the program at some point during the year. Many members enter the program then leave as their situation changes, such as when they acquire health insurance through their employer. As of June 30, 2010, Insure Oklahoma enrollment totaled 31,860.



### What's OHCA doing?

After months of planning, development, and testing, Online Enrollment became available to the public September 7, 2010.

Individuals who believe they may qualify for SoonerCare or SoonerPlan may go to [www.mysooner.org](http://www.mysooner.org) to access the application. Applicants receive a real-time eligibility response when they submit the application and if qualified,

## GOAL # 1: ELIGIBILITY



can access medical services immediately. Potential members may also receive assistance with the application process at their local Department of Human Services county office or County Health Department. Future plans include two more phases in which other program applicants can enroll online, including Insure Oklahoma and Oklahoma Cares (Breast and Cervical Cancer Program).

**All Kids Act.** In 2007, the state passed legislation (Senate Bill 424) giving OHCA the authority to cover children whose family income was at or below 300 percent of the FPL. In December 2009, the Centers for Medicare and Medicaid Services (CMS) approved a State Plan request to begin providing coverage for children.

The All Kids Act allowed OHCA to establish a program to provide coverage for children age 18 and younger between 186 and 300 percent of the federal poverty level although at this time the agency allows income levels between 186 and 200 percent. An increase in FPL would be phased in over a period of time as funds become available. The program was established via CHIP (Children's Health Insurance Program) State Plan Amendment through Insure Oklahoma and is not subject to the same expenditure cap as adults.

Rules have been revised to expand the Insure Oklahoma ESI and IP programs. Effective July 2010, ESI and IP were broadened to offer coverage for dependent children of Insure Oklahoma members who are earning income between 186 and 200 percent of the federal poverty level.

**CHILDREN.** Research data shows uninsured children are at a distinct disadvantage when it comes to accessing medical care. Statistics indicate they are less likely to receive needed medical services, including preventive care, dental care, and immunizations.

Children who come from families with income less than 186 percent of the FPL and are age 18 years and under make up over 65 percent of the SoonerCare population.



## GOAL # 1: ELIGIBILITY

Through CHIP funding and state dollars that were set aside in 2007 when the Oklahoma Legislature passed the All Kids Act, children can now qualify for Insure Oklahoma through their parents' participation. To find out more about this, visit the Insure Oklahoma website at [www.insureoklahoma.org/](http://www.insureoklahoma.org/).

**ADULTS.** The importance of adults' health status rarely affects only themselves. Typically, someone is counting on them for some reason, such as productivity, parenting, and/or caretaking. Many adults have several roles with multiple responsibilities. When considering health care costs, it comes as no surprise that adults with health insurance are much more likely to receive the care they need than their uninsured counterparts.



According to the September 2010 Kaiser Commission report on Medicaid and the Uninsured, about one-quarter (26%) of uninsured adults go without needed care each year due to cost. Studies repeatedly show that the uninsured are less likely than those with insurance to receive preventive care and services for major health conditions, including heart attacks and chronic diseases—and many suffer serious consequences.

SoonerCare coverage for adults is limited to the aged, blind, or disabled, and pregnant women, as well as parents of minor dependent children whose income falls at or below 37 percent of the federal poverty level.

Effective January 2010, CMS approved OHCA providing coverage for working adults up to 250 percent of the FPL. The program change was approved via Waiver under Insure Oklahoma.

The revisions will expand the current Insure Oklahoma ESI and IP program guidelines to include employees and working adults whose family income does not exceed 250 percent of the FPL. The increase from 200 to 250 percent of the FPL will be phased in over a period of time as funds become available. Currently, individuals with income levels up to 200 percent are being admitted to the program. This expansion to the Insure Oklahoma program could help increase access to health care for Oklahomans thereby reducing the amount of uncompensated care provided by health care providers.

## GOAL # 1: ELIGIBILITY

**OBJECTIVE** TO STRIVE TO ENROLL QUALIFYING CHILDREN, PARENTS, AND OTHER ADULTS INTO SOONERCARE.

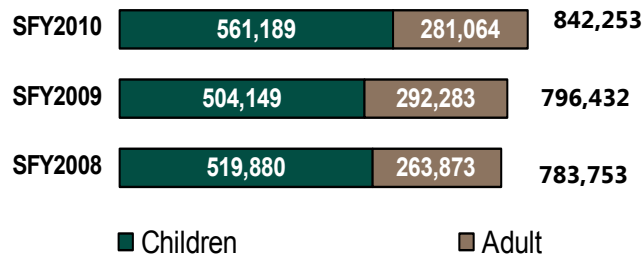
Unduplicated Number of Children Enrolled in SoonerCare  
Unduplicated Number of Adults Enrolled in SoonerCare

**What’s being measured?**

These measures break out enrollment for adults and children. OHCA continues to follow the demographics of our membership by tracking enrollment through eligible categories. This page displays the breakdown of individuals enrolled.

Figure 17

SoonerCare Enrollment by Child/Adult



Source: OHCA MMIS

\*Insure Oklahoma enrollment numbers are not included in this chart. Enrollment information for the Insure Oklahoma program can be found on page 22.

**What do the Results Mean?**

These measures indicate the demographic characteristics, nature, and scope of several OHCA populations. OHCA uses past and current enrollment when estimating future enrollment. These numbers are also used to formulate ideas for new programs or recommend changes for existing programs.

**QUALIFYING FOR SOONERCARE**

To qualify for health benefits through SoonerCare, individuals must meet specific criteria. Besides income, other factors determine the category of membership and define the benefits for which they qualify.

Figure 18

Qualifying Category	SFY2008	SFY2009	SFY2010
CHIP	115,433	114,804	116,968
ABD	162,750	167,537	200,457
TEFRA	229	308	385
Oklahoma Cares	7,541	6,834	6,522
SoonerPlan	34,260	31,755	39,479
Dual Eligibles	111,145	112,999	115,693

Source: OHCA MMIS

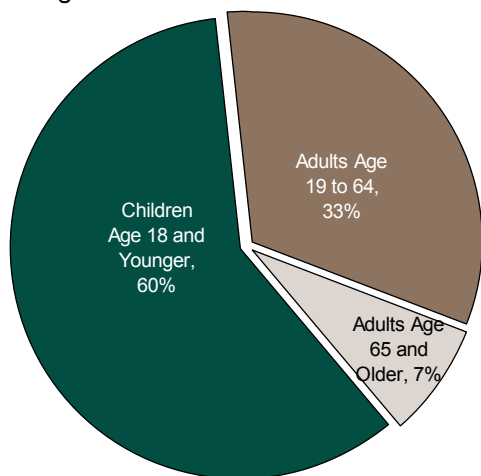
\* Members may be counted in more than one category, i.e. a child counted in TEFRA may also be counted in the ABD population.

\*\*ABD calculation method was changed to reflect all enrolled members who had ever been categorized as an ABD member versus reporting the last category of record. Previously reported numbers were 2008 - 143,895 and 2009 - 146,791. The 2010 numbers were not available at the time of this report.

**CHIP.** The federal Children’s Health Insurance Program (CHIP) allows states to increase the federal poverty level (FPL) limit for children. SoonerCare covers children with family income up to 185 percent of the FPL (federal Medicaid minimum is 133 percent). The state receives an enhanced federal matching rate for children above 133 percent.

## GOAL # 1: ELIGIBILITY

Age of SoonerCare enrollees SFY 2010



Source: SFY2010 Annual Report

Figure 19

**ABD.** Aged, blind or disabled (ABD) members make up a small percentage of SoonerCare, but account for a large portion of expenditures(53%).

**TEFRA.** The Tax Equity and Fiscal Responsibility Act (TEFRA) population are children under the age of 19 years old with physical or mental disabilities that meet the criteria for institutional care. TEFRA allows a child to qualify on his/her own income rather than the family, whose income is above SoonerCare limits. Children qualifying through TEFRA are able to remain in the home and receive medical benefits. TEFRA is a subset of the ABD population.

**Oklahoma Cares.** This category is made up of women under the age of 65 who have been diagnosed with breast or cervical cancer, have a precancerous condition, or require further testing due to abnormal results from previous tests. They have access to all SoonerCare benefits until they no longer need treatment for breast or cervical cancer or they no longer meet the qualifying criteria.

**SoonerPlan.** SoonerPlan is a family planning, limited benefits package available to men and women ages 19 and older with income at or below 185 FPL.

**Other Demographics.** OHCA releases an Annual Report that includes information about its programs, members, and administration. The surrounding charts are from the SFY2010 Annual Report and provide a look at some of the characteristics of the members served by OHCA. The Annual Report can be accessed on OHCA’s website at [www.okhca.org/research/Reports](http://www.okhca.org/research/Reports).

The agency also releases monthly Fast Facts on several key areas including enrollment, programs, specific member groups and the uninsured. The Fast Facts are available on the OHCA website at [www.okhca.org/research/Statistics and Data](http://www.okhca.org/research/Statistics and Data).

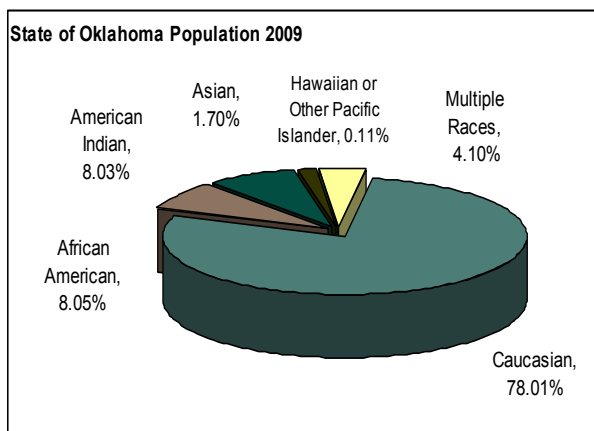


Figure 20

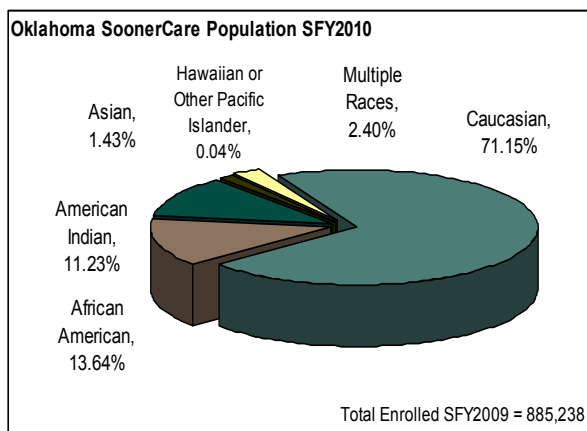


Figure 21

Source: SFY2010 Annual Report

**HEALTH COVERAGE FOR WORKING OKLAHOMANS**



According to the Census Bureau’s 2010 Current Population Survey, more than 659,000 Oklahomans were uninsured in 2009. Of that number, 82.3 percent were adults over 18 years old. At this time, Federal Medicaid laws prevent SoonerCare from covering specific populations including childless adults and parents earning over 37 percent of the FPL.

The Insure Oklahoma (IO) program, funded by federal dollars matched to state tobacco tax funds, assists individuals, working people, and small businesses to close the gap created by Federal Medicaid enrollment limitations. Individuals with household income at or below 200 percent of the FPL may qualify for one of two plans.

Employer Sponsored Insurance (ESI) partners with the business community and the private insurance industry to make affordable health insurance available to employees. Insurance companies may participate in the program by offering qualified plans covering a minimum set of benefits. Oklahoma based employers with less than 100 employees may participate in the program. Employers and employees pay a percentage of premium payments and the state covers the remainder. Employees are responsible for paying deductibles and co-pays.

Centers for Medicare & Medicaid Services (CMS) recently approved OHCA’s requested state plan amendment to add children to the Insure Oklahoma program . The amendment covers children younger than age 19 in families with workers from any size business whose household income is 186 percent to 300 percent of the (FPL). Due to budget concerns, OHCA will only implement the enrollment of children between 186 and 200 percent of FPL at this time.

The Individual Plan (IP) covers individuals who meet the income criteria, and are: (1) employed by a business eligible for ESI but not participating; (2) self-employed; (3) unemployed (eligible for unemployment assistance); or (4) in the Ticket-to-Work program. IP members are enrolled in a public product with limited benefits. Members pay minimal premiums, deductibles, and co-pays. Member responsibility for these out-of-pocket costs are limited to 5 percent of a member’s annual gross household income.

Figure 22

**Insure Oklahoma Enrollment on June 30, 2010**

<b>Employer Sponsored Insurance:</b>	<b>SFY2008</b>	<b>SFY2009</b>	<b>SFY2010</b>
Number of Businesses Approved	2,742	4,752	5,496
Number of People Enrolled*	8,761	14,217	18,696
Percent Change in Enrollment	263%	62%	32%
<b>Individual Plan:</b>	<b>SFY2008</b>	<b>SFY2009</b>	<b>SFY2010</b>
Number of People Enrolled*	2,923	7,381	12,908
Percent Change in Enrollment	6%	153%	75%

\* These are not unduplicated. Numbers reflect status for a point in time on June 30, 2010.

Source: OHCA Fast Facts



## GOAL # 1: ELIGIBILITY

and national levels.

OHCA carefully tracks program and administration costs associated with providing SoonerCare to Oklahomans. The information is used to evaluate trends in expenditures, forecast and prepare for future financial needs, and to analyze policy and program effectiveness and efficiency.

### What do the results mean?

In SFY2010, the rise in health care costs showed no signs of slowing down. Because of budget difficulties at the state level, OHCA was forced to face several benefits and provider rate cuts in order to balance the agency budget. More information on the budget cuts can be found under Goal 5 starting with page 73.

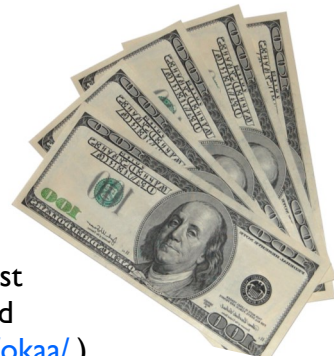
The gaps caused by funding shortages at the state level were temporarily filled by enhanced stimulus funding provided by the American Recovery and Reinvestment Act (ARRA). ARRA has funneled millions of dollars into Oklahoma's economy. Some of this funding comes in the form of the enhanced federal matching rate (FMAP) for SoonerCare. While total Medicaid costs increased in SFY2010, the state's share decreased due to the extra federal dollars. Before ARRA, Oklahoma's FMAP rate brought in approximately two federal dollars for every state dollar spent. Since February of 2009, the enhanced rate raises it to approximately three federal dollars per state dollar spent. The federal matching enhanced rate has been extended to the end of June 2011. The enhanced federal matching rate (FMAP) was 76.51 while the rate for SFY 2012 will be 63.88. This is anticipated to leave a large hole requiring state dollars to keep benefits and rates at the current level. For more information on FMAP, go to page 68.

OHCA continues to analyze expenditure trends and works closely with state officials to ensure responsible stewardship of program funds. Of utmost importance is the assurance to vulnerable Oklahomans that medical care will continue to be available to them.

### What's OHCA doing?

The cost of health care insurance continues to rise in all sectors. National attention has been focused on these trends for years, especially in publicly funded Medicare and Medicaid programs. Policy, program, and health care experts as well as political and advocacy groups have been researching and analyzing the cost and benefits of maintaining, reducing, or expanding these national programs. The fact that Medicaid is being considered as a cornerstone for expanding coverage to all low income individuals points to the economical advantage of utilizing this infrastructure to reduce the burden of uncompensated care. However, the cost to the states during these economic times may make this method unsustainable.

Oklahoma's Medicaid funded program, SoonerCare, covers almost one in four Oklahomans (23.8 percent). OHCA receives the third highest of state appropriations (See OpenBooks, at [www.ok.gov/okaa/](http://www.ok.gov/okaa/).)





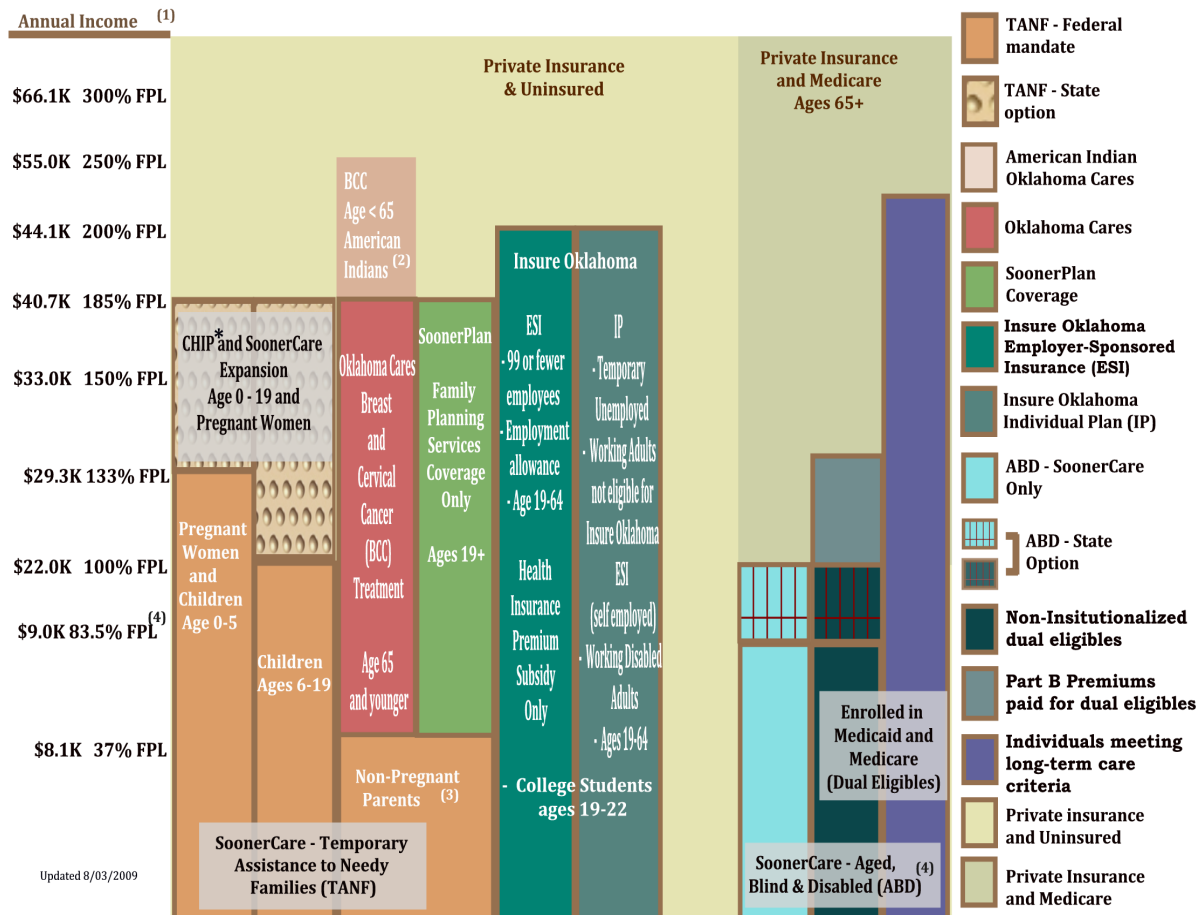
## GOAL # 1: ELIGIBILITY

As mentioned earlier, monthly enrollment continues to increase at a higher rate than in the past. OHCA anticipates membership (unduplicated enrollment) to top 907,000 in SFY2011 and potentially reaching 930,000 in SFY2012. OHCA staff is mindful that the enhanced FMAP rate will end in June 2011 as well as the number of state dollars needed to maintain SoonerCare at its current level of service.

During the 2010 Oklahoma Legislative Session, HB2437 was passed. This bill imposed a 1% access payment on paid health insurance claims. Congress earmarked the funds to be used with the Federal FMAP available to the state. The expected revenue was to be used to fund continued services to SoonerCare members. The State Supreme Court ruled the bill unconstitutional which created an anticipated \$52 to \$78 million hole in the OHCA SFY2011 budget.

Figure 25

### 2010 FEDERAL POVERTY GUIDELINES (FPL) AND COVERAGE



(1) 2009 Federal Poverty Guidelines. U.S. Department of Health and Human Services. Based on a family of four.

(2) Oklahoma Cares qualifications are up to 250% FPL for American Indians only.

(3) Approximately 37 percent of federal poverty level (FPL) based on single parent family.

(4) Income shown is for single individuals.

\* CHIP is the Children's Health Insurance Program.

**IMPORTANT** - the above information is a very basic overview of the federal poverty level and coverage groups. Each group has varying qualifying criteria. Specific details can be found at [www.okhca.org](http://www.okhca.org) under Individuals.



## Goal # 2: Satisfaction and Quality

TO PROTECT AND IMPROVE MEMBER HEALTH AND SATISFACTION, AS WELL AS ENSURE QUALITY WITH PROGRAM SERVICES AND CARE.

SoonerCare incorporates a number of benefits and services bound by federal and state legislation and administrative and procedural requirements. SoonerCare also encompasses several waiver programs. The agency makes every effort to ensure that members receive the benefits for which they are qualified, receive them timely, and are satisfied with the services. SoonerCare and Insure Oklahoma programs serve members with diverse health conditions and needs. Each member bases their satisfaction on different factors. Quantifying quality and levels of satisfaction for such an array of members and benefits is a challenge.

Adding to this challenge is the constantly changing health care industry, new innovations in delivery of care, and operating changes. OHCA is constantly adapting to provide the services our members need. For purposes of monitoring quality and satisfaction, OHCA conducts reviews and internal research studies, contracts for independent annual surveys of our members, and participates in external research studies. OHCA collaborates with stakeholders to explore new opportunities and improve our services.

The Quality Assurance and Quality Improvement Department (QA/QI) of OHCA leads our quality and satisfaction efforts. Below are some of the activities OHCA is engaged in to ensure quality and to report results.

### CAHPS

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys have been 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. The CAHPS survey is conducted annually, alternating between an adult survey and a child survey. See page 36 for results on CAHPS.

### MINDING OUR P'S & Q'S

OHCA reports ongoing quality initiatives undertaken by the agency in the annual *Minding Our P's & Q's—Performance and Quality* report. This report details agency activities such as

## GOAL # 2: SATISFACTION AND QUALITY

updates on the Emergency Room Utilization Project, new and continuing research studies, and new grant opportunities the agency is exploring. The reports are available on OHCA's website at [www.okhca.org/research/annual-reports/ Minding our Ps and Qs](http://www.okhca.org/research/annual-reports/Minding_our_Ps_and_Qs).



### OKLAHOMA ELECTRONIC HEALTH RECORD INCENTIVE PROGRAM

The American Recovery & Reinvestment Act of 2009 developed the Health Information Technology for Economic and Clinical Health Act (HITECH ACT) to provide incentive payments for the “meaningful use” of certified EHR technology to Medicare and Medicaid programs. Legislation’s purpose for HITECH is to improve outcomes, facilitate access, simplify care, and reduce costs of health care nationwide by providing: financial support, technical assistance, and a framework for improving healthcare quality and outcomes.

Oklahoma’s program begins in January 2011. The program is designed with an incentive for providers to adopt (acquire and install), implement (commence utilization, train staff, deploy tools, exchange data), upgrade (expand functionality or interoperability), or meaningfully use (meet specified criteria) a certified EHR System.

Providers must enter the program by 2016 to qualify for incentive payments. They can receive one incentive payment per year. The first year maximum payment is \$21,250. Maximum incentives are \$63,750 over 6 years.

### OHCA’S PERFORMANCE

Following are key measures selected to inform our audience of the evaluation of our performance in providing quality services and meeting our members’ needs.

## GOAL # 2: SATISFACTION AND QUALITY

### OBJECTIVE

TO MAINTAIN A RATE OF LESS THAN 1 PERCENT OF THE ANNUAL SOONER-CARE POPULATION WHOSE ISSUES ELEVATE TO FORMAL APPEALS.

Outcome:	Number of Member Appeals Filed During the Period <i>Benchmark 2010 - &lt; 75 Benchmark 2011 - &lt; 220</i>
Output:	% of OHCA's Decisions Overturned in the Appeals Process <i>Target 2009 - &lt; 10 Target 2010 - &lt; 10</i>
Outcome:	Ratio of Appeals Filed to Total SoonerCare Population <i>Target 2009 - &lt; 1/4 of 1% Target 2010 - &lt; 1/4 of 1%</i>

### What's being measured?

The appeals process, as a measure of member satisfaction with the quality of services offered, is measured in three different ways: the ratio of filed appeals to total members, the number of member appeals filed, and the percentage of OHCA decisions that were overturned.

### Why is this important?

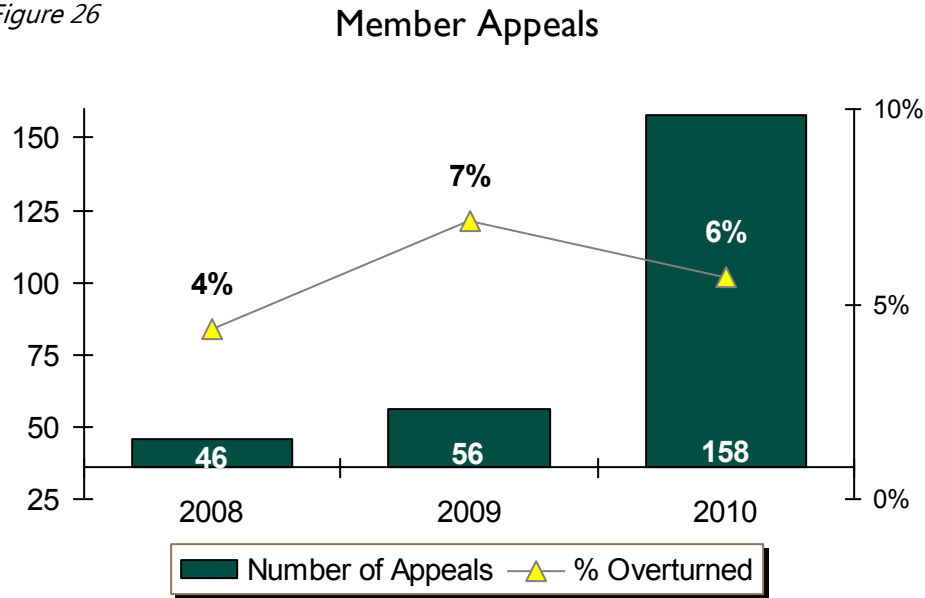
The appeals process is provided to give members an opportunity to express concerns or complaints; it is in place to protect members. The information received from grievances is used to monitor member satisfaction. Through this process, the agency can identify issues that arise and the information is used to improve programs and services. Appeals can bring to light the need for policy or procedure adjustments, education topics for members and/or providers, and ideas that may lead to pursuing program changes through state and federal policy or legislation.

Because the agency does not use the number of appeals as "success" indicators, no targets are set for them. OHCA does report a benchmark as a point of reference for the coming year. The benchmark is developed using past information as well as the anticipated impact of future events, such as the implementation of new programs and changes in enrollment.



## GOAL # 2: SATISFACTION AND QUALITY

Figure 26



Source: OHCA Legal Division

### What do the results mean?

The Insure Oklahoma's Individual Plan (IP) enrollment significantly increased during the year. Appeals by members of the Insure Oklahoma IP program go through OHCA's appeal process. The agency expects the numbers to continue to increase in future years due to the following changes: OHCA processing appeals related to the Advantage program starting in SFY2011, moving to Online Enrollment will add member appeals regarding eligibility, and anticipated growth of the SoonerCare population.

### What are we doing?

Along with monitoring member appeals, the agency also conducts consumer satisfaction surveys (see page 36).

GOAL # 2: SATISFACTION AND QUALITY

OBJECTIVE:

TO SEEK AND EVALUATE MEMBER FEEDBACK ON SATISFACTION WITH SERVICES RECEIVED WHEN ACCESSING SOONERCARE BENEFITS.

Outcome:

Customer Satisfaction Survey Results  
*Benchmark—Trend information*

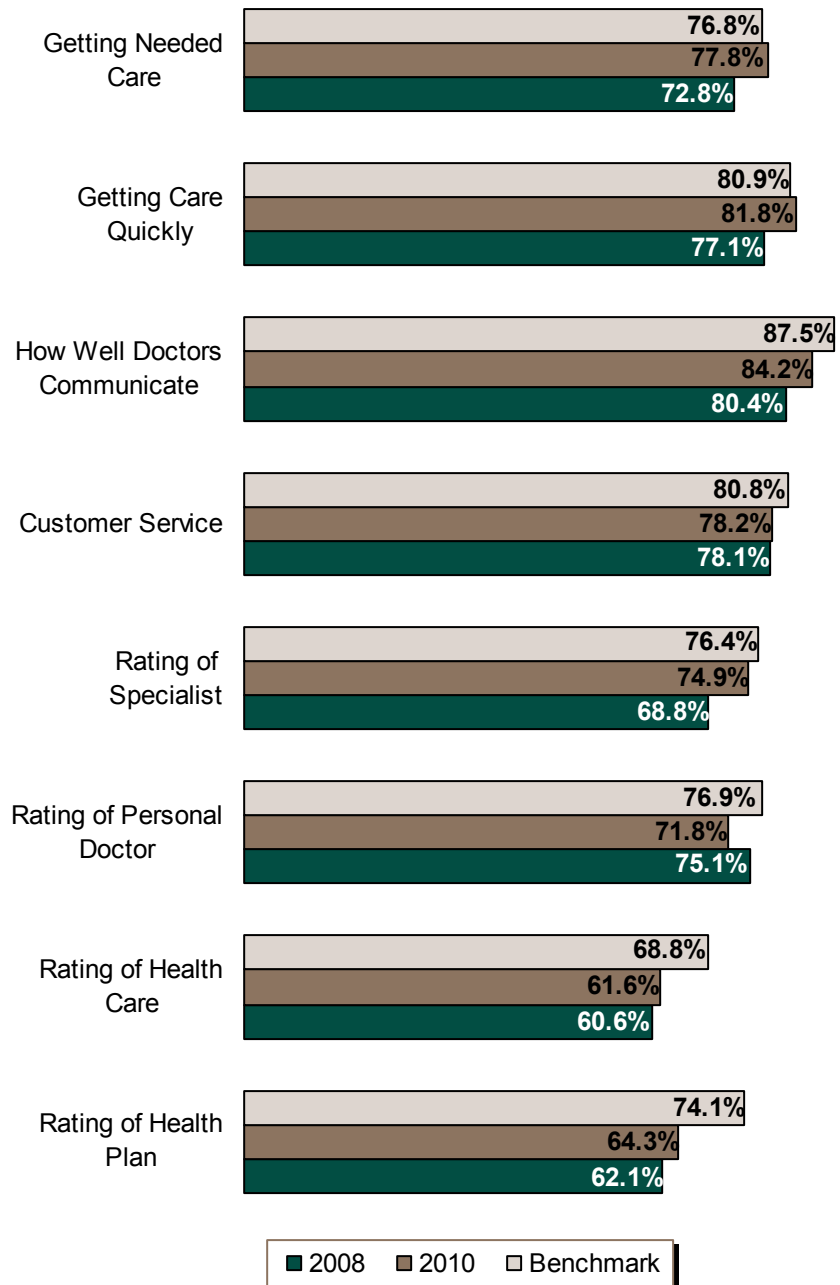
What’s being measured?

CAHPS, the Consumer Assessment of Health Plans Study, is a survey measuring members’ satisfaction with medical services they received. Measures range from “Rating of Health Plan” to “How Well Doctors Communicate.” The survey usually alternates annually between the adult population and the child population. For 2010, adult’s experiences were surveyed.

It should be noted that the information reported in 2010 was based on members enrolled in SoonerCare Choice between December 1, 2008 and November 30, 2009.

Figure 27

Customer Survey (CAHPS®) - Adult



Source: CAHPS® Adult Health Survey for SoonerCare Choice, Report for Fiscal Year 2010



## GOAL # 2: SATISFACTION AND QUALITY

### Why is this important?

Responding to the survey gives members an opportunity to express their feelings about the program and treatment they receive. During provider training sessions, issues that come up in the survey will be used as possible training points. Provider training is discussed in more detail in Goal 6. The responses received from SoonerCare members are compared to a national average. The national average combines data from all participating states as reported by the Agency for Health Research and Quality (AHRQ).



The survey showed that SoonerCare members indicate high levels of satisfaction with the eight measures of the survey. All areas show positive trends and how often they were able to get care quickly showed a statistically significant increase. The measure went up 4.7% with a higher rate than the national average.

### What's OHCA doing?

**Other Surveys.** SoonerPlan Family Planning Program. SoonerPlan offers limited family planning benefits to uninsured men and women. The SoonerPlan Survey “was designed to capture member perceptions and determine the extent to which they are satisfied with the program.” Very satisfied is the way 79.9 percent of members in the program rated their “Overall Satisfaction with SoonerPlan.” On a scale of one to ten (ten being the highest), 79.5 percent rated their health provider between eight and ten. The report is available online at [www.okhca.org/research/studies/member\\_satisfaction\\_surveys](http://www.okhca.org/research/studies/member_satisfaction_surveys).



## GOAL # 2: SATISFACTION AND QUALITY

### OBJECTIVE

TO ACHIEVE AND MAINTAIN STANDARD QUALITY RATINGS FOR SOONER-CARE CHOICE AT THE HIGHEST RATING.

Outcome:

SoonerCare Choice Quality Scores  
*Target - 1.00*

### What's being measured?

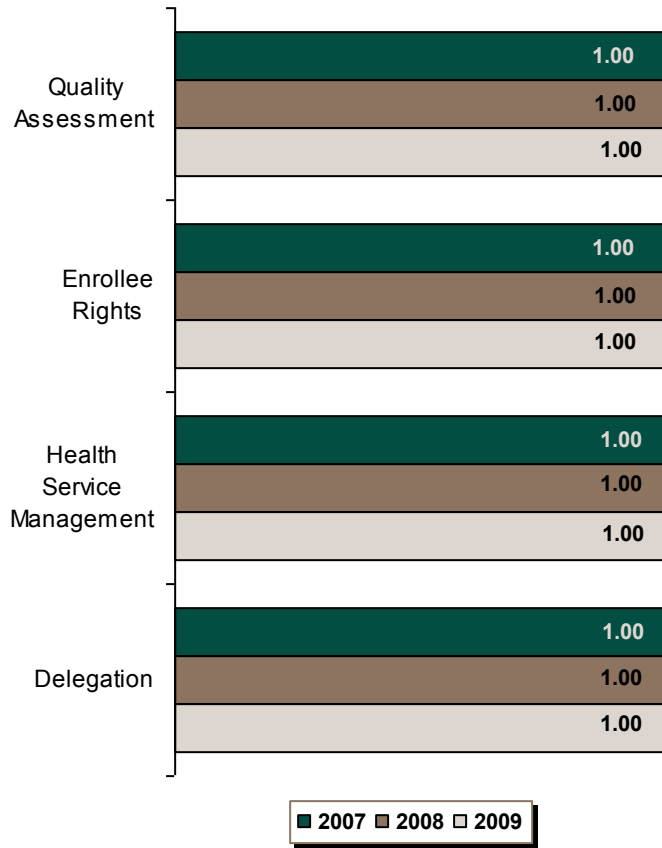
Yearly, an external review organization reviews different aspects of the OHCA's functions to report on our efforts to provide quality controls and quality assurance. OHCA continually strives to meet and exceed expectations in both programs and operations.

The quality review is segmented into four domains with a total of 122 measures. A score of one indicates success at meeting the expectations of the domain. The four domains are:

- Quality Assessment and Performance Improvement,
- Member Rights,
- Health Services Management – includes availability and accessibility of services, coordination of care, and
- Delegation – accountability for responsibilities delegated to other entities.

Figure 28

### SoonerCare Choice Quality Scores



Source: OHCA External Quality Review Report, SoonerCare Choice, Report for Contract: State Fiscal Year 2010, Data Reviewed: State Fiscal Year 2009, Submitted: July 2010

### Why is this important?

The results of this review are one tool that can be used to evaluate the agency's commitment to maintaining superior quality standards of performance.

## GOAL # 2: SATISFACTION AND QUALITY

### What do the results mean?

This review gives OHCA insight on the degree to which obligations under state and federal laws and regulations have been met. The review found OHCA in full compliance with all four domains' criteria. This is the fourth year in which OHCA received the highest score across the board.



### What kind of quality research is OHCA conducting?



The Quality Assurance/Quality Initiative Department has conducted several member satisfaction surveys and participated in several studies during the year. The reports for these quality activities are available on OHCA's website at [www.okhca.org/research/studies/studies and reports](http://www.okhca.org/research/studies/studies_and_reports).

Some of the studies are discussed below.

*Behavioral Health Follow-Up Care & Recidivism study* – examines the frequencies of follow-up care and patterns of recidivism/readmission for members under 21 who utilized inpatient behavioral health services.

*Comprehensive Diabetes Care Study* - evaluates the compliance of SoonerCare members diagnosed with diabetes on ten different diabetes care measures.

- Hemoglobin A1c (HbA1c) testing in 2008
- Poorly controlled hemoglobin A1c (HbA1c >9.0%) in 2008
- Control of hemoglobin A1c (HbA1c <8.0%) in 2008
- Good control of hemoglobin A1c (HbA1c <7.0%) in 2008
- Retinal eye exam performed in 2007 or 2008
- Low-density Lipoprotein Cholesterol (LDL-C) screening in 2008
- Low-density Lipoprotein Cholesterol controlled (LDL-C <100 mg/dL) in 2008
- Medical attention for nephropathy in 2007 or 2008
- Blood pressure controlled at <140/90 mm Hg in 2008
- Blood pressure controlled at <130/80 mm Hg in 2008



*Emergency Room Utilization Study* - provides data about SoonerCare members with frequent ER use who need but are not receiving behavioral health treatment.

## GOAL # 2: SATISFACTION AND QUALITY

### OBJECTIVE

TO PARTNER WITH OKLAHOMA'S SURVEY AND CERTIFICATION AGENT TO STRIVE FOR QUALITY LONG-TERM CARE FACILITIES.

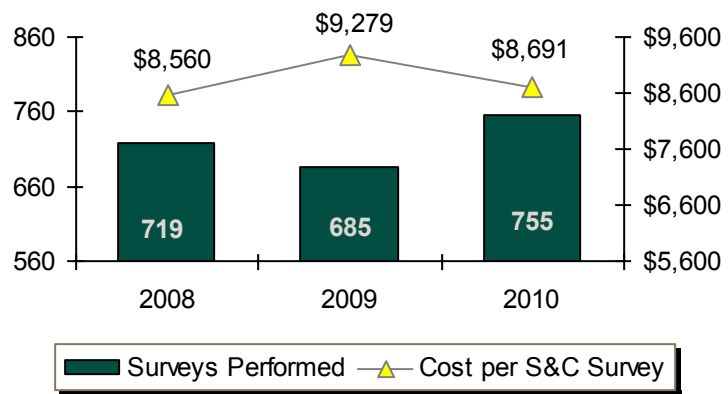
Outcome:	Number of Survey & Certifications (S&C) Surveys Performed* <i>*Provided by Oklahoma Department of Health; Estimates not available</i>
Output:	Cost Per S&C Survey* <i>*Number of Surveys Provided by Oklahoma Department of Health; Estimates not available</i>
Outcome:	Cost of S&C Contract <i>Estimated 2010—\$7,011,000      Estimate 2011—\$7,011,000</i>

Figure 29

### What's being measured?

These measures report how many surveys were performed on all nursing homes, the total cost per survey, and the cost of the contract in total. OSDH provides the number of surveys data; no projections are available at this time for 2011.

Certification Surveys Performed/Cost Per Survey



Source: Oklahoma Department of Health; OHCA Financial Services Division

The Centers for Medicare and Medicaid Services require a quality and safety review process be performed on nursing homes. Oklahoma State Department of Health (OSDH) is contracted with OHCA to perform the Survey and Certification reviews. The surveys evaluate compliance with federal and state regulations related to facilities' condition, medical record keeping, patient safety, etc. An initial survey is conducted on new nursing homes and recertification visits are conducted at regular intervals. To find out more detailed information on survey requirements, go to [www.cms.gov/Certification and Compliance/NH.asp](http://www.cms.gov/Certification and Compliance/NH.asp). To see results of these surveys, go to Nursing Home Compare at [www.medicare.gov.NH compare](http://www.medicare.gov.NH compare).

### Why is this important?

The care of Oklahoma's nursing home residents is monitored by the OHCA, OSDH, and CMS, to determine that facilities are meeting the quality and performance standards outlined in the Social Security Act. People enter nursing homes for a variety of reasons and varying lengths of stay. Nursing homes provide a place to live while recuperating so skilled nursing services and/or therapies can be received. They offer a long-term solution for individuals who have lost the ability to live independently. Nursing homes can offer a broad range of benefits including personal care, social interaction, and medical services. Ensuring safe surroundings and quality services is vital for members accessing these services. These surveys keep the partners informed of the condition and quality of nursing homes.

## GOAL # 2: SATISFACTION AND QUALITY

### What do the results means?

Surveys are performed at the nursing homes' locations throughout the state by several surveyors. The Oklahoma State Department of Health decides on the number of surveys conducted.

### What's OHCA doing in the area of Long-Term Care?

OHCA has several on-going initiatives directly impacting the quality of nursing homes. Below is a brief description of some of them.

**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.** In July 2007, OHCA implemented the Focus on Excellence (FOE) Program charged with collecting data from participating nursing homes on ten performance measures. The goals of the program are: (1) enable the value-based purchasing of nursing home care by OHCA, (2) improve provider performance through timely feedback and easy comparison with peer performance, and (3) inform consumer choices when seeking long-term care. Individuals can access the Nursing Home Ratings website at [www.oknursinghomeratings.com](http://www.oknursinghomeratings.com) and search for an Oklahoma nursing home by location and/or star rating.

The program gathers information in areas such as quality of life, resident and family satisfaction, clinical measures, staffing ratios and employee satisfaction. Up to five stars can be earned on each measure. Enhanced reimbursement of up to 4 percent is provided for Medicaid licensed facilities meeting certain criteria.

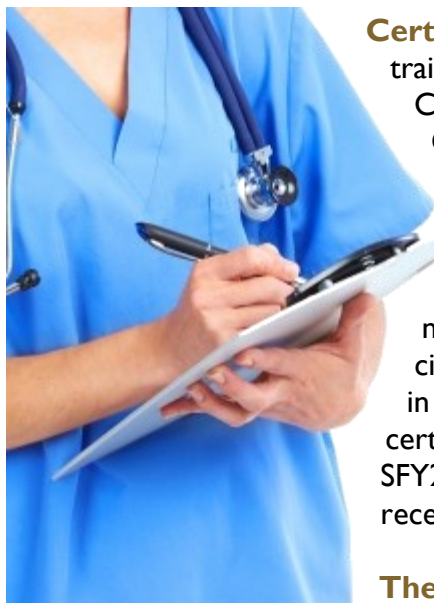
FOE received an Independent Evaluation conducted by The Pacific Health Policy Group that was released in October 2009. The report includes a comparison to such activities undertaken in other states, a comparison to the federal website maintained by the Centers for Medicare and Medicaid (Nursing Home Compare), provider perceptions, citizen perceptions, and best practices and opportunities for improvement. This report can be accessed at [www.okhca.org/research/Focus on Excellence](http://www.okhca.org/research/Focus on Excellence).

Initially the FOE programs reimbursement was based on a bell curve. On January 1, 2010, the program moved to a fixed target for reimbursement. The targets were set based on the data collected during the first two years of the program. There is a fixed target for each measure. The change allows facilities the opportunity to look at themselves each quarter and set higher expectations for their facilities. By the end of the reporting period, 98% of the Medicaid licensed facilities in Oklahoma were participating.





## GOAL # 2: SATISFACTION AND QUALITY



**Certified Nurse Aid Training.** The Certified Nurse Aide training program is a joint effort among the Oklahoma Health Care Authority, Oklahoma State University-Oklahoma City, Oklahoma State Department of Health, Oklahoma Foundation for Medical Quality, and several long-term care facilities.

There is a need for direct care in long-term care facilities; the CNA program was designed to fill this need. Prospective nurse aides can receive free, quality training in sixteen different cities across the state. The newly certified aides agree to work in a SoonerCare facility for 12 months of a 24 month certification period in return for receiving the free training. In SFY2010, there were 878 students in the program with 688 receiving certification.

**The Living Choice Project.** People with disabilities or long-term illnesses, at least 19 years of age, can enjoy community living through the Living Choice program. Individuals have choice and control of the services and supports necessary to live in and be part of the community. The program connects individuals who qualify for institutional care with community services that afford them the ability to live in a home setting.

The Money Follows the Person grant provides additional federal reimbursement for home and community-based services for members that transition from institutions. During SFY2010, 65 individuals transitioned from institutional care to Living Choice: 37 persons with intellectual disabilities, 17 persons with physical disabilities, and 11 elderly persons.

Individuals who have resided in a nursing facility for at least six months, have SoonerCare (Oklahoma Medicaid) for at least one month prior to transition, have an interest in moving back to the community, and have a support system in the home and community, are candidates for the Living Choice program. OHCA is currently working on new rules, which if approved, will reduce the nursing facility residency requirement from six months to 90 days. More information on Living Choice can be found at [www.oklivingchoice.org](http://www.oklivingchoice.org) members. You may also contact the program by email at [info@oklivingchoice.org](mailto:info@oklivingchoice.org) or call (888)287-2443.



## GOAL # 2: SATISFACTION AND QUALITY

### 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 2010 - < 32    Benchmark 2011 - < 50*

### What's being measured?

This measure reports the number of SoonerCare providers with whom contractual relationships were ended due to noncompliance or rendering services that were not provided in an appropriate and/or necessary manner for the well-being of our members.

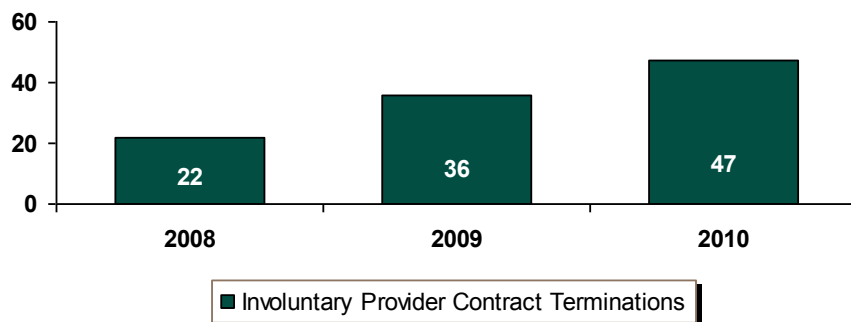
OHCA does not set a target for this measure to achieve, but a benchmark to stay beneath. Due to increased oversight of SoonerCare providers by OHCA and other entities, including the federal government, it is difficult to project the number of providers that may be terminated in future years.

### What do the results mean?

Figure 30

Involuntary Terminations of Provider Contracts

In specific circumstances, a contracted provider may have two types of contracts that serve members in distinct or specialized sub-populations. In these cases, we count the contracts separately. All other individual providers are counted once. During SFY2010, there was one provider with two contracts that were ended.



It should be noted that 10 of the 47 provider contracts terminated were with facilities such as clinics or nursing homes. These facilities may utilize more than one of our contracted providers. Providers affiliated with these facilities, whose contracts were canceled, are included in the number reported.

SoonerCare provider contracts are terminated if: (1) they are identified through program integrity efforts as not meeting quality standards, medical necessity, or contractual requirements, (2) their license is suspended or revoked, or (3) they appear on a federal or state exclusion list such as OIG Medicare Exclusion Database (MED).

## GOAL # 2: SATISFACTION AND QUALITY

### Why is this important?

OHCA contracts with a variety of providers in a number of specialty areas to ensure members have access to appropriate, timely, and quality care. Having access to a member's doctor or dentist of choice can add a sense of satisfaction and encourage the relationship necessary to maintain the best possible health.

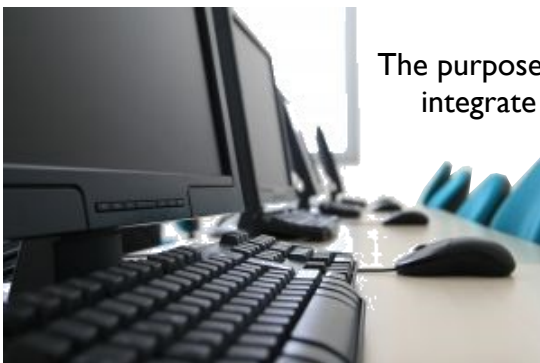
Quality care and integrity of operations are key factors in ensuring a positive outcome for a patient. Specific requirements outlined in the provider contract must be met in order to maintain a working relationship with OHCA and serve our members. When noncompliance or unsatisfactory quality of services is identified and remains unresolved by the provider, OHCA terminates the provider contract.

### What's OHCA doing?

OHCA communicates with and educates providers in many ways. Through formal training events, individual office visits, a dedicated helpdesk line, and written and electronic communication, OHCA keeps providers informed of policy issues, procedural instructions, and relevant topics to ensure providers have what they need to successfully serve SoonerCare members.

**Patient-Centered Medical Home.** On January 1, 2009, OHCA implemented the Patient-Centered Medical Home (PCMH) primary care delivery system. Originating as a high priority of the Medical Advisory Task Force, the goals of the PCMH are to:

- Guarantee the availability of a medical home with a primary care provider for all SoonerCare Choice members,
- Enhance patient choice and participation in health decisions,
- Assure all members receive all necessary preventive and primary care, including immunizations and health screenings,
- Increase the provider network,
- Reduce inappropriate emergency department visits and hospitalizations,
- Realign payment incentives to improve cost effectiveness & quality, and
- Promote the use of health information systems.



The purpose of the medical home is to better coordinate and integrate medical care with a “whole person” focus. This new approach enables a personal physician to create a proactive plan based on the patient's needs and coordinate with specialists and other medical professionals to put the developed plan into practice. In addition, it revises the fee payment structure, aligning incentives through an enhanced reimbursement system that is structured to recognize the cost of performing the functions of a medical home.



## Goal # 3: Members' Personal Responsibilities

TO PROMOTE MEMBERS' PERSONAL RESPONSIBILITIES FOR THEIR HEALTH SERVICES UTILIZATION, BEHAVIORS, AND OUTCOMES.

Being healthy involves making good choices about exercise, diet, and personal behavior. To become healthier, individually, and as a state, Oklahomans must take personal responsibility for their health choices and behaviors. This is particularly true of individuals accessing SoonerCare services. SoonerCare serves low-income populations who are more likely to report themselves in poor health. Professor Sara Rosenbaum of George Washington University states that the Medicaid "...population is markedly less healthy than average."

In 2010, the United Health Foundation ranked Oklahoma's overall health as 46th in the nation, up three spots from 2009. The Foundation studies each state's health by investigating numerous factors that affect health outcomes, such as smoking, obesity, crime, poverty, and access to insurance, and primary care physicians. Oklahoma ranks low in smoking prevalence (48<sup>th</sup>) and obesity prevalence (46<sup>th</sup>). Oklahoma also ranks low in the number of Primary Care Physicians (49<sup>th</sup>), but is relatively high in public health funding (14<sup>th</sup>) and prevalence of binge drinking (10<sup>th</sup>). According to the rankings, in the past five years, the rate of uninsured population declined from 19.9 percent to 16.1 percent. In the past ten years, the incidence of infectious disease decreased from 42.4 to 13.4 cases per 100,000 population.

These rankings help explain why Oklahoma receives poor grades from the State Department of Health in several important health indicators. For example, when it comes to chronic lower respiratory disease deaths, which are caused primarily by smoking, Oklahoma received a grade of F, the worst state in the nation. In addition, Oklahoma received a grade of D for heart disease deaths and diabetes, which are caused largely by obesity.



Poor health outcomes can only be improved when Oklahomans take more personal responsibility for their health habits. Properly utilizing health care, following physician's recommendations, and

## GOAL # 3: MEMBER PERSONAL RESPONSIBILITY



maintaining healthy lifestyles are critical to an individual's health.

SoonerCare continually seeks to ensure members are taking personal responsibility for their health by providing access to preventive and early intervention services and guiding members as they navigate the health care delivery maze. The Medical Home concept helps providers track their SoonerCare patients' health development and provide better continuity of care (See page 44). OHCA also give providers the opportunity to educate members on how to lead more healthy lifestyles, such as being more active and eating healthier.

In addition to emphasizing healthy behavior, OHCA is also focusing on the operational aspect of personal responsibility in terms of utilization of services. For example, OHCA monitors persistent ER utilization by SoonerCare members. Many of these highly expensive ER visits are unnecessary and the member's primary care physician could have effectively delivered the care being sought. To address this issue, OHCA has developed outreach programs to educate members on their responsibilities as health care consumers. In the case of persistent ER utilization, simple outreach in the form of letters and phone calls has helped drastically reduce the number of members persistently utilizing the ER. Members receive higher quality care at a lower cost to the state when they visit their primary care physician instead of the ER.

### **OHCA'S PERFORMANCE**

Following are key measures selected to represent OHCA's efforts to assist members in taking personal responsibility for their health and measures that help in assessing members' utilization of OHCA services.

## GOAL # 3: MEMBER PERSONAL RESPONSIBILITY

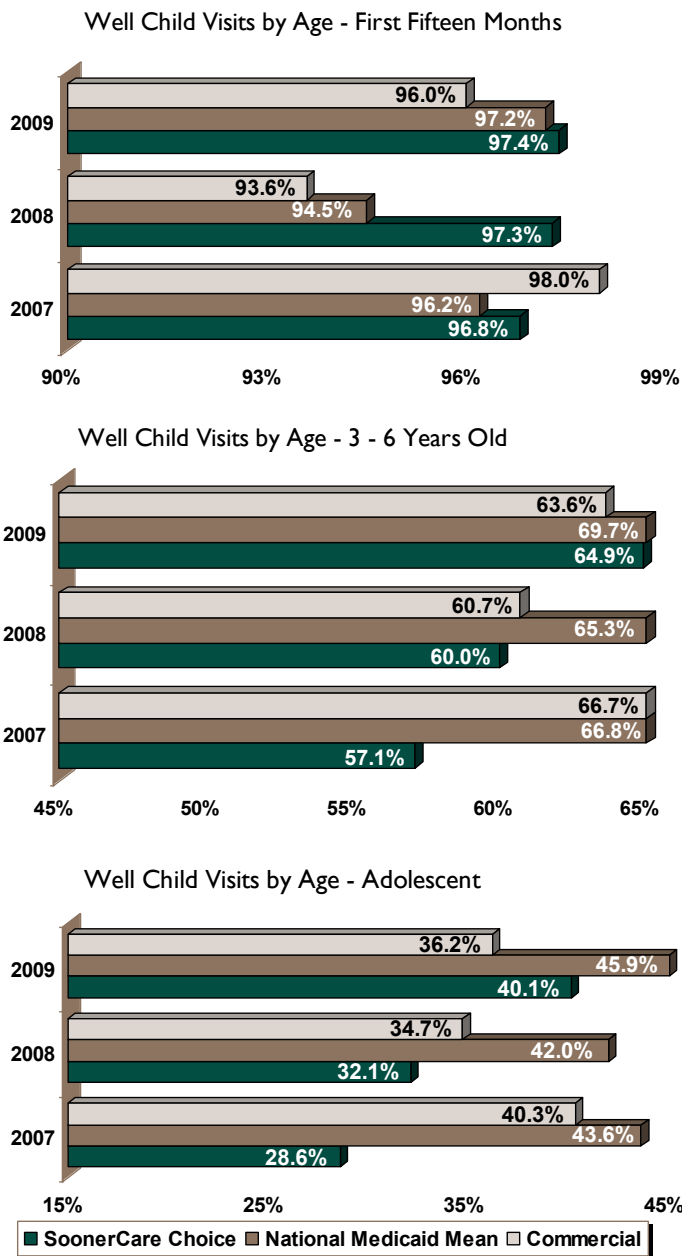
### OBJECTIVE

TO STRIVE FOR SOONERCARE CHILDREN TO RECEIVE NECESSARY PREVENTIVE CARE THROUGH CHILD (EPSDT) SERVICES.

Outcome: % of Children Accessing Well-Child Visits—Child Health / EPSDT  
First 15 Months - 3–6 Years - Adolescents

### Well-Child Visits by Age—Calendar Years 2007—2009

Figure 31



Source: OHCA's MMIS Claims Processing System using HEDIS criteria.

### What's being measured?

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 measure shows the percent of SoonerCare children who visited their primary care provider for a well child visit during the calendar years 2007, 2008, and 2009. The data is calculated using HEDIS criteria. HEDIS measures are reported on a calendar year basis.

**NOTE:** The National and Commercial percentages are based on HEDIS data reported on June 2009 for measurement year 2008 (1/1/2008-12/31/2008). The OHCA percentages are based on data collected for measurement year 2009 (1/1/2009-12/31/2009).

### Why is this important?

Babies, kids, and teenagers need to get regular check-ups to stay healthy. Seeing a health care provider on a regular schedule, even when feeling well, may help prevent serious health problems in the future. Children and teens

## GOAL # 3: MEMBER PERSONAL RESPONSIBILITY

enrolled in SoonerCare should take part in these preventive health care services.

Regular check-ups are one of the best ways to detect physical, developmental, behavioral, and emotional problems. They also provide an opportunity for the clinician to offer guidance and counseling to the parents.

### What do the results mean?

Babies in Oklahoma continue to visit their primary care provider for well-child visits at a rate above the national average. As children get older, their rate of visits fall in percentage and in relation to the national Medicaid average. However, Oklahoma has seen a sharp increase in the rate of well-child visits by children and adolescents (4.9% and 8.0%). This increase is due in part to provider training and quality initiatives such as OHCA's contract with OU Family Medicine to use practice facilitation to assist providers in identifying and implementing practices that can improve well-child visit attendance. The implementation of the Medical Home program also contributed to the increase.



### What's OHCA doing?

OHCA is doing several things to encourage members to visit their primary care physicians, including:

- Sending reminder letters to members when well-child visits are due or past due,
- Incentive payments to PCPs who meet or exceed a screening ratio of 65%,
- Reviewing the OHCA periodicity schedule and all components of the well-child visit at provider trainings and promoting their importance,
- Child Health Unit staff providing information about well-child visits to OSDH immunization representatives with the hope that these representatives will promote the importance of well-child visits when meeting/talking with providers,
- OHCA collaborating with OU Department of Family Medicine and others on the Practice Enhancement Assistant (PEAs) Project. PEAs assist practices in integrating best practices for quality improvement, including working with them to improve the quantity and quality of well-child visits, and
- Through a CHIPRA Outreach Grant from CMS, OHCA is working with state and community partners across the state to provide information on well-child visits.

In SFY2010, OHCA surpassed the national goal for the EPSDT (well-child visit) screening ratio. The goal was 80 percent and the recent CMS 416 report reflected a screening ratio of 83 percent for SoonerCare children.



## GOAL # 3: MEMBER PERSONAL RESPONSIBILITY

### 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.

Outcome:

Oklahoma's percent compliance with Healthy People by 2010 Campaign Immunization Rate — Target / 90%

### What's being measured?

This measure reports the percentage of Oklahoma's children receiving recommended immunizations in the age group of 19 - 35 months based on 4:3:1:3:3:1 vaccines.

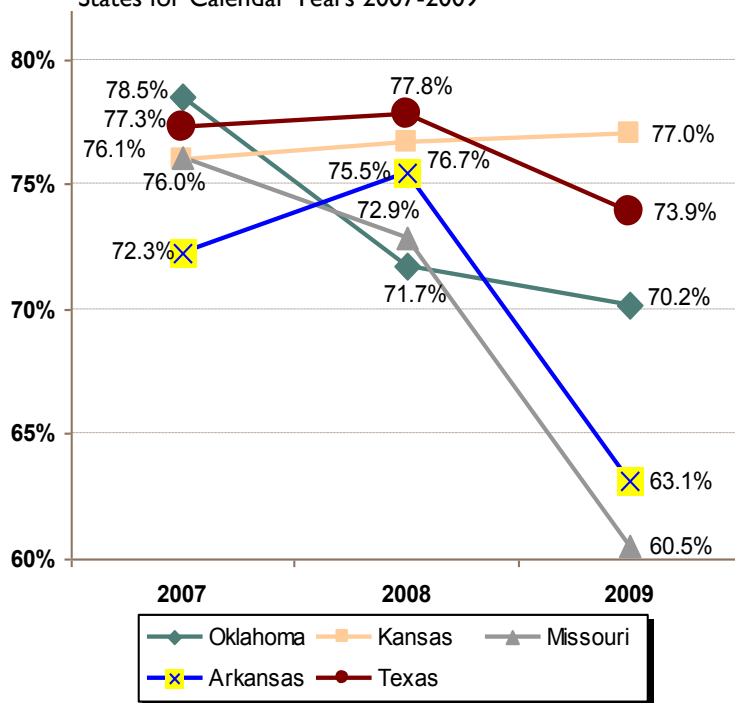
Medication / Doses in the 4:3:1:3:3:1 Categories are:

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

For the 2010 SEA Report, OHCA began reporting the 4:3:1:3:3:1 after reporting the 4:3:1:3:3 for several years. The change in the measure was due to CDC changing the type of

measurement that will now be used to measure compliance with the Healthy People by 2010 Campaign. The new measure being used is the 4:3:1:3:3:1.

Immunization Rates for Oklahoma and Surrounding States for Calendar Years 2007-2009 *Figure 32*



### Why is this important?

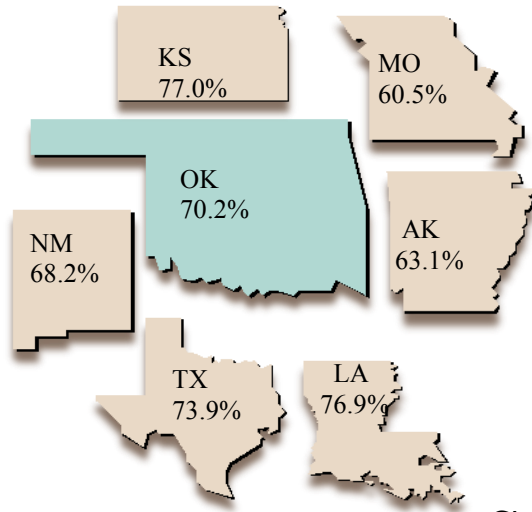
Vaccines save lives and protect people against permanent disabilities or death. Before the development of vaccines, thousands of infants and children died or were disabled from infectious diseases such as measles, polio, pertussis (whooping cough), and rubella. Because of vaccines, Oklahoma doctors rarely see diseases that once devastated families and disrupted lives. Unfortunately, vaccine-preventable diseases continue to pose a threat to

Source: Centers for Disease Control, National Immunization Program at [www.cdc.gov/vaccines/stats-surv/limz-coverage.htm#chart](http://www.cdc.gov/vaccines/stats-surv/limz-coverage.htm#chart)

### GOAL # 3: MEMBER PERSONAL RESPONSIBILITY

Immunization Rates for Oklahoma and Surrounding states Calendar Year 2009

Figure 33



Source: Centers for Disease Control and Prevention, National Immunization Program

children in Oklahoma. Vaccination remains a critical health strategy as cures are unavailable for most vaccine-preventable diseases. Young children especially need vaccines early and often to ensure their immune systems are able to respond when needed. Maintaining high childhood immunization levels is vital to assuring the public's health.

#### What do the results mean?

Immunization rates in Oklahoma and surrounding states have remained stable, fluctuating only a few percentage points since last year. Immunization rates are often dependent upon the available supply of vaccines and the public perception of the need for vaccinations.

Children that do not receive recommended immunizations are susceptible to life-threatening illness. It is important that OHCA and SoonerCare continue to strive to increase the percentage of children receiving these vaccinations.

#### What's OHCA doing?

Children enrolled in SoonerCare receive free medical, vision, hearing and dental check-ups, and services. Immunizations are a part of SoonerCare covered well-child visits. The goal of the program is to improve the health status of children by making sure they receive preventive services and follow-through care. Seeing a health care provider regularly, even when feeling well, may help prevent serious health problems in the future.



## GOAL # 3: MEMBER PERSONAL RESPONSIBILITY

**OBJECTIVE** TO DECREASE EMERGENCY ROOM UTILIZATION BY INCREASED USE OF AMBULATORY CARE SERVICES.

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

### What's being measured?

This measure reports HEDIS results for adults who have accessed ambulatory care. These adults have sought preventive or early intervention and decreased the likelihood for the need of emergency care. The information is calculated on a calendar year basis and 2009 is the most recent information available. For comparison, the National Medicaid Mean and Commercial Insurance Mean are calculated based on HEDIS criteria and are also reported for the same periods.

### Why is this important?

Access to primary care correlates with reduced hospital and emergency room use while also preserving quality. Studies show that costly and inappropriate care can be reduced through shared decision-making between well-informed physicians and patients. Physicians play a central role in nurturing these quality-enhancing strategies that can help to slow the growth of health care expenditures. Continued rising health care costs in the U.S. affect all levels of the health care delivery system. Encouraging and making access to primary and preventive care services available is one strategy to lower hospital utilization while maintaining the quality of care delivered.

### What do the results mean?

SoonerCare members in the 20 to 44 year old age group and the 45 to 60 year old age group have continued to use preventive/ambulatory care at slightly increasing rates over the previous year.



### GOAL # 3: MEMBER PERSONAL RESPONSIBILITY

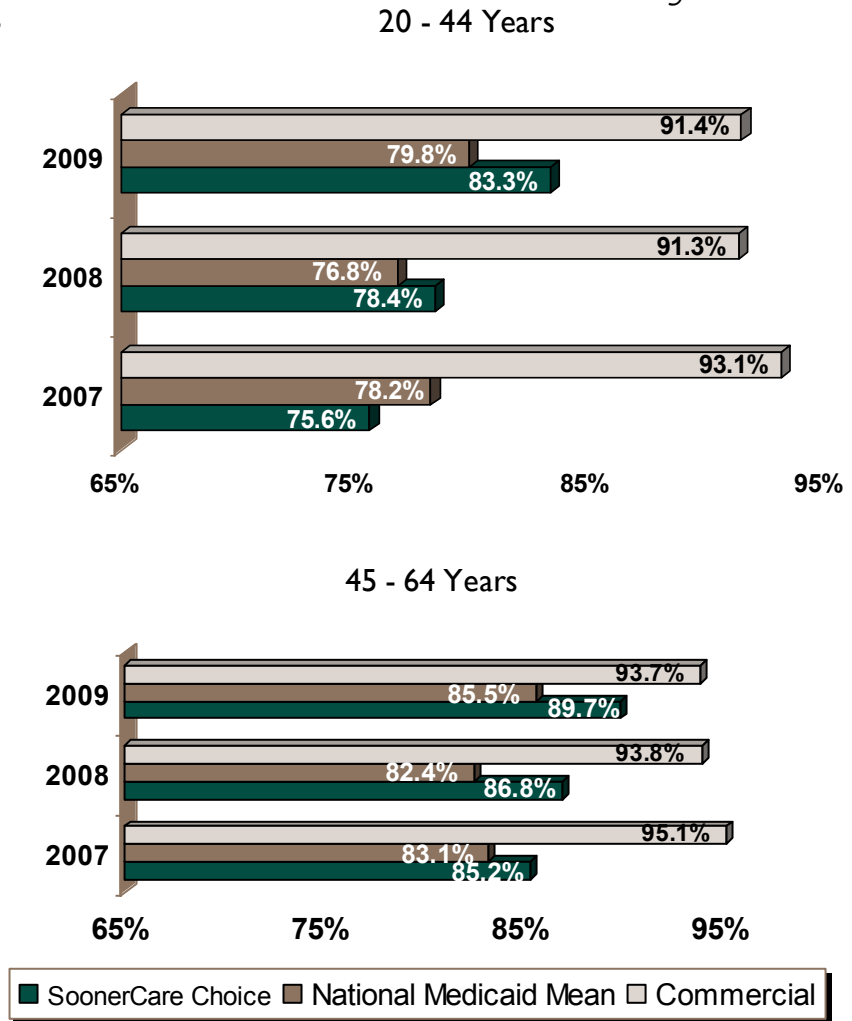
They continue to slightly outpace the national Medicaid average. While last year's increase of 4.9% brought the rate up to 83.3%, the rate of access is still 8.1% below the commercial insurance carrier averages.

#### What's OHCA doing?

In February 2008, OHCA launched the SoonerCare Health Management Program (HMP). The program is designed to benefit SoonerCare Choice high-risk members and their primary care providers (PCP). Predictive modeling software is used to select members who, based on their medical history, are at the highest risk for adverse outcomes. Initially, the program estimated its targeted group to include 5,000 Choice members. As of June 30, 2010, 4,812 members were engaged in the HMP. Over the life of the HMP, 10,388 members have been enrolled. Through practice facilitation, one component of the HMP, OHCA has provided services to 75 practices which touch over 90,000 SoonerCare member lives.

Adults use of Preventive / Ambulatory Care by Age for Calendar Years 2007—2009

Figure 34



Source: OHCA's MMIS Claims Processing System using HEDIS criteria.



## GOAL # 3: MEMBER PERSONAL RESPONSIBILITY

### HMP SERVICES AVAILABLE:

*Nurse Care Management* - In person or by phone, a nurse provides education, support, care coordination and self-management tools aimed at improving the member's health.

*Behavioral Health Screening* - It is very common for members with chronic health conditions to feel stressed or concerned about their health. Sometimes poor emotional health can make the medical condition worse. All HMP members will be asked to complete a behavioral health screening to identify areas they may need help with managing.

*Pharmacy Review* - Each HMP member fills out a medication list with the help of their nurse care manager. The nurse can ask for this list to be reviewed by a pharmacist if any problems are identified. This will lessen the chance of a medication error.

*Community Resources* - All nurse care managers are in contact with a resource specialist to help members locate appropriate resources.

*Primary Care Provider Involvement* - Nurse care managers send monthly updates to their members' PCPs. These updates include self-management goals, progress made, and the health status of the member.

*Practice Facilitation* - A professional, highly-trained practice facilitator works with participating practices to redesign office systems. This redesign focuses on applying quality improvement techniques in order to improve care delivered to members with chronic conditions.





### GOAL # 3: MEMBER PERSONAL RESPONSIBILITY

**OBJECTIVE** TO DECREASE EMERGENCY ROOM UTILIZATION BY INCREASED USE OF AMBULATORY CARE SERVICES.

**Output:** Emergency Room Visits Per 1,000 Member Months

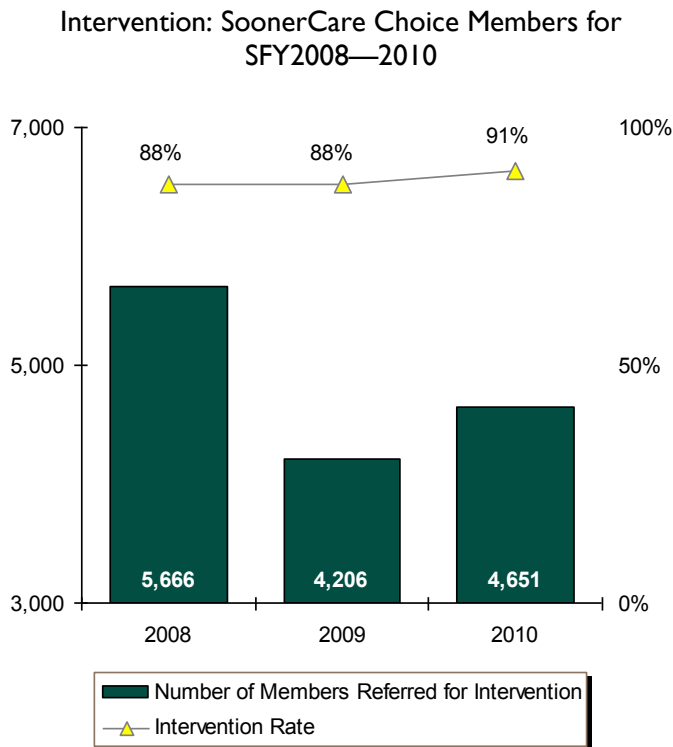
During SFY2004, OHCA undertook a quality initiative to evaluate the emergency room (ER) utilization of SoonerCare Choice members. OHCA was concerned that many of the high ER utilizers might be substituting ER services for acute care services with their PCP. Two projects emerged, one for providers and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



**Providers.** The provider component 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 developing 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 notified of high ER utilizing patients have moved to the lowest category.

**Members.** The member element 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 OHCA's Member Services unit for intervention.



Initial contact letters are sent to all identified members. This project continues to evolve as more information is analyzed. Beginning in 2007, emphasis was placed on addressing members with 30 or more visits to the emergency room in three consecutive quarters. Deemed "super users," this group receives a 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.

Source: SoonerCare Operations

Figure 35



### GOAL # 3: MEMBER PERSONAL RESPONSIBILITY

Figure 36 ER Project: Method of Intervention Contact & Referrals to Care Management for SFY2008—2010

SFY	Number Identified	Face-to-Face Interviews	Phone Interviews	No Contact Due to Loss of Eligibility	Unable to Reach
2008	46	16	12	8	9
2009	32	20	0	7	5
2010	35	16	0	10	0

Source: OHCA Medical Operations Division

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.

#### What's being measured?

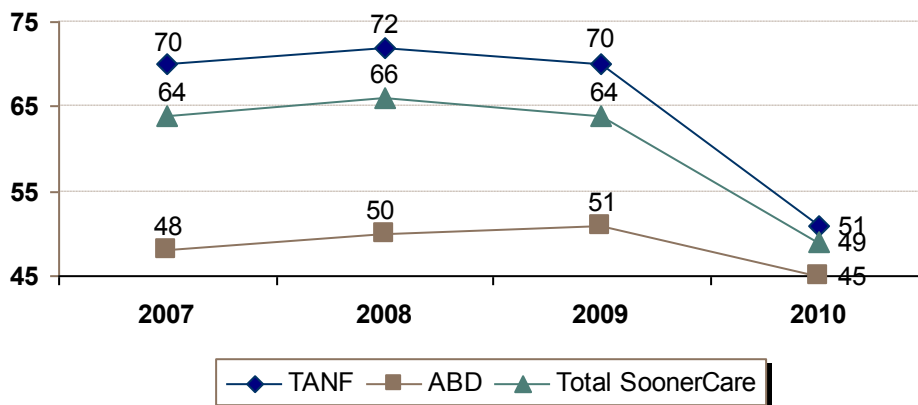
This measure reports SoonerCare members’ use of ER services per 1,000 member months of eligibility. The data is disaggregated by members qualifying through Temporary Assistance to Needy Families (TANF) and Aged, Blind and/or Disabled (ABD) criteria.

#### Why is this important?

By law, emergency rooms (ER) are required to provide care to all patients regardless of their ability to pay. As a result, an increasing number of patients seek care in the ER as a substitute for their primary care providers. Inappropriate utilization of the emergency room may result in overcrowding, increased costs, and, potentially, decreased quality of care.

Figure 37

Emergency Room Visits per 1,000 Member Months by Selected Populations for SFY2007—2010



Source: OHCA MMIS

### GOAL # 3: MEMBER PERSONAL RESPONSIBILITY

Figure 38 Intervention: SoonerCare Choice Members for SFY2008—2010

Also, 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.

Number of Contacts by:	2008	2009	2010
Letter	6,012	4,454	4,993
Telephone	1,269	1,187	1,386
Total	7,281	5,641	6,379
Referred to Care Management	5	1	2

Source: SoonerCare Operations

SOURCE: The Kaiser Family Foundation, Characteristics of Frequent Emergency Department Users, October 2007

#### What do the results mean?

OHCA is aware of the high costs associated with increased and inappropriate use of the ER. As the number of high utilizers continues to decline, it is evident that OHCA’s ER Utilization Program is achieving its goal of reducing ER costs.

#### What’s OHCA doing?

Since October 2005, the ER Utilization Program has been contacting members with 4 or more ER visits per quarter for educational outreach.

The ER Utilization Program continues to provide outreach to SC members with 4 or more ER visits in a quarter; excluding those ER visits that result in an inpatient stay. Education is offered to all identified members through a letter and outreach call. Members identified as having 30



## GOAL # 3: MEMBER PERSONAL RESPONSIBILITY



or more ER Visits in three previous, consecutive quarters are considered to be high utilizers. Education is offered through letter, phone, and face to face contact to encourage the timely and appropriate use of primary care services in lieu of emergency room utilization.

*General Interventions:* Since November 2006, every SoonerCare member with 4 or more ER visits in a quarter is mailed an education letter.

In addition, interventions are accomplished through telephone contact each quarter. Two telephone attempts are made to contact each SoonerCare member. If telephone contact is successful, the member is encouraged to use the services of the primary care provider (PCP) for routine care instead of the ER. SoonerCare members who are not successfully contacted by telephone receive a letter giving them the name of a Member Services representative that they may call directly.

A drastic decline was seen in repeat ER visits by members who had been contacted after each identification period. The reduction of ER visits from the identification period compared to the next quarter ranged from 77 percent to 82 percent. Primary Care Provider (PCP) notification letters for each SoonerCare Choice member identified are mailed to each PCP's office quarterly. Information on each member's ER utilization for the quarter is included.

From July to September 2009, a group of 1,278 SoonerCare members had 6,524 ER visits. After contacting these members through the ER Utilization Program, this same group of members only had 2,337 ER visits.

The ER Utilization Program is responsible for saving OHCA a significant amount of money through cost avoidance. From the inception of the program through SFY 2009 (the latest data available), the program has cumulatively avoided costs of \$14.9 million and demonstrated a cumulative ER visit reduction of 63,980.

SOURCE: ER Utilization Fast Facts April – June 2009

### GOAL # 3: MEMBER PERSONAL RESPONSIBILITY

**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



**What's being measured?**

This indicator tracks the number of members locked into a specific pharmacy due to misuse of services.

**Why is this important?**

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 monitors 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.

**What do the results mean?**

SoonerCare members in the lock-in program have increased steadily the last three years. Members are locked-in originally for two years, and then extended one year if warranted by a review.

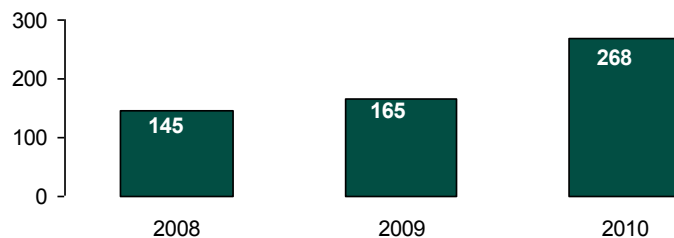
**What’s OHCA doing?**

In order to be assigned to the lock-in review program, an individual must be currently enrolled in SoonerCare or the Insure Oklahoma Individual Plan.

*Figure 39*

If the member’s utilization is determined to be potentially inappropriate, the lock-in process is started, and the member is required to fill all prescriptions at a single pharmacy. The member is able to choose a designated pharmacy. This pharmacy is contacted for consent prior to the member being locked-in.

SoonerCare Members Assigned to the Lock-In Program for SFY2008 -2010



■ Members Assigned to Lock-In

Source: OHCA Program Integrity; Oklahoma University College of Pharmacy

### GOAL # 3: MEMBER PERSONAL RESPONSIBILITY

<b>OBJECTIVE</b>	TO INCREASE THE NUMBER OF PREGNANT WOMAN 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

#### What's being measured?

These measures 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.

The method of calculation for this measure was changed for SFY2010, and prior years were restated using the same method. The total number of births did not change, but the breakdown by trimester was changed from months to weeks.

Previously: 1st Trimester (first 3 months), 2nd Trimester (4-6 months), and 3rd Trimester (7-9 months)

Now: 1st Trimester (first 13 weeks), 2nd Trimester (14-26 weeks), and 3rd Trimester (27-40 weeks)

#### Why is this important?

Prenatal care is beneficial for all mothers-to-be. Women who see a health care provider regularly during pregnancy have healthier babies, are less likely to deliver prematurely, and are less likely to have other serious problems related to pregnancy.

SoonerCare Members Who Sought Prenatal Care - By Trimester - SFY2008—2010

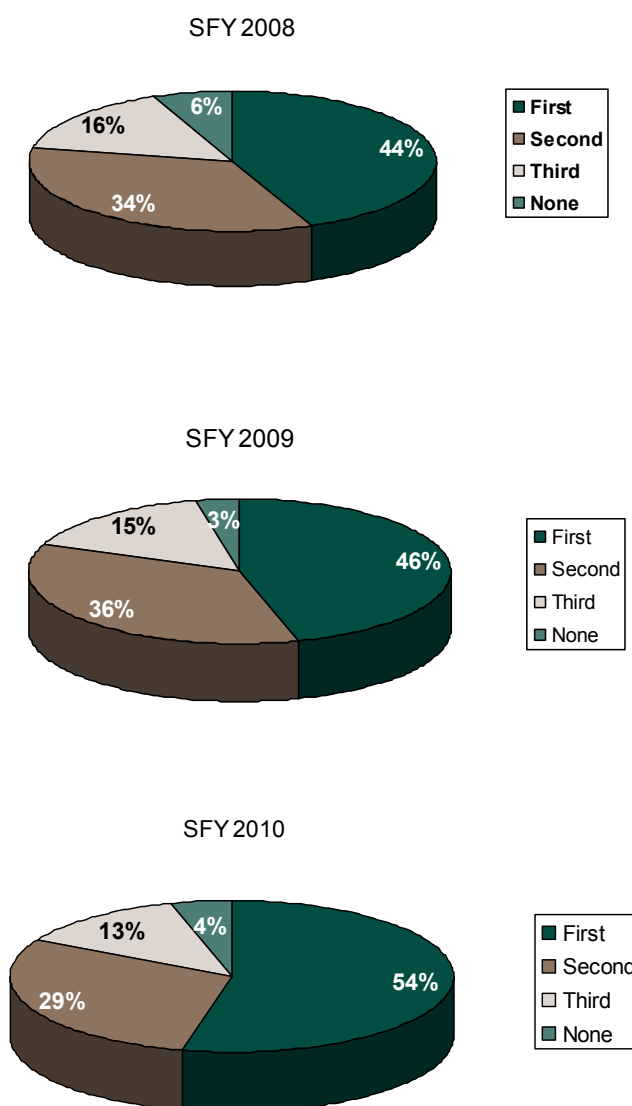


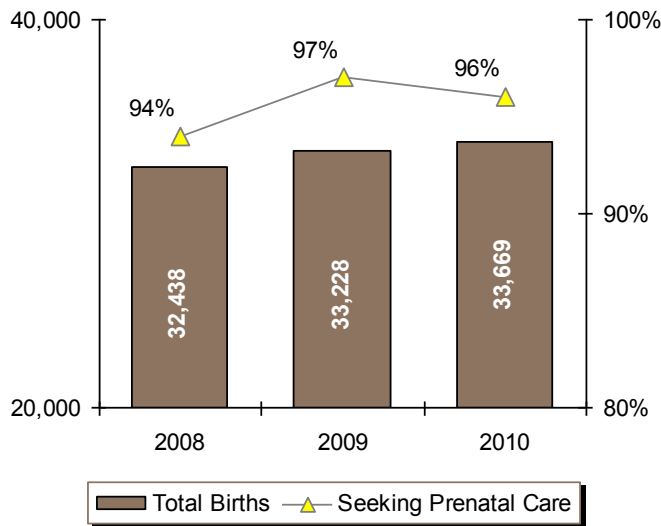
Figure 40

Source: OHCA MMIS



### GOAL # 3: MEMBER PERSONAL RESPONSIBILITY

Total Births to SoonerCare Members and Percent seeking Prenatal Care for SFY2008-2010



Source: OHCA MMIS

Figure 41

According to the March of Dimes, “The goal of prenatal care is to monitor the progress of a pregnancy and to identify potential problems before they become serious for either mom or baby.” For more information, <http://www.marchofdimes.com/Pregnancy/prenatalcare.html>.

#### What do the results mean?

The number of SoonerCare mothers-to-be seeking prenatal care at some point in their pregnancies in 2010 was 96%. The number of women seeking prenatal care in the first trimester of their pregnancies is still drastically below the Healthy People 2010 campaign benchmark of 90%. However, the number of women seeking care in the first trimester increased 8% (45.5% to 53.5%) from SFY2009 to SFY2010.

#### What’s OHCA doing?

OHCA continuously seeks to increase the benefits and services available to mothers and babies. Since its first meeting in May 2005, the OHCA-OSDH Perinatal Advisory Task Force has made several recommendations regarding expansion of benefits and services to pregnant women. OHCA has been able to implement many of these recommendations. Learn more at [www.okhca.org/about-us/Perinatal Task Force](http://www.okhca.org/about-us/Perinatal-Task-Force).



These changes include:

- Smoking/Tobacco Use Cessation Counseling,
- Ultrasounds,
- Perinatal Dental,
- Prenatal Risk Assessment,
- Obstetrical High Risk Care,
- Maternal & Infant Health Social Work Services,
- Lactation Consultation Services,
- Genetic Counseling Services, and
- Soon-To-Be-Sooners.





## Goal # 4: Member Benefits

TO ENSURE THAT PROGRAMS AND SERVICES RESPOND TO THE NEEDS OF MEMBERS BY PROVIDING NECESSARY MEDICAL BENEFITS TO MEMBERS.

As a condition of receiving federal funds, OHCA must provide a basic level of benefits to its members. In addition to the basic benefits, state Medicaid agencies have the option of including other services. Federal law provides flexibility in allowing state Medicaid agencies to tailor benefit packages to fit the needs of members. Because of this, OHCA can provide the services most needed by members when developing the SoonerCare benefits package.

Every state has a unique health profile influenced by many factors. For example, health related statistics such as rates of smoking, teen pregnancies, and the prevalence of diabetes contribute to a state's overall health profile. Population demographics such as income levels, average age, levels of education, and primarily urban versus primarily rural populations also play a role. Local cultures and attitudes toward health and healthy lifestyles are also important elements. A state's health profile can help determine which benefits are most needed by members. With this in mind, OHCA strives to offer a package of SoonerCare benefits that provides the most comprehensive and cost-effective care possible, while meeting or exceeding the National Medicaid Standards.

Measures relating to costs, to quality of care, and to administrative requirements are taken into account when determining the scope and value of the SoonerCare benefits package. The most essential measure, however, is the level at which benefits that are most needed by our members are actually utilized or accessed. The following measures explore several categories of care available to SoonerCare members and how they are utilized.

## GOAL # 4: MEMBER BENEFITS

### 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

### What's being measured?

This measure reports the percentage of SoonerCare children, by age groups, who accessed primary care services. SoonerCare percentages are presented along with the national Medicaid percentages and the commercial insurance percentages for comparison. Percentages are based on the Health Effectiveness Data and Information Set (HEDIS) criteria that are calculated on the calendar year.

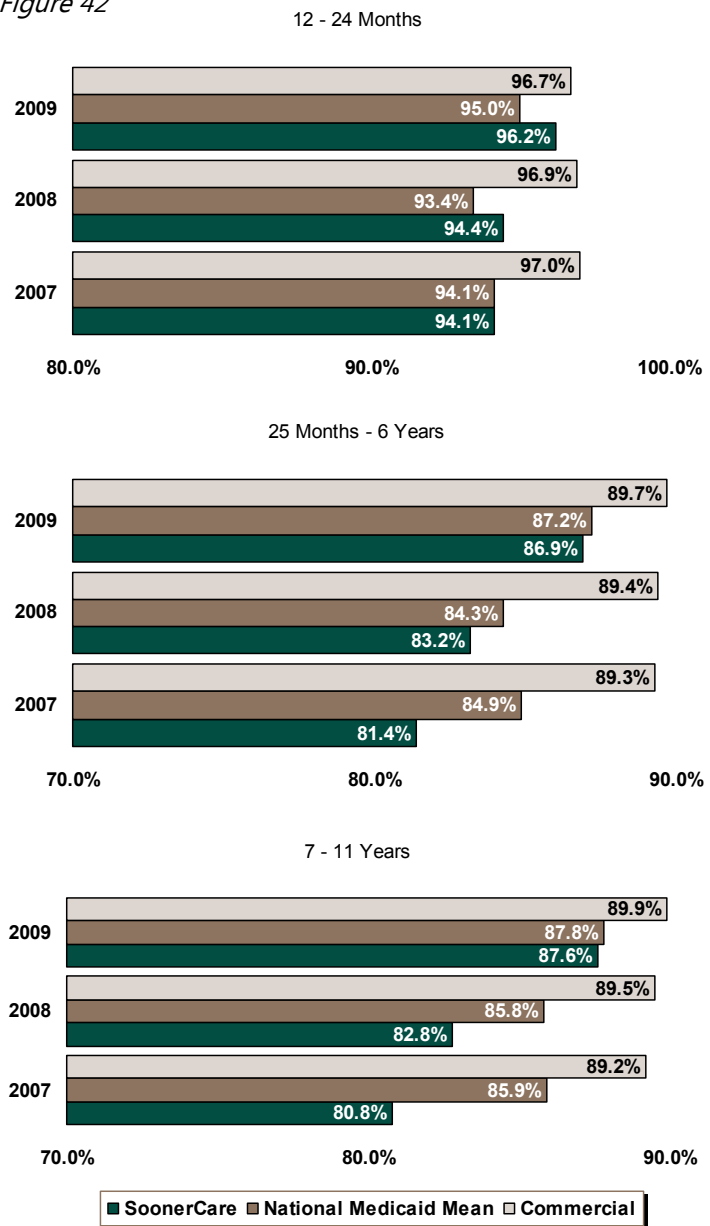
**NOTE:** The National and Commercial percentages are based on HEDIS data reported on June 2009 for measurement year 2008 (1/1/2008-12/31/2008). The OHCA percentages are based on data collected for measurement year 2009 (1/1/2009-12/31/2009).

### Why is this important?

According to familiesusa.org, "The federal government and the states use Medicaid managed care utilization data to monitor whether plans provide appropriate care, to compare service use under managed care Medicaid, and to help set future capitation rates." Children make up

SoonerCare Children's Health Care Use for Calendar Year 2007 - 2009

Figure 42



Source: OHCA QA / QI Division

## GOAL # 4: MEMBER BENEFITS

the largest group of SoonerCare members (69 percent). However, being covered by insurance is not enough. It is important that children actually access primary care services once they are covered. The early diagnosis and treatment of medical needs is vital to healthy living. This is especially true for children because health issues can impact their growth and future health status. Comparing utilization rates between years and to the national Medicaid means and commercial insurance means is one way to gauge the effectiveness of SoonerCare in ensuring that members, especially children, are accessing appropriate levels of health care.

### What do the results mean?

The percentage of SoonerCare children who accessed primary care services in the past year, continues to increase slightly every year. In fact, the utilization rates for SoonerCare children in the 7 to 11 year old age range has risen by 6.8 percent since SFY2007. There have been similar increases in the 25 months to 6 years category (5.5 percent) and the 12 to 24 months category (2.1 percent) over the last two years, as well. The percentages of children in every age category are very close to the Medicaid mean percentages or higher. Historically, children covered through Medicaid access primary care at rates lower than children covered by private commercial insurance. This tendency continues to hold true but SoonerCare is gaining ground.

### What's OHCA doing?

Increasing primary care utilization among SoonerCare children is a priority of the Child Health Unit staff at OHCA. Efforts are directed towards members, providers and other stakeholders including:

- Mailing letters to members as reminders that Child Health Check-Ups are due or past due,
- Child Health Check-Up bonus payments for SoonerCare Choice providers,
- Supplemental payments to Choice providers for 4<sup>th</sup> DTaP,
- Partnership with Smart Start Oklahoma (SSO) to produce a toolkit for SSO Community Coordinators to assist with SoonerCare outreach and enrollment efforts. Toolkits include information related to utilization of member benefits and services. OHCA provided some basic materials related to SoonerCare and IO, as well as input and guidance, and
- Utilization is promoted as an important second step (after enrollment) at a variety of state and community stakeholder events and meetings.



## GOAL # 4: MEMBER BENEFITS

### ADULT HEALTH CARE USE (RECAP)



Another measure of the effectiveness of benefits provided by SoonerCare is the rate of adult members' use of preventive/ambulatory care.

Members are provided outpatient access to preventive care and intervention. It is important that medical conditions are treated in their early stages. Between calendar years 2007 and 2009 utilization rates for members in the 20 to 44 year old age group have increased by nearly 8 percent

to 83.3 percent. Similarly, member utilization for those in the 45 to 64 year old age group has risen by 4.5 percent to 89.7 percent. These measures also address issues related to adults taking responsibility for their health care. Therefore, they are reported in detail in Agency Goal 3. See page 45 for more information related to these measures.

#### OBJECTIVE:

TO PROVIDE NECESSARY BENEFITS AS INDICATED BY THE NUMBER OF MEMBER BENEFITS COMPLAINTS THAT ENTER THE APPEALS PROCESS COMPARED TO TOTAL MEMBERS.

### MEMBER APPEALS (RECAP)

SoonerCare members have the right to appeal decisions made concerning their care. The number of member appeals is an indirect measure of how well SoonerCare benefits are meeting members' needs. The number of appeals that were filed increased from 56 in SFY2009 to 158 in SFY2010. This was largely due to an increase in the number of appeals related to Insure Oklahoma and was the result of a significant increase in the number of members in the program. Because these measures also address member satisfaction, they are reported under Agency Goal 2. See page 34 for more information.



## GOAL # 4: MEMBER BENEFITS

### OBJECTIVE

TO ENSURE THAT LONG-TERM CARE MEMBERS ARE CORRECTLY PLACED IN THE APPROPRIATE LEVEL-OF-CARE FACILITIES.

### What's being measured?

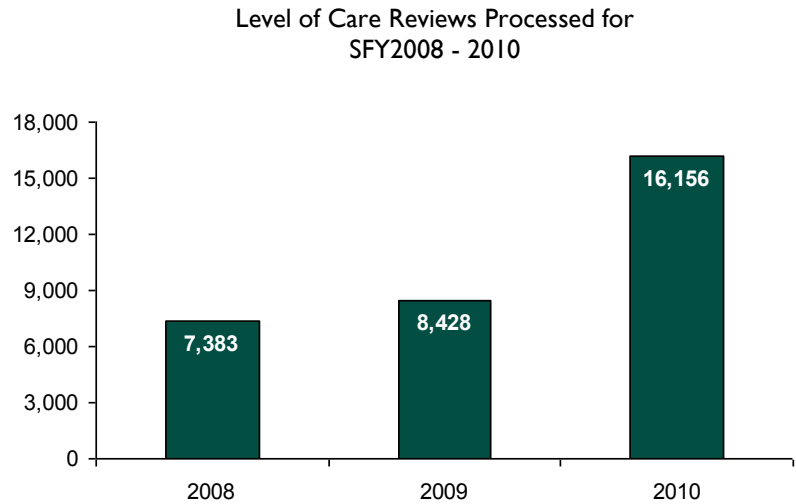
This measure reports the number of Pre-Admission Screening and Resident Reviews (PASRR) that were processed during the periods SFY2008 - 2010.

### Why is this important it?

The federal government requires that PASRRs are administered to each individual entering long-term care facilities, including transfers between facilities. The purpose of the screenings is to ensure that long-term care patients with a possible developmental disability (DD), mental retardation (MR), and/or mental illness (MI) are placed in facilities capable of providing the appropriate level of care for their needs. 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.

### What do the results mean?

Between SFY2009 and SFY2010, the number of level one PASSR screens for Medicaid increased by 91.7 percent while the number of private pay level one PASSR screens decreased by 52.6 percent. This flip-flopping can be attributed, in part, to general economic conditions resulting in more people being qualified for SoonerCare. Overall, the number of PASSR reviews processed continues to increase slightly every year.



Source: OHCA Quarterly SEA Data

### What's OHCA doing?

PASRR is a federally required process. In the past, PASRR was a paper process that took several weeks to complete. In addition, there was no penalty to a facility for not submitting the paperwork. In many cases it was never completed. In 2006, OHCA implemented policies requiring a completed PASRR to be submitted to OHCA in order for the provider to be paid

## GOAL # 4: MEMBER BENEFITS

for the review. Only services rendered within 10 days preceding receipt of the PASRR review qualify for payment. OHCA has now implemented an electronic reporting option for providers. PASRR reviews can be submitted online and real-time confirmations can be printed. The electronic option is accessed through the OHCA website. For those who chose to submit the paper form, a confirmation letter is mailed out the month following submission. As well as providing instant confirmation and reducing data entry, the electronic reporting system has reduced the number of confirmation letters mailed by half.



## GOAL # 4: MEMBER BENEFITS

### OBJECTIVE

TO ASSIST MEMBERS' ABILITY TO ATTEND HEALTH CARE APPOINTMENTS BY PROVIDING TRANSPORTATION THROUGH SOONERRIDE.

Outcome: Number of SoonerRide Trips Made

Efficiency: Cost per One-Way Trip

### What's being measured?

The measures report the number of SoonerRide non-emergency transportation (NET) trips made (one-way) and the average cost per trip for SFY2007 - 2010. A trip, in this context, indicates transportation from home to an appointment or home from an appointment. A round trip is counted as two trips.

### Why is this important?

For low-income individuals and the elderly, a lack of reliable transportation is often an obstacle to accessing medical services. Receiving the needed care is an essential element of an overall health care plan. The best health care coverage is useless if members cannot get to where the services are being provided.

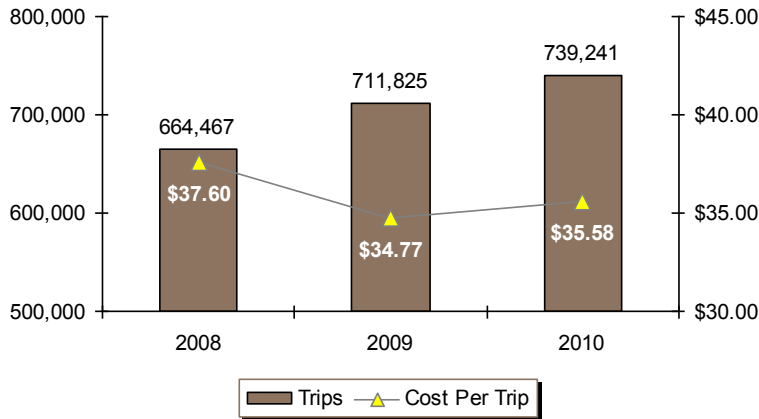
### What do the results mean?

The number of non-emergency trips made by SoonerCare members using SoonerRide has risen steadily since SFY2005. However, the number of SoonerCare members using the service and the average cost per trip has remained fairly stable from year-to-year. Members can schedule drop-off and pick-up services to and from qualifying medical appointments. Members are made aware of the SoonerRide program through the member handbook, letters, and when they call member services. A brochure is also available on the OHCA website.



## GOAL # 4: MEMBER BENEFITS

Figure 44 SoonerRide Trips and Cost Per Trip for SFY2008 - 2010



Source: OHCA Quarterly SEA Data

### What's OHCA doing?

OHCA contracts with LogistiCare, Inc. to provide non-emergency transportation for SoonerCare members. The service ensures that members have the ability to get to scheduled health care appointments and back home in a safe, timely manner.

### FMAP RATE & MEDICAL INFLATION

Oklahoma partners with the federal government to finance health care coverage for our members. The Federal Medical Assistance Percentage (FMAP) is the percentage of program costs paid for with federal funds. ARRA increased state Medicaid FMAPs from October 1, 2008 - December 31, 2010. These increases have been extended for the second and third quarters of federal fiscal year (FY) 2011 (January 1, 2011 - June 30, 2011). For every dollar Oklahoma spends, the federal government matches it with approximately three dollars. The Region 6 FMAP shows the average FMAP of the other four states in the region, as defined by CMS. Those states are Arkansas, Louisiana, New Mexico, and Texas. The Medical Inflation Rates for calendar years 2008 and 2009 (the most recent available rate) are presented, as well.

Figure 45

Federal Financial Participation: FMAP Rate for Federal Fiscal Years 2008 - 2011 and Medical Inflation Rate for Calendar Years 2008 & 2009

Year*	Oklahoma	Region 6	Medical Inflation
2008	67.10%	69.25%	3.7%
2009	75.16%	76.80%	3.2%
2010	76.51%	78.48%	NA
2011	71.90%	73.58%	NA

**NOTE:** This data is presented for informational purposes and does not represent a performance measure or benchmark.

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

Source: FMAP—Federal Funds Information for States/ Federal Register; Medical Inflation—Bureau of Labor Statistics

## GOAL # 4: MEMBER BENEFITS

### OBJECTIVE

TO STRIVE FOR OKLAHOMA SOONERCARE CHILDREN TO MEET OR EXCEED THE NATIONAL MEDICAID AVERAGE FOR CHILD HEALTH/EPSTD WELL-CHILD VISITS.

### WELL-CHILD VISITS (RECAP)

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services are available through SoonerCare. Well-child visits, also known as child health check ups, are essential to the health of Oklahoma's children.



Preventive care improves the chances that healthy children will remain healthy and that any health concerns that may arise can be dealt with in a timely manner increasing the likelihood that they will grow into healthy adults.

The percentages of SoonerCare children attending well-child visits have increased in all age groups. Most notably, between 2008 and 2009 the percentage of SoonerCare children attending well-child visits increased by 4.9% to 64.9% for children ages 3-6 years old and by 8% to 40.1% for adolescents. These significant increases can be attributed, in part, to ongoing provider training and quality initiatives such as the use of practice facilitation to assist providers in identifying and implementing practice improvement around child health checkups. Additionally, it is believed that the implementation of the medical home model of care in 2009 contributed to the increases.

Because these measures also address members' personal responsibilities, they are reported under Agency Goal 3. See page 47 for performance measures and more information.

## GOAL # 4: MEMBER BENEFITS

### 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%.

### IMMUNIZATIONS (RECAP)

This measure reports the immunization rate for Oklahoma children ages 19 to 35 months and includes those enrolled in Oklahoma's SoonerCare health care program. The rate for Oklahoma for calendar year 2009 is 70.2%. Beginning in 2010, OHCA began reporting the 4:3:1:3:3:1 series after reporting the 4:3:1:3:3 series for several years. The newly reported vaccination series includes 1 dose of the varicella vaccine. The change in the measure was due to CDC changing the series that is used to measure compliance with the Healthy People 2010 Campaign from the 4:3:1:3:3 series to the 4:3:1:3:3:1 series. The Healthy People 2010 Campaign is set to change over to the Healthy People 2020 campaign.



Because these measures also address members' personal responsibilities, they are reported under Agency Goal 3. See page 49 for performance measures and more information.

The rate reported here refers to vaccination series 4:3:1:3:3:1 which includes 4 doses of the DTP vaccine, 3 or more doses of the polio vaccine, 1 dose of MCV (measles containing vaccines), 3 or more doses of Hib (haemophilus influenza type B), 3 or more doses of Hepatitis B vaccines and 1 dose of the varicella vaccine.

## GOAL # 4: MEMBER BENEFITS

Input: Total Cost of Services  
 Input: Oklahoma Cost of Services

### Cost of Services

These measures report information on the cost of services provided to SoonerCare members. The total SoonerCare program costs and costs per member served are broken out to 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. The numbers in both of the charts below have been restated from SFY2008 through the estimate provided for SFY2011, see page 90 for more details. Page 29 provides information regarding growth and utilization for the figures reported below.

Figure 46

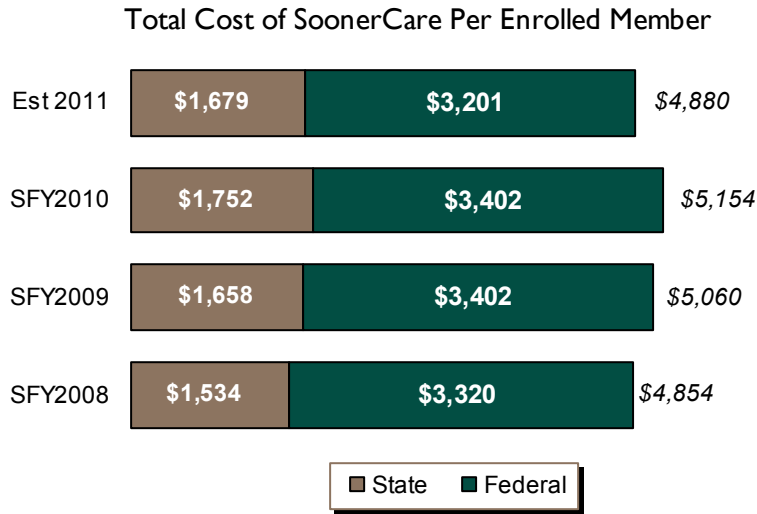
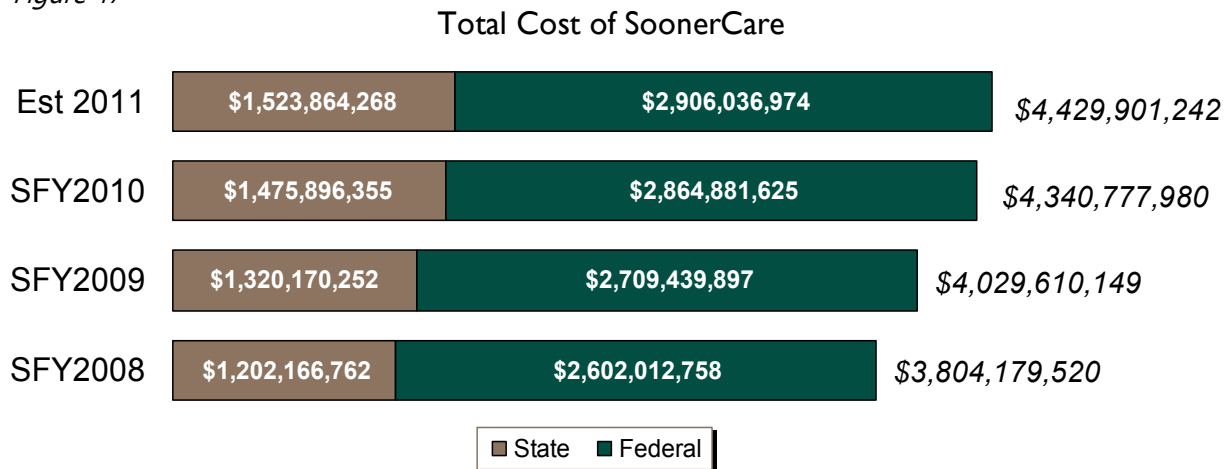


Figure 47



Source: OHCA Financial Services Division and OHCA MMIS

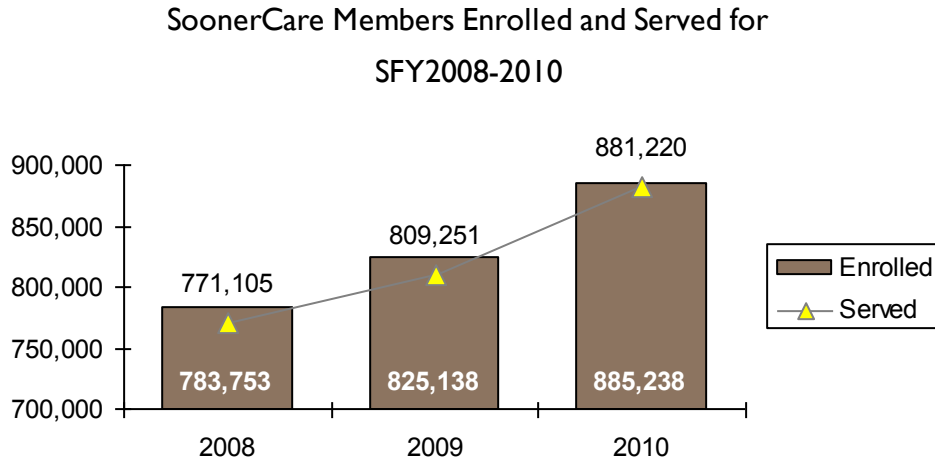
\*It should be noted that cost per member served is calculated based on reporting requirements in order to ensure comparability of the data with the numbers reported at the national level. The difference between OHCA's financial reports and data reported to CMS is that drug rebate and collections are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

## GOAL # 4: MEMBER BENEFITS

### SoonerCare Members Enrolled & Members Served

The number of Oklahomans who were enrolled in SoonerCare and the number that were served can be seen in the following chart. See page 22 for more information on enrollment numbers.

Figure 48



Source: OHCA Financial Services Division and OHCA MMIS



## Goal # 5: Responsible Financing / 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.

An important consideration when crafting the SoonerCare benefits package is the availability of funding to finance the care. The recent downturn in the economy has resulted in significantly lower revenues being collected by the state which has led to decreased funding for all programs, including Medicaid. The American Recovery and Reinvestment Act (ARRA) provided some relief to Medicaid through the implementation of enhanced FMAP rates. Even with the relief from ARRA, nearly every state implemented at least one new Medicaid policy to control spending, with more states implementing provider cuts and benefit restrictions than in the previous few years.

Like other state agencies, OHCA's general appropriations for SFY2010 were cut by 7.5 percent, or almost \$44 million in state funds. In order to meet the balanced budget requirement, the OHCA board authorized agency staff to take the needed steps to reduce the budget. OHCA staff worked closely with providers and advocates to determine precise cuts that would have the smallest negative impact possible. With this in mind, it was necessary for OHCA to implement cuts in the dental program, durable medical equipment (DME), pharmacy, provider rates, and OHCA administration. On the other hand, increased third party liability collections and claim review collections along with sound fiscal management by OHCA have helped to offset those cuts.

In addition to the issues related to the recession, OHCA is also considering the effect of recent legislation that may impact the role of Medicaid in the nation's health care system.

## GOAL # 5: RESPONSIBLE FINANCING / PURCHASING

<b>OBJECTIVE</b>	<b>TO REIMBURSE HOSPITAL PROVIDERS A REASONABLE PERCENTAGE OF COSTS.</b>
Input:	Cost of Hospital Services <i>Estimated 2010— \$1,000,287,599 Estimate 2011—\$945,599,886</i>
Outcome:	Reimbursement as a Percentage of Hospitals' Costs <i>Target: 100% of Reimbursable Costs</i>

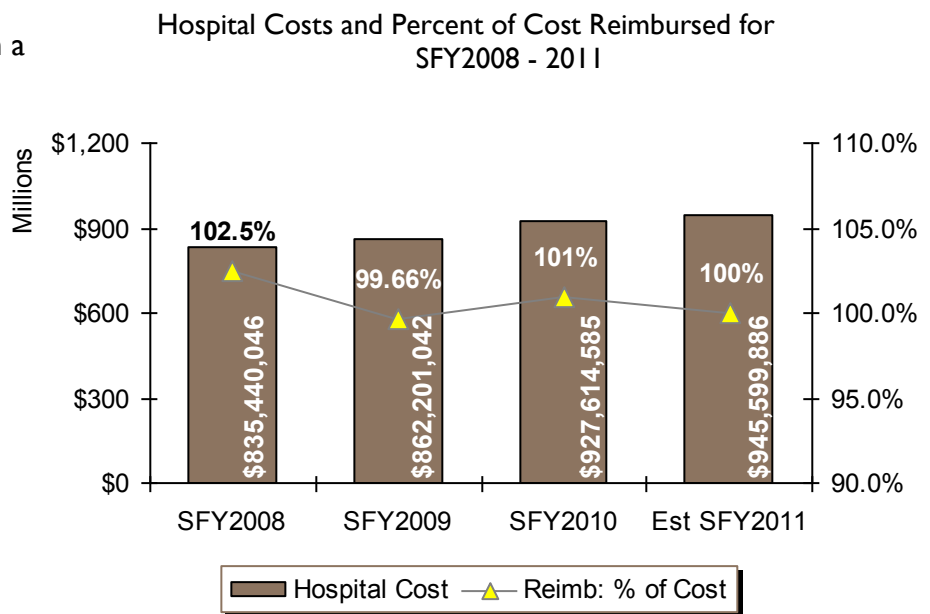
### What's being measured?

This measure reports the costs incurred by hospitals in providing services to SoonerCare members and the percentage of those costs reimbursed. (Hospital reimbursement percentages are based on federally required cost reports provided by hospitals.)

### Why is this important?

Hospitals have always been a critical component of the state's health care safety net. In today's climate of increasing medical costs, coupled with a financial recession, it is a struggle for hospitals to provide services to a wide range of Oklahomans with diverse medical needs while covering costs and remaining in compliance with state and federal regulations.

Figure 50



Source: OHCA Financial Services Division

### What do the results mean?

OHCA consistently reimburses hospitals' costs of providing services to SoonerCare members in accordance with applicable cost report percentages.

## GOAL # 5: RESPONSIBLE FINANCING / PURCHASING

### OBJECTIVE

TO REIMBURSE LONG-TERM CARE FACILITIES A REASONABLE PERCENTAGE OF COSTS.

Input:	Cost of Long-Term Care <i>Estimated 2010— \$573,679,681 Estimate 2011—\$547,572,073</i>
Outcome:	Reimbursement as a Percentage of Nursing Homes' Costs <i>Estimated 2010— 100% Estimate 2011—100%</i>
Outcome:	Reimbursement as a Percentage of ICF/MR Facilities' Costs <i>Estimated 2010— 100% Estimate 2011—100%</i>

### What's being measured?

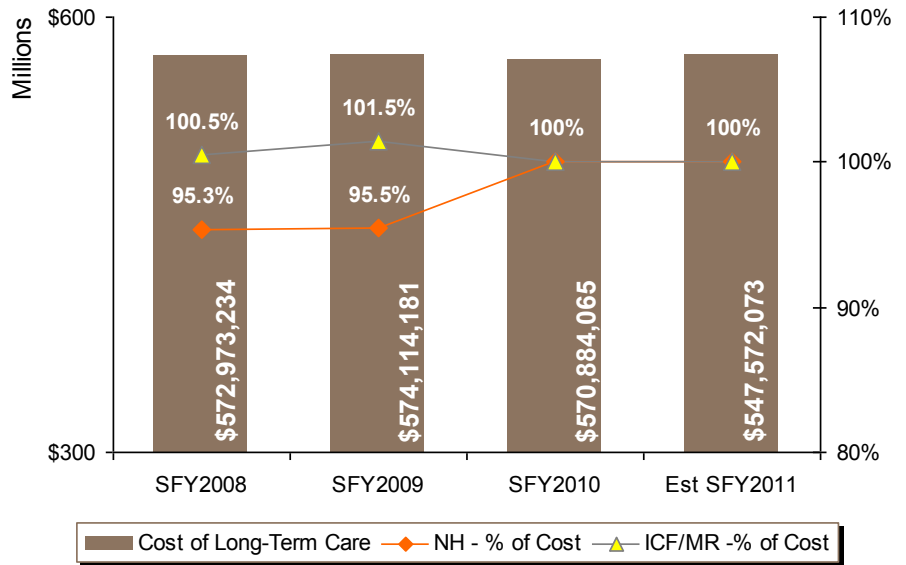
This measure reports the cost of long-term care services provided to SoonerCare members as well as the percentage of long-term care facilities' costs that were reimbursed. Costs are based on audited cost reports that facilities are required to submit after the end of the fiscal year. Information received following the issuance of the report may result in slight changes to historical data to accurately reflect percent of costs reimbursed. The most recent data, for SFY2009, is presented below.

### Why is this important?

Due to the aging population, long-term care issues remain at the forefront of health care discussions.

Medicaid is the main source of long-term care coverage and financing in the U.S. Over 10 million Americans, including about 6 million elderly and 4 million children and working-age adults, need long-term services and supports. Medicaid covers about 7 of every 10 nursing home residents and finances over 40% of nursing home spending and long-term care spending overall.

Cost of Long-Term Care and Percent of Cost Reimbursed for SFY2008 - 2011



Source: OHCA Financial Services Division

Figure 51

## GOAL # 5: RESPONSIBLE FINANCING / PURCHASING

### What do the results mean?

Even as costs continue to rise, OHCA has continued to reimburse long-term care facilities a high percentage of the costs of providing services to SoonerCare members.

### What's OHCA doing?

OHCA will continue to request funding to be able to reimburse long-term care providers a reasonable percentage of costs.

In addition to paying long-term care facilities, SoonerCare operates five programs to provide home and community care as a cost-effective alternative to institutionalization. These are known as "waiver" programs because they allow a portion of federal Medicaid requirements to be waived. The waiver programs provide some services that are not otherwise covered under SoonerCare.

### THE 1915C HOME AND COMMUNITY-BASED SERVICES WAIVERS INCLUDE:

*ADvantage*: Serves frail elderly individuals age 65 or older and adult Oklahomans age 21 and older with physical disabilities who would otherwise require placement in a nursing facility.

### THE FOUR WAIVERS LISTED BELOW ARE FOR PEOPLE WITH INTELLECTUAL DISABILITIES:

*Developmental Disabilities Service Division (DDSD) Community waiver*: A division of OKDHS, DDSD in the Community waiver serves individuals who are 3 years of age and older who have mental retardation and certain persons with related conditions who would otherwise require placement in an intermediate care facility for the mentally retarded.

*Homeward Bound waiver*: Serves individuals who are 18 years of age and older who have mental retardation and certain persons with related conditions.

*In-Home Supports for Adults waiver*: Serves the needs of individuals 18 years of age and older with mental retardation who would otherwise require placement in an ICF/MR.

*In-Home Supports for Children waiver*: Serves the needs of children ages 3 through 17 years with mental retardation who would otherwise require placement in an ICF/MR.



## GOAL # 5: RESPONSIBLE FINANCING / PURCHASING

### OBJECTIVE

TO APPROPRIATELY REIMBURSE PROVIDERS WITHIN STATE AND FEDERAL REGULATIONS.

Input:

Cost of Managed Care

*Estimated 2010— \$29,176,372      Estimate 2011—\$31,086,445*

### What's being measured?

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.

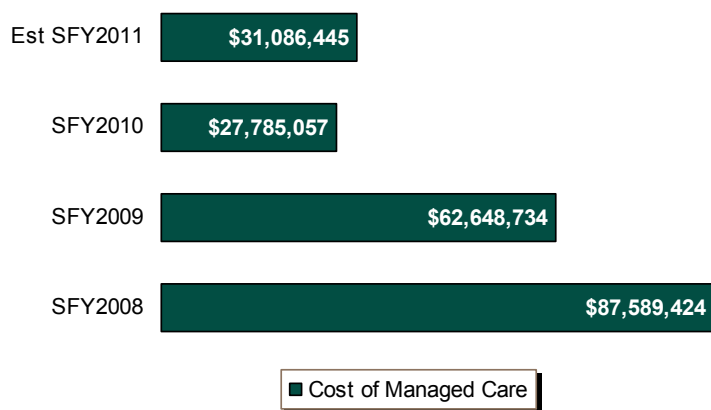
### Why is this important?

Prior to January 1, 2009, OHCA paid each SoonerCare Choice PCP a fixed monthly capitated payment for case management and a limited set of primary care services. Beginning in January 2009, OHCA began the transition to a Patient Centered Medical Home model. The PCMH includes a capitated monthly care coordination payment for the physician work that falls outside of a face-to-face visit and for the health information technologies needed to achieve better outcomes. Bundling of services into a monthly fee removes volume-based incentives and promotes efficiency. The prospective nature of the payment recognizes the up-front costs to maintain the required level of care. The PCMH also includes a visit based fee-for-service component and an expanded performance component. Fee-for-service costs are reported as “Cost of Physicians / Other Providers.”

### What do the results mean?

The cost of services has increased as SoonerCare has grown. Capitation payments have decreased with the implementation of PCMH after 2009 due to PCMH’s mid-year implementation and have continued to fall even more dramatically in SFY2010 (the first full year of PCMH). It is expected that the decrease in managed care capitation costs will be offset by an increase in physician costs resulting from the switch to the PCMH model of health care delivery. The anticipated increase in managed care estimates for SFY2011 is attributable to increased enrollment.

Cost of Managed Care Services for SFY2008 - 2011 Figure 52



Source: OHCA Financial Services Division

GOAL # 5: RESPONSIBLE FINANCING / PURCHASING

**OBJECTIVE** TO APPROPRIATELY REIMBURSE PROVIDERS WITHIN STATE AND FEDERAL REGULATIONS.

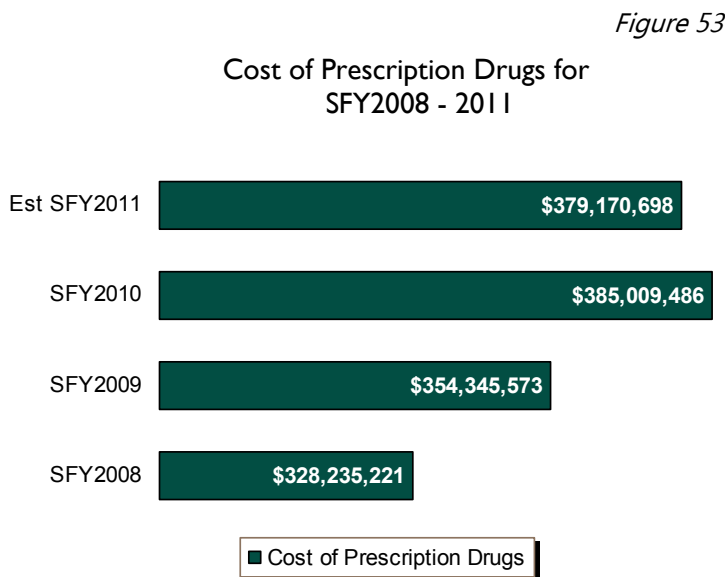
**Input:** Cost of Prescription Drugs  
*Estimated 2010— \$380,330,014 Estimate 2011—\$379,170,698*

**What's being measured?**

This measure reports the cost of providing prescription drugs to qualifying members.

**Why is this important?**

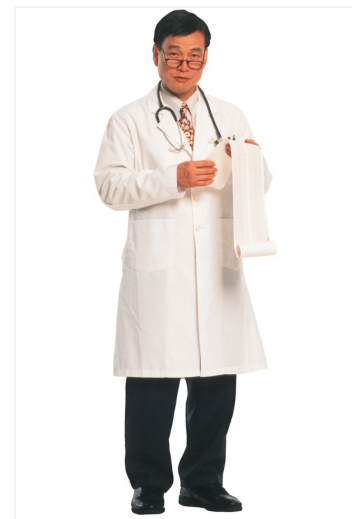
Prescription drugs have been an important driver of Medicaid spending growth for the last several years, prompting heightened state efforts to control drug utilization and costs. However, the greater need for prescription drugs and financial vulnerability found within the Medicaid population means that efforts to control spending must be balanced against maintaining beneficiaries' access to needed therapies.



Source: OHCA Financial Services Division

**What do the results mean?**

After implementation of Medicare Part D, an initial decrease in Medicaid prescription drug costs in 2006 has been followed by a period of steadily increasing costs. However, indications are that for SFY 2011, costs will remain flat. OHCA compares costs over time and uses trend analysis to support projections of future costs. Like many sectors of the health care industry, drug costs have continued to rise at a significant rate. At the same time, SoonerCare enrollment continues to increase at a record pace. Higher drug costs coupled with increased enrollment equates to higher costs to OHCA.





## GOAL # 5: RESPONSIBLE FINANCING / PURCHASING

### What's OHCA doing?

Part of the mission of OHCA is: *“to purchase state and federally funded health care in the most efficient and comprehensive manner possible....”* OHCA utilizes several pricing methodologies in order to keep drug costs as low as possible. SoonerCare also receives drug rebates from the manufacturers in accordance with the Medicaid Drug Rebate Program and the supplemental state rebate program. The savings realized through lower costs ensures that funds are available to help meet the needs of more SoonerCare members.

One cost saving pricing methodology, the State Maximum Allowable Cost (SMAC) program, limits pharmacy reimbursement for generic products. SoonerCare has one of the highest generic utilization rates of any benefit plan in the nation, with an average of more than 76 percent of all prescriptions dispensed as generic drugs. When the SMAC program was started in 2000, 400 products were included. The most recent list includes more than 1,100 drug products.

Also, the Medicaid Drug Rebate Program requires a drug manufacturer to enter into and have in effect a national rebate agreement with the Secretary of the Department of Health and Human Services (HHS) for states to receive Federal funding for outpatient drugs dispensed to Medicaid patients. The drug rebate program is administered by the Centers for Medicare & Medicaid Services' Center for Medicaid and State Operations (CMSO). A drug manufacturer must sign an agreement in order to have its drugs covered by Medicaid. Approximately 550 pharmaceutical companies currently participate in this program. Forty nine states, (Arizona is excluded), and the District of Columbia cover drugs under the Medicaid Drug Rebate Program.



Another cost saving measure, the supplemental state rebate program, allows manufacturers of drugs with higher retail prices to choose to participate in the rebate program to avoid prior authorization. The manufacturers can negotiate with OHCA to meet a lower “benchmark” price for a particular drug which results in that drug being moved off of prior authorization status and being placed on the preferred list of medications. Several pharmaceutical manufacturers have agreed to sign supplemental rebate agreements with the agency.

## GOAL # 5: RESPONSIBLE FINANCING / PURCHASING

### OBJECTIVE

TO APPROPRIATELY REIMBURSE PROVIDERS WITHIN STATE AND FEDERAL REGULATIONS.

Input:

Cost of Behavioral Health Services

*Estimated 2010— \$265,076,435    Estimate 2011—\$291,173,372*

### What's being measured?

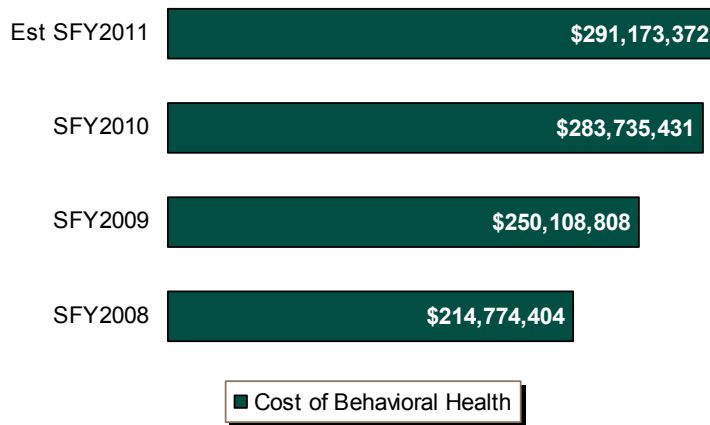
This measure reports the cost of behavioral health services paid on behalf of SoonerCare members.

### Why is this important?

The effects of mental health issues on an individual can be great. However, mental health issues affect more than just the individual suffering through them. 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.

*Figure 54*

Cost of Behavioral Health Services for SFY2008 - 2011



Source: OHCA Financial Services Division

### What do the results mean?



Behavioral Health costs, like other medical costs, continue to rise. A growing population, a sagging economy, and rising unemployment are a few of the factors contributing to the demand for mental health services.

### What's OHCA doing?

SoonerCare provides a behavioral health treatment package for eligible Oklahomans in need of services that are dealing with stressful life situations/changes, serious mental illnesses, emotional disturbances, and/or alcohol, and other drug disorders. Mental health, alcohol, and other drug disorder

treatment benefits for those enrolled in SoonerCare include: Adult and children's acute psychiatric inpatient care, facility-based crisis stabilization and intervention, emergency care, alcohol, or other drug medical detoxification, psychiatric residential treatment (children only), and outpatient services.

## GOAL # 5: RESPONSIBLE FINANCING / PURCHASING

<b>OBJECTIVE</b>	TO APPROPRIATELY REIMBURSE PROVIDERS WITHIN STATE AND FEDERAL REGULATIONS.
Input:	<b>Cost of Medicare Buy-In</b> <i>Estimated 2010— \$117,994,998 Estimate 2011—\$136,566,184</i>

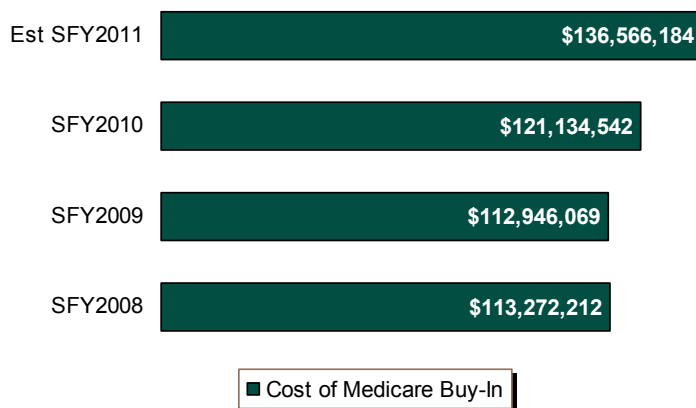
### What's being measured?

This measure reports the amounts paid for Medicare premiums for hospital and/or physician benefits for dual eligible members. Dual eligible members qualify for both Medicare and Medicaid services. It reflects 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 categories.

### Why is this important?

These payments assist qualifying low-income Medicare beneficiaries by 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 portion of the payments. These potential increases must be taken into consideration when projecting future funding needs.

Figure 55 Cost of Medicare Buy-In for SFY2008 - 2011



### What do the results mean?

The cost of Medicare Buy-In continues to rise. Once again, the effects of a sagging economy along with the aging “baby-boomer” generation has resulted in an increased demand in every facet of the health care sector. As more and more people become dually eligible, the cost will continue to rise.

### What’s OHCA doing?

SoonerCare pays only the deductibles and a portion of the co-insurance for SoonerCare services that are covered by Medicare. OHCA also pays the monthly Medicare Part B premium for SoonerCare members age 65 or older and for certain blind or disabled persons. If an eligible person has other medical insurance, that insurance company must be billed before SoonerCare is billed.

## GOAL # 5: RESPONSIBLE FINANCING / PURCHASING

### OBJECTIVE

TO REIMBURSE PROVIDERS, WHEN APPLICABLE MEDICARE RATES ARE AVAILABLE, AT 100% OF MEDICARE RATES.

Input:

Cost of Physicians & Other Practitioners' Services

*Estimated 2010— \$762,323,143 Estimate 2011—\$730,726,108*

Outcome:

Reimbursement as a Percentage of Medicare Rates

*Target: 100% of Medicare Rate*

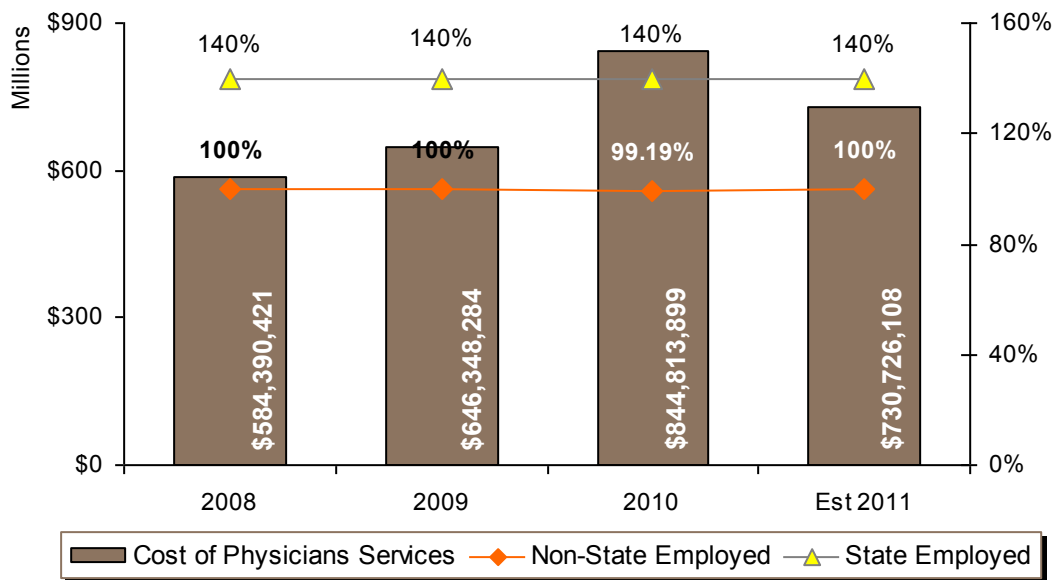
### Why is this important?

It is vital to the health of SoonerCare members that they have a medical home in which to seek health care services, including advice and education. In order to ensure that SoonerCare providers are able to maintain quality services, ensure technical expertise, and utilize current best practices, it is critical that they are reimbursed at appropriate rates. These measures track costs over time which allows for year-to-year analysis of trends.

### What's being measured?

These measures track the costs of medical services provided to members. Providers include: physicians, labs, radiologists, dentists, home health care providers, ambulatory clinics, and other practitioners. Reimbursement of costs is also tracked as a percentage of Medicare reimbursement rates for comparison.

Figure 49 Cost of Physicians/Other Providers and Rate of Reimbursement Compared to Medicare Rates for SFY2008 - 2011



Source: OHCA Financial Services Division

## GOAL # 5: RESPONSIBLE FINANCING / PURCHASING

### What do the results mean?

**Non-State Employed Physicians** - In the past, non-state employed physicians have been reimbursed at 100 percent of Medicare rates. This was true for the first 3 quarters of SFY2010, as well. However, budget constraints prompted OHCA to implement a 3.25 percent provider rate decrease for the fourth quarter of the SFY. The net effect of the decrease was to bring the reimbursement as a percentage of Medicare rates for non-state employed physicians down to 99.19 percent, for the year.

**State Employed Physicians** - State employed physicians, (those employed by the Colleges of Medicine at Oklahoma University and Oklahoma State University), are paid at 140 percent of Medicare rates. The universities pay the state share of costs that are higher than the regular SoonerCare reimbursement rates. Because of the 3.5 percent provider rate cut, the universities have increased their payments of the state share by a corresponding 3.5 percent.

It should be noted that labs are reimbursed based upon a CMS mandated schedule. Payment is the lesser of the amount billed, the local fee for a geographic area, or a national limit. For more information go to [https://www.cms.gov/ClinicalLabFeeSched/02\\_clinlab.asp](https://www.cms.gov/ClinicalLabFeeSched/02_clinlab.asp).

### What's OHCA doing?

OHCA is committed to reimbursing providers at appropriate rates. Every effort was made to minimize provider rate cuts in SFY2010 and agency management will continue to strive to prevent further rate cuts. The 3.25 percent cut is considered temporary and it is anticipated that rates will be restored when fiscal conditions allow. OHCA has requested the funding to return rates to 100 percent of Medicare in the 2012 budget request.



Recent changes to the primary care delivery system of SoonerCare were designed to benefit both members and providers. At the recommendation of the OHCA Medical Advisory Task Force, a patient-centered medical home (PCMH) model of care was implemented on January 1, 2009. Providers receive the traditional fee-for-service along with incentive payments like those in managed care models.

With PCMH, providers receive visit-based payments and additional reimbursements for providing each panel member enrolled these enhanced services and supporting infrastructure. SoonerExcel is the performance-based component that recognizes Primary Care Providers' achievement of quality and efficiency goals. In SFY2010, 85 percent of the SoonerCare Choice providers received incentive payments.

**GOAL # 5: RESPONSIBLE FINANCING / PURCHASING**

**OBJECTIVE**

TO APPROPRIATELY REIMBURSE PROVIDERS WITHIN STATE AND FEDERAL REGULATIONS.

Input:

Cost of Miscellaneous Medical Payments

*Estimated 2010— \$30,229,336      Estimate 2011—\$30,009,791*

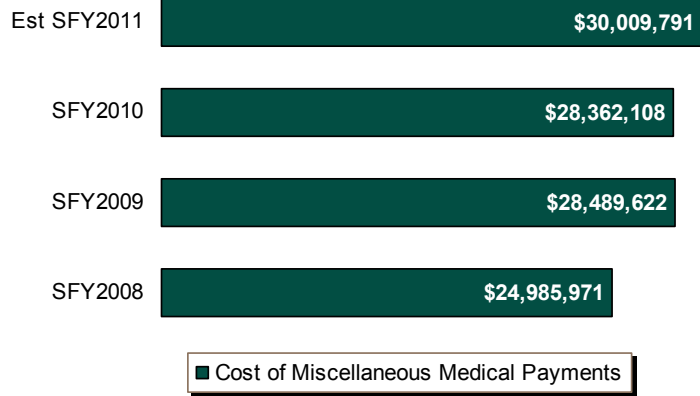
**What's being measured?**

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.

*Figure 56*      Cost of Miscellaneous Medical Payments for SFY2008 - 2011

**Why is this important?**

OHCA is committed to providing members access to the care they need. Sometimes that care is not available in the state of Oklahoma. In certain cases, members may travel out-of-state to seek the care they need.



**What do the results mean?**

As with other health care costs, the cost of miscellaneous medical payments continues to rise. Also, as more people become SoonerCare members, more people take advantage of SoonerCare benefits, including emergency transportation and room and board while receiving care outside of Oklahoma.

**What's OHCA doing?**

OHCA remains committed to providing the greatest possible benefit package to its members and will continue to offer the benefits paid for through miscellaneous medical payments.





## GOAL # 5: RESPONSIBLE FINANCING / PURCHASING

### OBJECTIVE

TO APPROPRIATELY REIMBURSE PROVIDERS WITHIN STATE AND FEDERAL REGULATIONS.

Input:

Cost of Non-Emergency Transportation

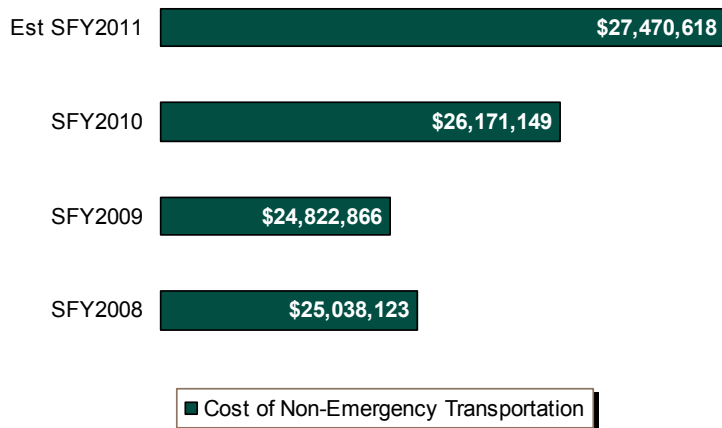
*Estimated 2010— \$26,092,736 Estimate 2011—\$27,470,618*

### What's being measured?

Figure 57

Cost of Non-Emergency Transportation Services for SFY2008 - 2011

This measure reports the cost of non-emergency transportation paid on behalf of SoonerCare members.



### Why is this important?

Lack of transportation can often be a barrier to accessing medical services, especially for members living in rural areas. Tracking the cost is one way to help analyze trends and support projections of future costs.

### What do the results mean?

The decrease between SFY2008 and SFY2009 is due to a reduction in the rates paid to the transportation contractor. Also, new state and federal citizenship verification requirements resulted in the disenrollment of some members leading to a temporary decrease in utilization. It is estimated that the costs will begin to rise again as more members begin to take advantage of this benefit.

### What's OHCA doing?

The best health insurance is worthless if members can not access the care they need. 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.

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## Goal # 6: Administration

TO FOSTER EXCELLENCE IN THE DESIGN AND ADMINISTRATION OF THE SOONERCARE PROGRAM.

More and more Oklahoma residents are applying for the SoonerCare program as the unemployment rate goes up. In fact, the percentage of Oklahomans enrolled in SoonerCare has risen by 1.3 percent from 22.5 percent to 23.8 percent between SFY2009 and SFY2010. Unfortunately, available funds are going down. The economic condition of Oklahoma has spiraled downward, as did the economy for the rest of the nation. State agencies across the board were forced to take cuts; OHCA was no different.



In order to make required budget cuts, the agency was forced to make changes to Medicaid prescriptions, Durable Medical Equipment, Dental, and Behavioral Health, along with other cuts. (The cuts are discussed in further detail in Goal 5.) Provider rates were cut by 3.5 percent; administration costs were also impacted. The agency was forced to take a 5 percent decrease in administration costs.

OHCA is continually improving the administration of its health programs to ensure the efficient use of scarce resources. Rising health care costs continue to consume an increasing portion of the state budget. SFY2010 challenged the agency, and there is more to come.

Recent national health care legislation may have a significant affect on administration costs in the coming years. OHCA is currently reviewing the legislation to provide state officials with information as they consider Oklahoma's future health care needs.

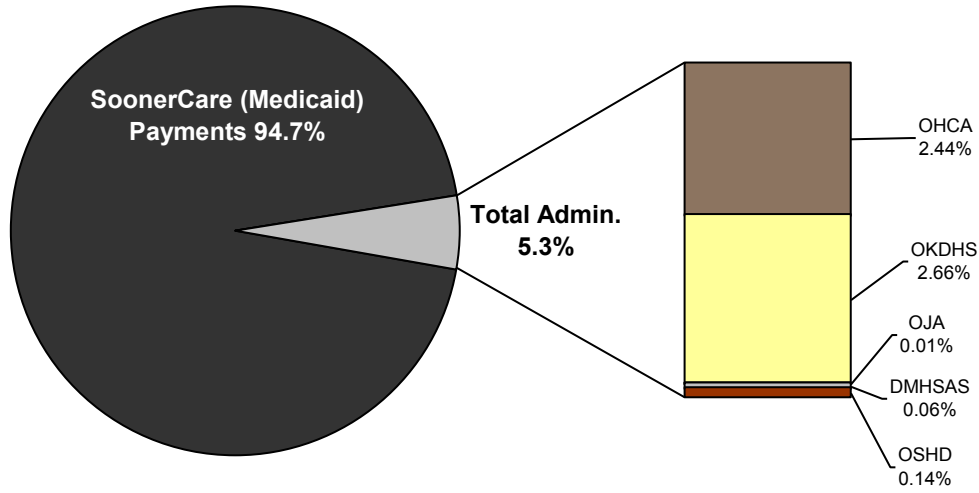
Even without funding limitations, administration of SoonerCare programs will remain challenging due to continually evolving medical needs of members and the expanding role of advanced medical technology. To address these issues, OHCA participates in CMS-sponsored program integrity training events and is working to implement modern health information technology, including the widespread adoption of electronic medical records. These efforts have multiple positive benefits for operations such as keeping abreast of the latest program integrity issues and technological advances. This section provides an overview of measures used to evaluate OHCA administrative performance.



GOAL # 6: ADMINISTRATION

Medicaid Expenditure Percentages for SFY2010

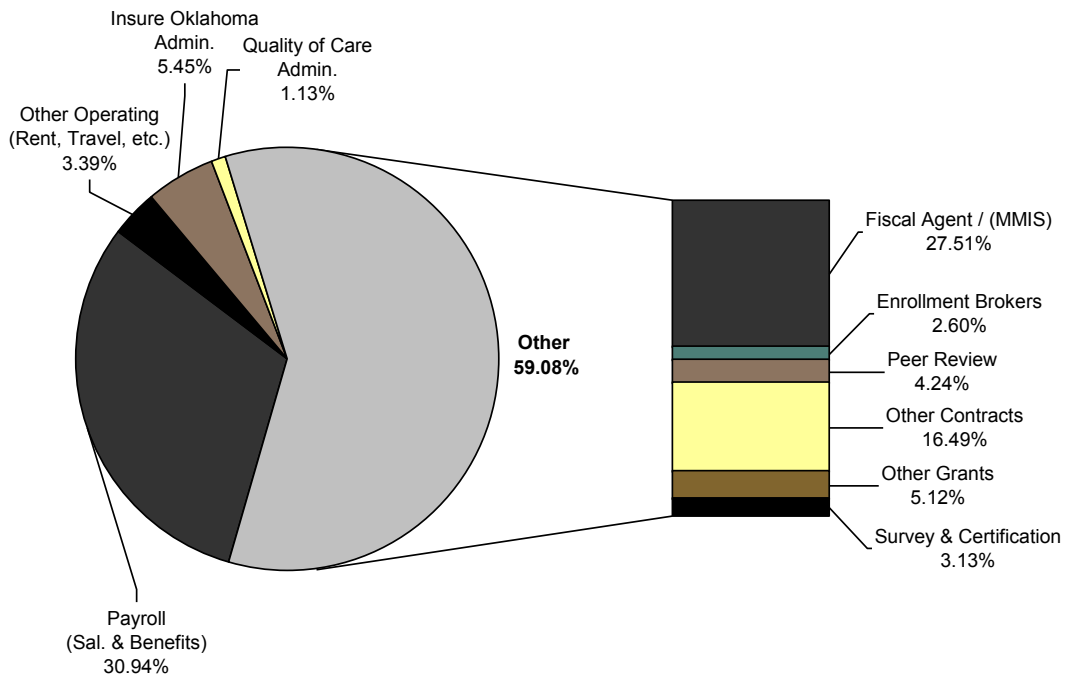
Figure 58



Source: OHCA's SFY2009 Annual Report

OHCA Administration Expenditures Percentages for SFY2010

Fig



Source: OHCA's SFY2009 Annual Report

**GOAL # 6: ADMINISTRATION**

**OBJECTIVE**

**TO CONSISTENTLY PERFORM ADMINISTRATIVE RESPONSIBILITIES WITHIN FUNDING BUDGETED.**

Outcome:

**Percent of Time Administration Costs Remain within Budget**  
*Target 2010 - 100%*      *Target 2011 - 100%*

**What’s being measured?**

This measure indicates the percentage of time administration costs remain within budget.

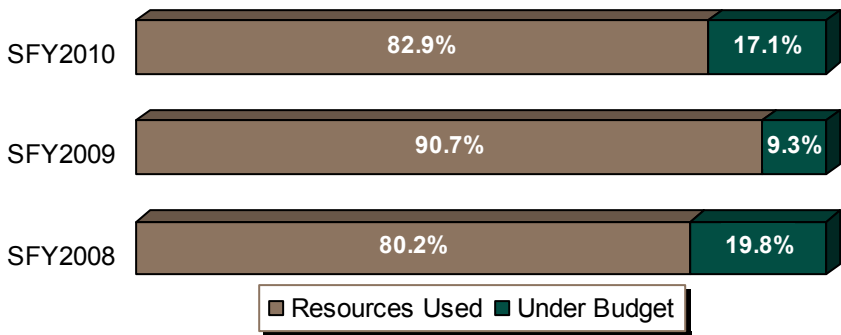


**Why is this important?**

Because resources are limited in today’s economy, being good stewards of public funds continues to be a responsibility of the agency. In order to know how prudent the Oklahoma Health Care Authority is in utilizing its resources, administrative expenses must be tracked and compared to the amount budgeted. This measure is also an indicator of how well the agency has planned for the business of SoonerCare. Despite careful planning in SFY2010, Oklahoma’s economy negatively impacted funding available to the program. The agency was forced to implement budget cuts, including cuts in administrative costs.

Figure 60

Percent of Administration Budgeted Dollars Used



Source: OHCA Financial Services Division

**What do the results mean?**

The agency’s administrative expenses were 100 percent within budget even after taking a 5 percent budget cut as directed by state legislators.

**What’s OHCA doing?**

During SFY2010, administration reduced costs by \$9 million, along with other program cuts (discussed in the introduction to Goal 5), to help balance the budget due to the state revenue shortfall.



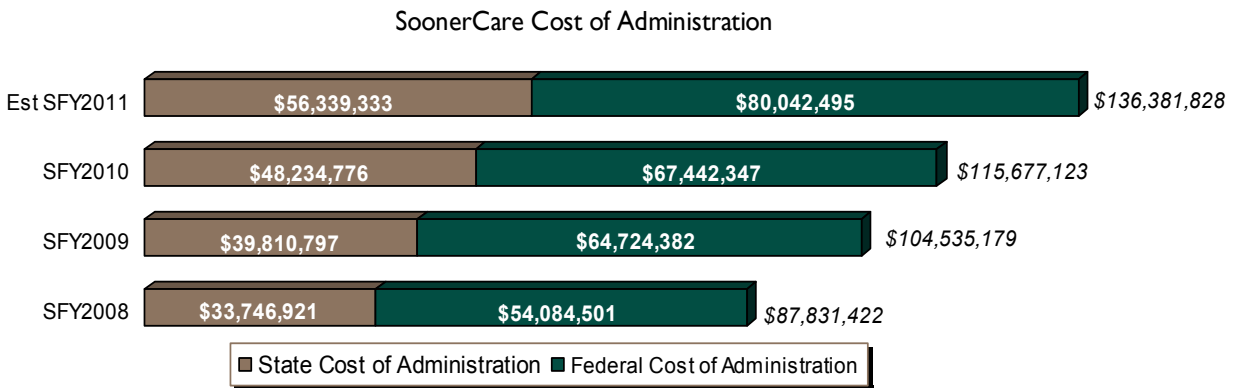
## GOAL # 6: ADMINISTRATION

Input:	Cost of Administration—State & Federal <i>Estimated 2010— \$89,188,067 Estimated 2011—\$136,381,828</i>
Efficiency:	OHCA Cost of Administration per Member—State & Federal <i>Estimated 2010— \$108.52 Estimated 2011— \$150.25</i>

### What’s being measured?

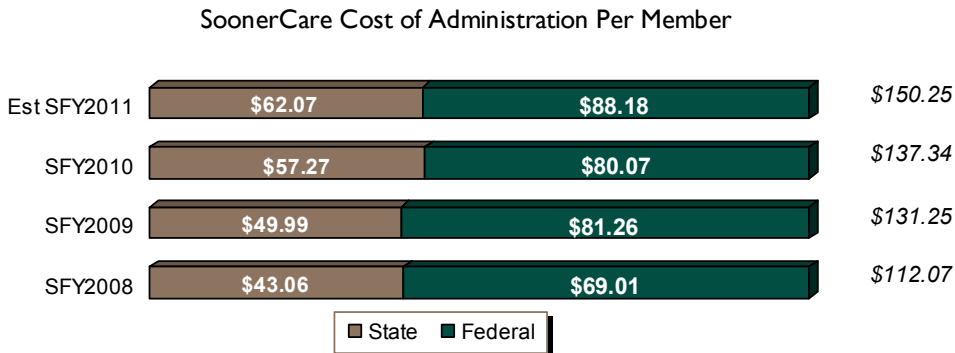
The state and federal resources invested in SoonerCare’s administration and cost of administration per member is reported below.

As stated earlier in the report, all costs of Insure Oklahoma premium assistance expenditures have been removed to reflect only SoonerCare costs; the restated figures are provided from SFY2008 through the SFY2011 estimate. The premium assistance dollars are not funded by Medicaid, but by tobacco tax dollars.



Source: OHCA Financial Services Division

Figure 61



Source: OHCA Financial Services Division

Figure 62



## GOAL # 6: ADMINISTRATION

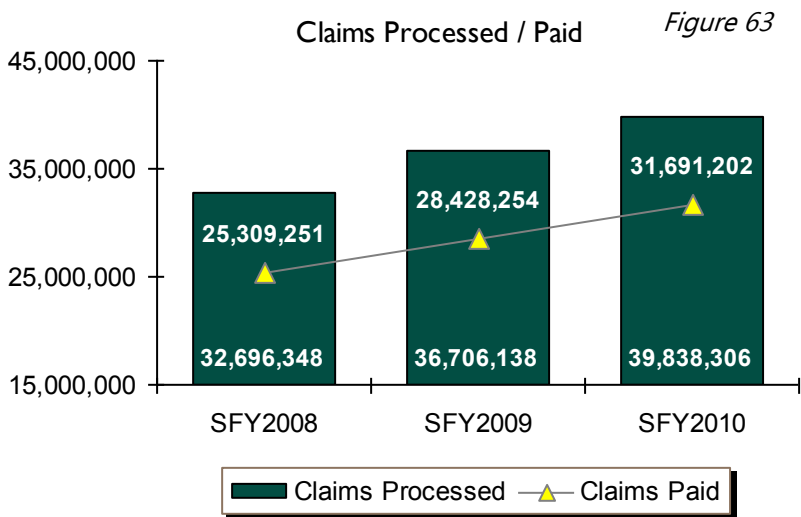
### OBJECTIVE

TO PAY SOONERCARE CLAIMS WITHIN AN ACCURACY RATE OF AT LEAST 97 PERCENT, CONSIDERING POLICY AND SYSTEMS ISSUES AND MEMBER ELIGIBILITY.

Outcome:	Number of Claims Processed <i>Estimated 2010 - &gt;39,000,000 Estimate 2011 - &gt; 43,000,000</i>
Output:	Number of Claims Paid <i>Estimated 2010 - &gt;30,000,000 Estimate 2011 - &gt; 45,000,000</i>
Outcome:	Payment Accuracy Measurement Rate <i>Target &gt;97%</i>

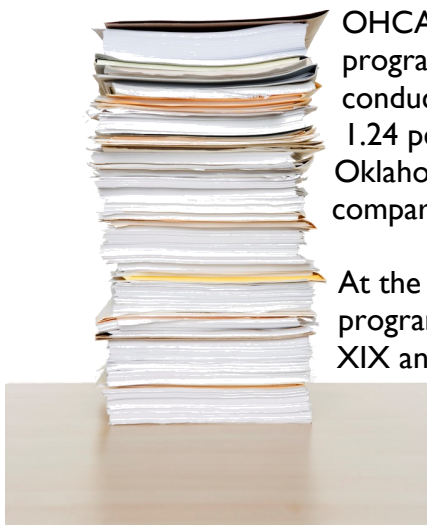
### What's being measured?

Payment Accuracy Measure (PAM) is an internal review based on a large sample of claims to validate the accurate processing of claims, appropriate documentation of services by providers, and the medical necessity of the services performed. The rate is determined on the dollar amounts of claims paid, rather than the number of claims, in accordance with the federal Payment Error Rate Measurement (PERM) program described below. OHCA performs the internal PAM review on an annual basis.



Source: OHCA MMIS

### Why is this important?

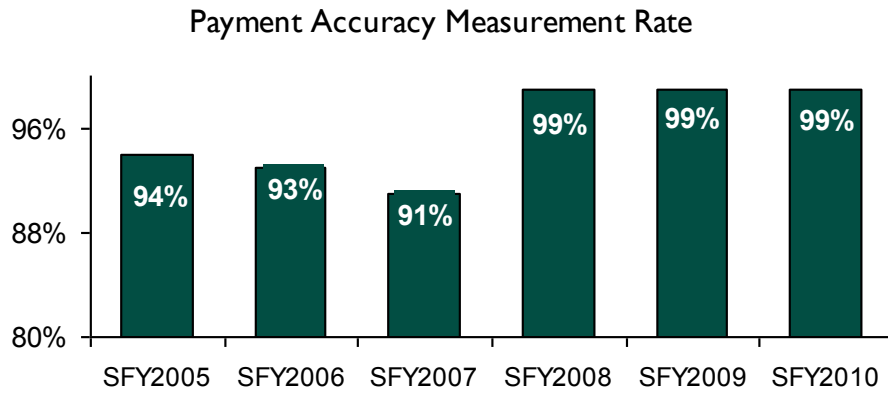


OHCA has modeled its PAM program after the Federal PERM program. The most recent PERM review of OHCA claims was conducted on claims paid in federal fiscal year 2009 and resulted in a 1.24 percent error rate while the national average was 1.89 percent. Oklahoma had the lowest overall Medicaid error rate when compared to the other 17 states measured in 2009.

At the federal level, the Title XIX (Medicaid) and Title XXI (SCHIP) programs are reviewed separately. The agency usually reviews Title XIX and Title XXI separately but reports a blended rate. Due to resource constraints both populations were not sampled. In SFY2010, Internal PAM 2009 was completed on SCHIP-Title XXI claims only. The PAM rate was 98.89 percent.

GOAL # 6: ADMINISTRATION

Figure 64



Source: OHCA Program Integrity Division

**What do the results mean?**

The changes in PAM results between SFY2007 and SFY2009 are due to an increase and enhancement of inpatient claims reviews. In 2007, there were fifteen errors related to inpatient hospital claims. For 2009, there was only one noted.



**What's OHCA doing?**

The Oklahoma Health Care Authority continues to provide training through provider letters and fax blasts as well as updates and policy clarifications. These efforts are meant to help providers to understand appropriate billing procedures.



## GOAL # 6: ADMINISTRATION

<b>OBJECTIVE</b>	TO ACCURATELY FORECAST, BASED UPON AVAILABLE INFORMATION, AND SUBSEQUENTLY REPORT AGENCY REVENUES IN A TIMELY MANNER.
Output:	Financial Statement Completeness <i>Target—100%</i>

### What's being measured?

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.

### Why is this important?

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.

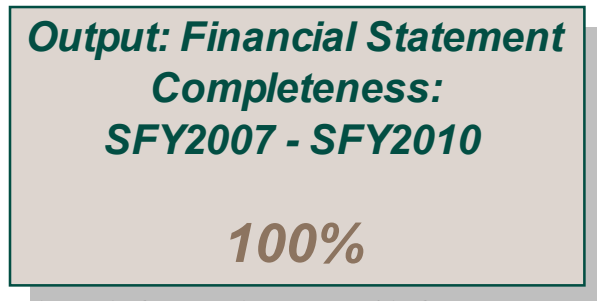
### What do the results mean?

OHCA has reported its use of resources on time 100% of the time.

### What's OHCA doing?

The financial status of the agency is reported to the Board monthly. During SFY2010, the financials were discussed frequently due to economic conditions and budget cuts the agency faced. The Board looks at actual revenue and expenditures versus budgeted revenue and expenditures.

Figure 65: Financial Statement Completeness for SFY2007 - SFY2010



Source: OHCA Financial Services Division / OHCA Board Minutes



## GOAL # 6: ADMINISTRATION

**OBJECTIVE** TO MAINTAIN AND/OR INCREASE PROGRAM AND PAYMENT INTEGRITY EFFORTS WHICH MAY RESULT IN RECOVERIES.

**Output:** Payment Integrity Recoveries  
*Estimate SFY2011—\$4,500,000*  
*Actual SFY2010—\$17,614,428*

### What’s being measured?

This measure reports the amount of recoupments identified in post-payment and program integrity reviews. It is one of the activities the agency performs to ensure that claims are paid accurately.



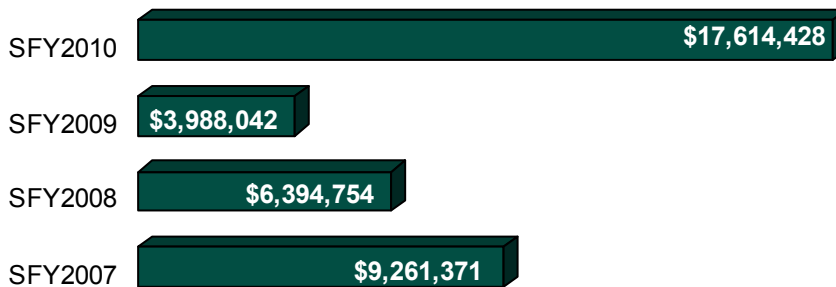
In addition to recoupments identified in post-payment and program integrity reviews, OHCA has also saved money through cost avoidance.

Cost avoidance occurs when OHCA identifies a policy, procedure, billing, or claim issue. If the issue is resolved and results in money not being paid to providers, it is categorized as costs avoided.

For example, from just two identified cases in SFY2010, OHCA avoided paying \$1,022,855 to providers after identifying billing errors. For SFY2011, OHCA plans to track all changes in policies, procedures, and billing that could result in cost avoidance.

Figure 66

Payment Integrity Recoveries



Source: OHCA Program Integrity Division

## GOAL # 6: ADMINISTRATION



### Why is this important?

OHCA uses audit and review functions, internal controls monitoring, and prepayment edits to prevent and detect erroneous claim payments and identify suspected fraud and abuse. These efforts result in payment integrity recoveries.

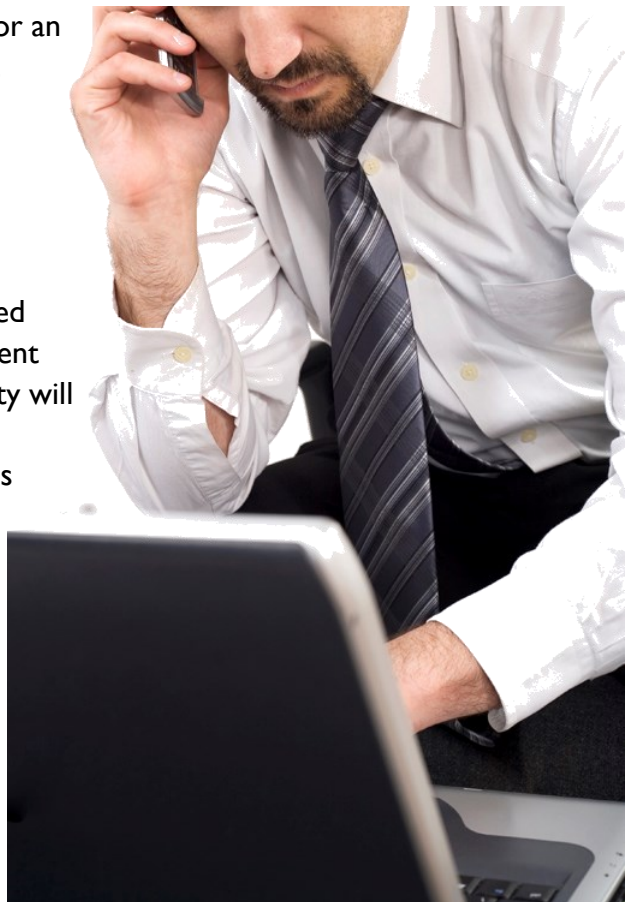
### What do the results mean?

Payment integrity recoveries in SFY2010 increased significantly. This increase was due to three large-dollar amount audits.

An audit of same-day discharges accounted for \$6,065,455 of the increase. These SoonerCare members were admitted to a hospital and discharged on the same day, yet the visits were billed as inpatient stays. OHCA rules dictate that a member must be present at the midnight census to be considered inpatient.

An audit of recorded baby weights accounted for an additional \$4,125,178 of the increase. Inpatient claims are paid according to the recorded baby weights of newborns and the hospitals had incorrectly recorded baby weights, resulting in increased payments.

The third audit, of hospital transfers, represented \$986,687 of the overall increase. OHCA payment methodology indicates that the originating facility will receive a flat transfer rate for baby transfers. Hospitals were receiving full payments on babies transferred to other facilities within 4 days of birth.



## GOAL # 6: ADMINISTRATION

The agency expects future payment recoveries to decrease due to the fact that the agency now conducts many follow-up reviews to ensure appropriate billing practices. The scope of audits performed for the first time typically includes longer periods. For example, 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.

### What's OHCA doing?

Various units within OHCA are responsible for separate areas of potential recoveries, cost avoidance, and fee collection. The Program Integrity and Accountability Unit safeguards against unnecessary utilization of care and services. The Pharmacy Unit reviews paid pharmacy claims to determine that claims are valid and in compliance with applicable federal and state rules and regulations. The Provider Audit staff performs audits and reviews of external providers in regard to inappropriate billing practices and noncompliance with OHCA policy. Reviews can be initiated based on complaints from SoonerCare providers, members, concerned citizens, or other state agencies, as well as through risk-based assessments.

The economic impact of unnecessary utilization, inappropriate billing practices, and noncompliance with OHCA policy, although enormous, is not the only harm done to Oklahoma's citizens. The people who depend on Medicaid, their friends, and their families are the ones who suffer the most as a result of the misuse of OHCA funds.

The Medicaid Integrity Program (MIP) and the State Program Integrity Assessment program (SPIA) have significant resources assigned to them as a result of the Deficit Reduction Act of 2005.

### MEDICAID INTEGRITY PROGRAM (MIP)

The Medicaid Integrity Group (MIG) was formed by the federal government to prevent fraud and abuse. This group oversees the MIP, which reviews state Medicaid programs, providers, and members. It also provides technical assistance and training to states. The MIG will be reviewing OHCA during SFY2011.

### STATE PROGRAM INTEGRITY ASSESSMENT (SPIA)

SPIA was also created by the MIG to collect standardized, national data on State Medicaid program integrity efforts for the purposes of program evaluation. State profiles will be developed from this data along with performance measures to assess the State's performance in an ongoing manner.



**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:

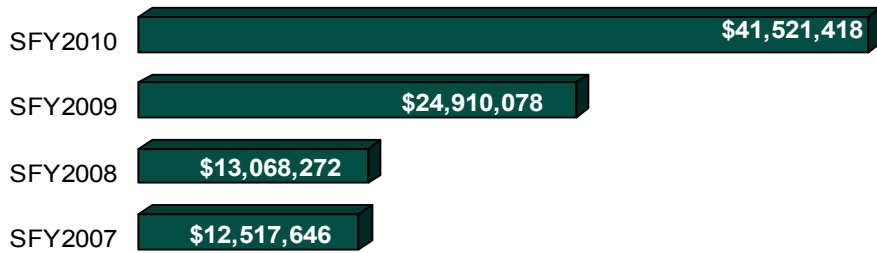
Third Party Liability Collections  
*Estimate—\$24.9 million*

**What’s being measured?**

By law SoonerCare is the payer of last resort. When a member is enrolled in SoonerCare they assign their rights to third party payments over to OHCA. The claims will be paid and then OHCA will recover from the liable third party. This measure reports the amount of resources collected from third party payers.

Figure 67

Third Party Liability Collections



Source: OHCA Financial Services Division

**Why is this important?**

The measure indicates that the agency is ensuring that appropriate payments are made as required by law when SoonerCare resources are claimed.

**What do the results mean?**

TPL collections increased by 91 percent from SFY2008 to SFY2009, and 66.7 percent from SFY2009 to SFY2010. The increase in TPL collections can be attributed to changes in legislation that have given the agency a longer window of time in which to pursue reimbursement from third party payers and data matching legislation that strengthened requirements for insurance companies to communicate with OHCA. Also, in SFY2009 and SFY2010, OHCA outsourced all remaining third party recoveries collection.

**What’s OHCA doing?**

OHCA has outsourced all third party recoveries collection to HMS, increasing the amount of collections significantly.

HMS has joined with Medicaid programs for 25 years to help the programs meet the federal mandate and ensure that Medicaid is the payer of last resort.



## GOAL # 6: ADMINISTRATION

### 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—>21%*



### What’s being measured?

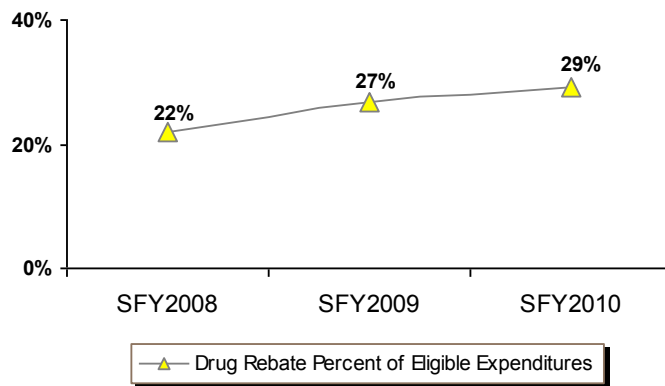
This measure reports the collections made through the prescription rebate program compared to resources expended for pharmacy services.

### Why is this important?

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 established through enactment of the Omnibus Budget Reconciliation Act of 1990. It was designed to allow the Medicaid program to receive rebates on reimbursed drugs so that the net cost to Medicaid would be equal to the lowest prices paid by other large purchasers or the lowest or “best” prices charged by manufacturers.

Figure 68

Drug Rebates as a Percent of Rebate Eligible Expenditures



Source: OHCA SoonerCare Operations Division

### What do the results mean?

The increase in the percentage can be explained by the policy change effective July 1, 2008, requiring outpatient claims to have the actual National Drug Code (NDC) listed on the claims’ line item for medications. The higher rate can be attributed, in part, to the agency receiving rebates for claims reflecting the new policy.

### What’s OHCA doing?

The Congressional Budget Office (CBO) estimates there will be a mandatory reduction in total Medicaid spending by \$2 billion over 10 years with the changes made to the calculation of drug rebates under H.R. 1586, Section 202. It is unclear whether the states will realize additional savings from the changes to rebate calculations.

## GOAL # 6: ADMINISTRATION

### OBJECTIVE

TO TRAIN AND EDUCATE SOONERCARE PROVIDERS, BOTH ON AN “AS-NEEDED” AND A PROACTIVE BASIS, THROUGH GROUP AND/OR INDIVIDUAL TRAINING AND OTHER COMMUNICATION.

### Output:

- Number of Provider Trainings**
- *Seminars/Workshops & Attendees*
  - *Onsite Trainings*
  - *Written Communications*

### What’s being measured?

There are several different training opportunities offered to providers. This measure tracks the number of providers who participate in trainings through seminars/workshops, on-site trainings, and written communications.

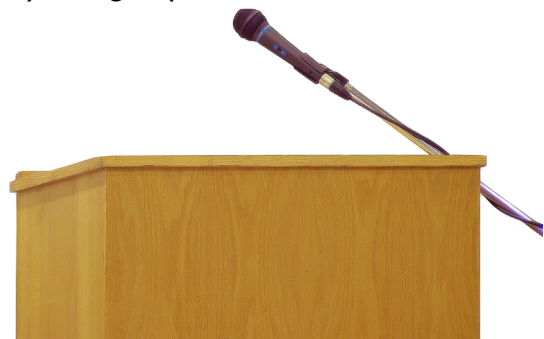
Figure 69

Provider Training	SFY2008	SFY2009	SFY2010
Seminars / Workshops	85	149	185
Attendees	8,590	9,584	11,739
On-Site Training	3,961	4,172	4,043
Written Communication	1,745,865	1,740,949	1,327,145

Source: OHCA Program Integrity Division

### Why is this important?

Providers submit a massive number of claims each year for payment. OHCA must ensure that providers are billing accurate, necessary, and appropriate claims. There are several different training options available to providers: seminars, workshops, bi-annual regional trainings, on-site trainings, and written communications. Written communication comes in several forms including: provider letters, fax blasts, and global messages/banners. These training opportunities cover topics such as: claims processing procedures, new or changing policies, and other topics relevant to the providers’ efforts. They also give providers the chance to ask questions.



## GOAL # 6: ADMINISTRATION

### What do the results mean?

The significant increase in the number of group trainings can be attributed to more events being offered by the agency's Quality Improvement Organization (QIO). APS has shifted some of their onsite trainings to group (web) training. Also during SFY2010, Oklahoma's Deputy State Medicaid Director, Becky Pasternik-Ikard, presented the Insure Oklahoma program at the National Academy of State Health Policy (NASHP), which accounted for 1,200 attendees.



The significant decrease in the number of written communications is due to a combination of factors. In SFY2010, the newsletter came out of the APS contract as a deliverable. There was only one

newsletter sent out during the state fiscal year. For the year, there were fewer policy letters than in previous years. The number of policy letters fluctuate depending on what provider types the letters are sent to, what changes have taken place during the year, and what new programs are added. The number of different letters produced during the year went up, but the number of providers that were actually sent the letters went down.

### What's OHCA doing?

OHCA now has Provider Training Videos on the OHCA Website. These videos contain information regarding current policy and procedures. The videos can be accessed at [www.okhca.org/about-us/trainings](http://www.okhca.org/about-us/trainings) under Providers homepage and then Training.



#### ***The OHCA policy department is going green!***

Providers will now have the option to receive their provider letters by either fax or email. This change will save the agency approximately \$500,000 in postage costs and \$150,000 in costs paid to a contractor for mailing out letters.

## GOAL # 6: ADMINISTRATION

### OBJECTIVE

TO ENSURE MEMBERS AND PROVIDERS HAVE ACCESS TO ASSISTANCE THROUGH MEMBER AND PROVIDER SERVICES.

### Output:

Number of Member and Provider Calls

*Estimate — >440,000*



### What's being measured?

OHCA Provider Services and Member Services along with the agency's fiscal agent (HP) all receive phone calls. HP is the first line of contact and answers questions regarding claims processing. Member Services researches and answers the more complex questions.

### Why is this important?

Tracking this measure is a way to illustrate to the taxpayers of Oklahoma that we are available to SoonerCare members and providers.

### What do the results mean?

There is no target set for the number of calls received, although the number of calls received has gone up from prior years.

Figure 70

Member & Provider Calls



Source: OHCA Call Tracking Integration System

### What's OHCA doing?

OHCA understands that it is very important to its providers and members to be able to speak to a representative concerning their issues. Therefore, people are dedicated to that service.

## ACRONYMS

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 advise OHCA on appropriate and optimal use of medications.
EDS	Electronic Data Systems Corporation	OHCA's contracted fiscal agent.
eNBI	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.
FOE	Focus on Excellence	New OHCA initiative to encourage excellence in nursing home care by reviewing and rating participating nursing homes on quality measures.



Acronym	Name	Description
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 provide technical assistance and training to states regarding program integrity efforts.
MMIS	Medicaid Management Information System	Electronic claims processing system for the Medicaid program.
MR	Mentally Retarded	Acronym used to denote a mental retardation diagnosis.
NCM	Nurse Care Manager	Nurses providing intervention services in the agency's Health Management Program.

## ACRONYMS

Acronym	Name	Description
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 administers 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.
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.

Acronym	Name	Description
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 from July to June.
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.

PERFORMANCE MEASURE TABLES



GOAL # 1: ELIGIBILITY

<i>Performance Measure</i>	<i>2005</i>	<i>2006</i>	<i>2007</i>
Outcome - % of Oklahomans Enrolled in Medicaid	19.50%	20.74%	21.1%
Output - Unduplicated Medicaid Enrollment - Total	696,743	742,152	763,565
Outcome - % of Enrollment Change (includes Insure Oklahoma)	3.9%	6.5%	2.9%
Input - Total State Cost	\$917,462,526	\$1,070,492,978	\$1,149,583,896
Input - Total Cost	\$2,863,476,393	\$3,154,002,105	\$3,420,671,434
Per Enrolled SoonerCare Member Total State Cost	\$1,317	\$1,444	\$1,511
Total Cost per Unduplicated SC Member Enrolled	\$4110	\$4,256	\$4,496

## PERFORMANCE MEASURE TABLES

TO PROVIDE AND IMPROVE HEALTH CARE ACCESS TO THE UNDERSERVED AND VULNERABLE POPULATIONS OF OKLAHOMA.

<i>2008</i>	<i>2009</i>	<i>2010</i>	<i>2011 (Est.)</i>	<i>2012 (Est.)</i>
21.91%	22.50%	23.78%	24.16%	24.53%
797,556	825,138	885,238	942,686	965,378
4.5%	3.5%	7.3%	6.5%	2.4%
\$1,202,166,762	\$1,320,170,252	\$1,475,896,355	\$1,523,864,268	\$1,569,464,268
\$3,804,179,520	\$4,029,610,149	\$4,340,777,980	\$4,429,901,242	\$4,476,588,348
\$1,534	\$1,658	\$1,752	\$1,679	\$1,687
\$4,854	\$5,060	\$5,154	\$4,880	\$4,812

## PERFORMANCE MEASURE TABLES



### GOAL # 2: QUALITY AND SATISFACTION

<i>Performance Measure</i>	<i>2005</i>	<i>2006</i>	<i>2007</i>
<i>Outcome - Ratio of Filed Appeals to Total Members</i>	<1/4 of 1%	<1/4 of 1%	<1/4 of 1%
<i>Output - # of Member Appeals Filed</i>	35	42	45
<i>Output - % of OHCA Decisions Overturned</i>	43%	10%	7%

#### *Customer Survey Results (CAHPS)\**

CHILD

<i>Outcome - Rating of Health Plan</i>	Not Available	65.5%	72.3%
<i>Outcome - Rating of Health Care</i>	Not Available	68.7%	74.2%
<i>Outcome - Rating of Personal Doctor</i>	Not Available	77.0%	75.1%
<i>Outcome - Rating of Specialist</i>	Not Available	72.8%	76.1%
<i>Outcome - Customer Service</i>	Not Available	82.6%	72.1%
<i>Outcome - Courteous / Helpful Office Staff</i>	Not Available	82.0%	89.2%
<i>Outcome - How Well Doctors Communicate</i>	Not Available	79.6%	88.7%
<i>Outcome - Getting Care Quickly</i>	Not Available	64.9%	74.8%
<i>Outcome - Getting Needed Care</i>	Not Available	80.1%	78.4%

#### *Choice Quality Scores*

<i>Quality Assessment</i>	1.00	1.00	1.00
<i>Enrollee Rights</i>	1.00	1.00	1.00
<i>Health Service Management</i>	0.99	0.99	1.00
<i>Delegation</i>	1.00	1.00	1.00
<i>Input - Total Cost of QISMC Reviews (OFMQ Contract)</i>	\$189,448	\$203,024	\$178,953
<i>Efficiency - QISMC / Cost per Capitated Member</i>	\$0.35	\$0.37	\$0.32

#### *Survey and*

##### *Certification*

<i>Input - Total Cost of Contract - Survey &amp; Certification</i>	\$5,282,549	\$5,551,738	\$6,291,593
<i>Output - # of Surveys Conducted thru S&amp;C Contract (LTC)</i>	710	770	785
<i>Efficiency - Cost Per LTC Facility Survey</i>	\$7,440	\$7,210	\$8,015

<i>% of Quality of Care Fee Collected</i>	100	100	100
<i>Output - # of Involuntary Contract Terminations**</i>	20	25	34



## PERFORMANCE MEASURE TABLES

TO PROTECT AND IMPROVE MEMBER HEALTH AND SATISFACTION, AS WELL AS  
ENSURE QUALITY WITH PROGRAMS, SERVICES, AND CARE.

2008	2009	2010	2011 (Est.)	2012 (Est.)
<1/4 of 1%	<1/4 of 1%	<1/4 of 1%	<1/4 of 1%	<1/4 of 1%
46	56	158	<220	<300
4%	7%	6%	<10%	<10%

ADULT	CHILD	ADULT	
62.1%	80.3%	64.3%	Not Available
60.6%	80.7%	61.6%	Not Available
65.1%	80.0%	71.8%	Not Available
68.8%	73.0%	74.9%	Not Available
78.1%	72.0%	78.2%	Not Available
83.1%	89.3%	Not Reported	Not Available
80.4%	82.3%	84.2%	Not Available
77.1%	74.0%	81.8%	Not Available
72.8%	79.8%	77.8%	Not Available

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
\$178,958	\$263,981	\$270,256	\$276,724	\$319,826
\$0.32	\$0.47	\$0.47	\$0.43	\$0.48

\$6,154,327	\$6,356,117	\$6,561,425	\$7,011,000	Not Available
719	685	755	Not Available	
\$8,560	\$9,279	\$8,691	Not Available	

100	100	100	100	100
22	36	47	<50	<50

PERFORMANCE MEASURE TABLES



GOAL # 3: MEMBER PERSONAL RESPONSIBILITY

<i>Performance Measure</i>	<i>2005</i>	<i>2006</i>	<i>2007</i>
<i>% of Children Accessing Well-Child Visits/EPSTD</i>			
<i>First 15 months</i>	95.2%	96.5%	96.8%
<i>3 to 6 years</i>	54.7%	56.7%	57.1%
<i>Adolescents</i>	25.9%	25.9%	28.6%
<i>Outcome - immunization rate</i>			
	75.7%	77.6%	78.5%
<i>Adults Health Care Use - Preventive / Ambulatory Care</i>			
<i>20 to 44 years</i>	72.0%	74.9%	75.6%
<i>45 to 64 years</i>	92.8%	84.2%	85.2%
<i>ER Visits per 1,000 Visits</i>			
<i>TANF</i>	70	70	70
<i>ABD</i>	48	47	48
<i>Total Population</i>	63	63	64
<i># of Members Identified for Intervention</i>			
	2,044	4,563	5,627
<i>Intervention Rate</i>			
	100%	95%	93%
<i>Contact Intervention</i>			
<i>Letter</i>	1,005	3,065	6,332
<i>Call / ER Education and Other Services</i>	1,015	1,509	2,950
<i>Call / Care Management Referral</i>	24	19	14
<i>Average # of Members in Pharmacy Lock-In</i>			
	369	212	199
<i>% of Members Seeking Prenatal Care</i>			
	92%	90%	93%
<i># of Births</i>			
	13,438	27,027	32,303
<i>% of Members Seeking Prenatal Care</i>			
<i>First trimester</i>	37%	56%	43%
<i>Second trimester</i>	21%	25%	35%
<i>Third trimester</i>	34%	10%	16%

## PERFORMANCE MEASURE TABLES

TO PROMOTE MEMBERS' PERSONAL RESPONSIBILITIES FOR THEIR HEALTH SERVICES UTILIZATION, BEHAVIORS, AND OUTCOMES.

2008	2009	2010	2011 (Est.)	2012 (Est.)
97.3%	97.4%		97.2% (Benchmark)	
60.0%	64.9%		69.7% (Benchmark)	
32.1%	40.1%		45.9% (Benchmark)	
71.7%	70.2%		90% (Target)	
78.4%	83.3%		79.8% (Benchmark)	
86.8%	89.7%		85.5% (Benchmark)	
72	70	51	Not Available	
50	51	45	Not Available	
66	64	49	Not Available	
5,666	4,206	4,651	Not Available	
88%	88%	91%	Not Available	
6,012	4,454	4,993	Not Available	
1,269	1,187	1,386	Not Available	
5	1	2	Not Available	
145	165	268	Not Available	
94%	97%	96%	90% (Target)	
32,438	33,228	33,669	Not Available	
44%	46%	54%	90% (Target)	
34%	36%	29%	Not Available	
16%	15%	13%	Not Available	

## PERFORMANCE MEASURE TABLES



### GOAL # 4: MEMBER BENEFITS

<i>Performance Measure</i>	<i>2005</i>	<i>2006</i>	<i>2007</i>
<i>Children's Health Care Use</i>			
<i>Children's Health Care Use - PCP (age 12-24 months)</i>	91.2%	94.3%	94.1%
<i>Children's Health Care Use - PCP (age 25 months to 6 years)</i>	78.0%	81.2%	81.4%
<i>Children's Health Care Use - PCP (age 7-11 years)</i>	81.2%	80.4%	80.8%
<i>See Adult Health Care Use under Goal #3</i>			
<i>See Appeals Data under Goal #2</i>			
<i>Output - # of Level of Care / Long Term Care Service Entry Reviews</i>	6,219	9,528	6,533
<i>See Well-Child Visits under Goal #3</i>			
<i>See Immunization Rate under Goal #3</i>			
<i>Comparative - Medical Inflation Per Year</i>	4.2%	4.0%	4.4%
<i>Oklahoma FMAP</i>	70.18%	67.91%	68.14%
<i>Region 6 FMAP</i>	70.24%	68.84%	68.94%
<i>Input - State Cost of Service</i>	\$899,943,763	\$1,047,960,756	\$1,126,464,001
<i>Input - Total Cost of Service</i>	\$2,807,288,146	\$3,090,006,199	\$3,353,270,704
<i>Total Program Cost Per Member Served - Oklahoma</i>	\$3,926	\$3,989	\$4,475
<i>Total Program Cost Per Member Served - National</i>	\$5,597	\$5,911	\$6,243

## PERFORMANCE MEASURE TABLES

TO ENSURE THAT PROGRAMS AND SERVICES RESPOND TO THE NEEDS OF MEMBERS BY PROVIDING NECESSARY MEDICAL BENEFITS TO OUR MEMBERS.

OKLAHOMANS ARE COUNTING ON US

<i>2008</i>	<i>2009</i>	<i>2010</i>	<i>2011 (Est.)</i>	<i>2012 (Est.)</i>
94.4%	96.2%	95% Benchmark		
83.2%	86.8%	87.2% Benchmark		
82.8%	76.7%	87.8% Benchmark		

7,383	8,428	16,156	Not Available	
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3.7%	3.2%	Not Available		
67.10%	75.16%	76.51%	71.90%	63.88%
69.25%	76.80%	78.48%	73.58%	64.85

\$1,168,419,841	\$1,280,359,455	\$ 1,427,661,579	\$1,467,524,935	\$1,509,524,935
\$3,716,348,098	\$3,925,074,970	\$4,225,100,857	\$4,293,519,414	\$4,331,491,923
\$4,735	\$4,648	\$4,937	\$4,654	\$4,928
\$6,593	\$6,963	Not Reported		

## PERFORMANCE MEASURE TABLES



### GOAL # 5: RESPONSIBLE FINANCING / PURCHASING

<i>Performance Measure</i>	<i>2005</i>	<i>2006</i>	<i>2007</i>
<i>Input - Cost of Physicians &amp; Other Providers</i>	\$343,365,122	\$467,799,496	\$526,971,220
<i>State Employed</i>	140%	140%	140%
<i>Non-State Employed</i>	89.23%	99.99%	99.99%

<i>Input - Cost of Hospital Services</i>	\$459,572,258	\$681,308,932	\$811,684,896
<i>Outcome - Hospital Reimbursement as % of "Costs"</i>	81%	80%	102.7%

<i>Input - Cost of Nursing Facilities &amp; ICF/MR</i>	\$496,768,830	\$486,701,460	\$544,216,963
<i>Outcome - Nursing Facility Rates as % of Cost<sub>1</sub></i>	93.8%	89.8%	95%
<i>Outcome - ICF/MR Rates as % of Cost<sub>1</sub></i>	99.9%	97.1%	101%

<i>Input - Cost of Managed Care</i>	\$71,222,507	\$77,057,536	\$87,227,985
<i>Input - Cost of Prescription Drugs</i>	\$475,606,181	\$404,270,572	\$300,169,210
<i>Input - Cost of Behavioral Health</i>	\$134,225,035	\$139,239,634	\$174,308,948
<i>Input - Cost of Medicare Buy-In</i>	\$81,269,288	\$96,692,889	\$107,753,230
<i>Input - Cost of Miscellaneous Medical Payments*</i>	\$9,576,685	\$18,078,588	\$22,675,493
<i>Input - Cost of Transportation (Non-Emergency)</i>	\$15,118,558	\$17,163,503	\$23,540,644



## PERFORMANCE MEASURE TABLES

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.

<i>2008</i>	<i>2009</i>	<i>2010</i>	<i>2011 (Est.)</i>	<i>2012 (Est.)</i>
\$584,390,421	\$646,348,284	\$844,813,899	\$730,726,108	\$909,842,737
140%	140%	140%	140%	140%
100%	100%	99.19%	100%	100%

\$835,440,046	\$862,201,042	\$927,614,585	\$945,599,886	\$1,122,711,410
102.5%	99.66%	101%	100%	100%

\$572,973,234	\$574,114,181	\$570,884,055	\$547,572,073	\$582,551,513
95.3%	95.5%	100% (Est.)	100%	100%
100.5%	101.5%	100% (Est.)	100%	100%

\$87,589,424	\$62,648,734	\$27,785,057	\$31,086,445	\$31,538,651
\$328,235,221	\$354,345,573	\$385,009,486	\$379,170,698	\$409,113,146
\$214,774,404	\$250,108,828	\$283,735,431	\$291,173,372	\$323,152,041
\$113,272,212	\$112,946,069	\$121,134,542	\$136,566,184	\$147,330,685
\$24,985,971	\$28,489,622	\$28,362,108	\$30,009,791	\$36,329,989
\$25,038,123	\$24,822,866	\$26,171,149	\$27,470,618	\$28,758,644

## PERFORMANCE MEASURE TABLES

### GOAL # 6: ADMINISTRATION



<i>Performance Measure</i>	<i>2005</i>	<i>2006</i>	<i>2007</i>
Outcome - % of Time Adm. Expenses Stay Within Budget	100%	100%	100%

State Cost of Administration	\$17,518,763	\$22,532,222	\$23,119,895
Total Cost of Administration	\$56,188,247	\$63,995,906	\$67,400,730
Per Member Enrolled - State Cost of Administration	\$28.08	\$30.40	\$30.39
Per Enrolled Member - Total Cost of Administration	\$80.64	\$86.35	\$88.60

Total Claims Processed	29,251,991	29,878,186	30,255,290
Total Claims Paid	22,678,837	23,621,535	23,332,124

Payment Accuracy Rate**	94%	93%	91%
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Financial Statement Completeness*	100%	100%	100%
<i>Payment Integrity Recoveries</i>	\$7,374,259	\$8,969,963	\$9,261,371
<i>Third Party Liability Recoveries</i>	\$8,488,397	\$14,135,694	\$12,517,646
<i>Drug Rebate Collections as % of Pharmacy Exp</i>	21%	35%	25%
Provider Training			
<i>Group Training-Seminars/Workshops/Bi-Annual</i>	NA	155	100
<i>Group Training-Attendees</i>	NA	7,282	7,215
<i>Individual - On-Site Trainings</i>	NA	4,684	5,112
<i>Written Communications-# of Providers Receiving</i>	NA	525,092	1,647,384

## PERFORMANCE MEASURE TABLES

TO FOSTER EXCELLENCE IN THE DESIGN AND ADMINISTRATION OF THE  
SOONERCARE PROGRAM.

OKLAHOMANS ARE COUNTING ON US

<i>2008</i>	<i>2009</i>	<i>2010</i>	<i>2011 (Est.)</i>	<i>2012 (Est.)</i>
100%	100%	100%	100%	100%

\$33,746,921	\$39,810,797	\$48,234,776	\$56,339,333	\$59,939,333
\$87,831,422	\$104,535,179	\$115,677,123	\$136,381,828	\$145,096,425
\$43.06	\$49.99	\$57.27	\$62.07	\$64.42
\$112.07	\$131.25	\$137.34	\$150.25	\$155.95

32,696,348	36,706,138	39,838,306	>43,000,000	>43,000,000
25,309,251	28,428,254	31,691,202	>45,000,000	>45,000,000

99%	99%	99%	>97%	>97%
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100%	100%	100%	100%	100%
\$6,394,754	\$3,988,042	\$17,614,428	\$4,500,000	\$4,500,000
\$13,068,272	\$24,910,078	\$41,521,418	\$35,000,000	\$35,000,000
22%	26.8%	29%	30%	30%

85	149	185	NA	NA
8,590	9,584	11,739	NA	NA
3,961	4,172	4,043	NA	NA
1,745,865	1,740,949	1,327,145	NA	NA