Final Report

Medicaid Reform Task Force

Oklahoma House of Representatives

Submitted February 3, 2006

Medicaid Task Force Members

Representative Kris Steele
Chairman

Representative Doug Cox, M.D.
Vice-Chairman

Representative John Auffet
Representative Thad Balkman
Representative Lee Denney
Representative Pam Peterson
Representative R.C. Pruett
Representative Dan Sullivan

Advisory Board Members

Pat Anderson, Oklahoma Hospital Association
Calvin Anthony, Tiger Drug Company
James Cash, M.D.
Tom Coble, Oklahoma Association of Health Care Providers
Nico Gomez, Oklahoma Health Care Authority
David Hadley, M.D.
Bruce Lawerence, Integris Baptist and Southwest Medical Center
Marc Marion, C.L. Frates and Company
Barry Smith, J.D.

Staff

Marcia Goff, Committee Staff-Research
Winston Barton, Committee Staff-Research
Mark Newman, Fiscal Staff
Sarah Brune, Committee Staff-Legal
Grace Shelton, Committee Staff-Legal

This publication, printed by the House Duplicating Shop, is issued by the Oklahoma House of Representatives. One hundred fifty (150) copies have been prepared and distributed at a cost of $4.50 each to the taxpayers of Oklahoma. Reference copies have been deposited with the Publications Clearinghouse of the Oklahoma Department of Libraries.

Introduction and Background

Medicaid–a partnership between the federal government and the states–was created by the Social Security Act in 1965 initially to provide medical benefits to welfare recipients. Over the years the program has evolved into a public health insurance program for low-income children and certain low-income adults and is the primary payment source for long-term care services for the elderly and individuals with disabilities.

In July 2005, the Speaker of House, Todd Hiett, announced the establishment of a Medicaid Reform Task Force. The purpose of the task force was to study the current structure and administration of the Oklahoma Medicaid program to identify areas of possible improvement and reform and to make recommendations to the House on changes that would make the program not only more efficient, but more effective at serving those most in need of assistance in obtaining quality health care.

The Speaker's appointment of the task force was in response to the growth of the Medicaid program in Oklahoma. According to the Oklahoma Health Care Authority (OHCA), there has been a 52% increase in the number of individuals eligible for the program since State Fiscal Year (SFY)1995. However, it is estimated that the state's population only grew by 8.6% from 1995 to 2005 (Source: House GIS Office). In SFY 1995, total expenditures for the program were approximately $1.1 billion; in SFY 2005, expenditures reached $2.8 billion. A chart detailing expenditures and revenue for the program, by year, is found below.

Oklahoma Medicaid Expenditures and Revenue Sources, 1995-2005

State Fiscal Year*	Total Expenditures	Federal Share	Other Revenue**	State Share - OHCA	State Share - Other Agencies
1995	$1,054,871,918	$738,937,779		$315,934,139	
1996	$1,021,231,344	$713,738,586		$307,492,758	
1997	$1,207,875,885	$869,474,048	$32,220,702	$250,131,050	$56,050,085
1998	$1,328,847,600	$917,107,356	$35,692,842	$308,012,119	$68,035,283
1999	$1,487,064,240	$1,021,093,307	$42,768,741	$335,408,642	$87,793,550
2000	$1,639,609,396	$1,147,484,713	$56,170,892	$328,705,610	$107,248,181
2001	$2,002,335,338	$1,416,570,113	$90,213,424	$358,174,870	$137,376,931
2002	$2,372,098,884	$1,649,376,278	$119,799,311	$445,842,697	$157,080,598
2003	$2,384,136,980	$1,669,197,685	$136,781,999	$388,181,072	$189,976,224
2004	$2,642,481,484	$1,897,667,825	$166,596,539	$408,889,974	$169,327,146
2005	$2,805,599,500	$1,920,731,328	$183,584,054	$492,641,139	$208,642,979

* 1995 through 1996 figures are based on federal fiscal year (October through September), 1997 through 2005 figures are based on state fiscal year (July through June)

** Drug rebate program, tobacco tax, etc.

Source: Oklahoma Health Care Authority

Of additional concern is the fact that the OHCA is steadily consuming a greater share of state appropriations. In SFY 2006, OHCA represented the third largest agency–behind common education and higher education–in terms of percent of state appropriations received (10.5%). In SFY 1996, OHCA's appropriation represented 7.2% of the total appropriations.

The Kaiser Commission on Medicaid and the Uninsured, in a summary of findings from its publication *Medicaid Budgets, Spending and Policy Initiatives in State Fiscal Years 2005 and 2006*, concludes that:

> "...Medicaid officials expressed more optimism than in past years about the future of Medicaid, but remain concerned about the long-term fiscal sustainability of the program due to continuing health care cost growth, demographic trends, and the erosion of private health insurance."

In order to make their study of the Medicaid program manageable, members of the task force examined the current program by dividing it up into six general categories:

Disease management
Emergency room utilization/Primary-preventive care
Patient empowerment
Provider reimbursement
Long-term care
Prescription drugs

In addition to the 13 task force meetings held at the State Capitol, the chairman of the task force, Representative Kris Steele, and vice-chairman, Representative Doug Cox, M.D., along with other task force members undertook a statewide fact-finding tour. They met with physicians, hospital administrators, other health care providers, Department of Human Services workers and Medicaid recipients. Communities included in the tour were:

Ada
Ardmore
Bartlesville
Chickasha
Duncan
Enid
Lawton
McAlester
Miami
Muskogee
Oklahoma City
Ponca City
Shawnee
Stillwater
Tulsa

Finally, the task force adopted a set of guiding principles for decision-making:

- Patient empowerment/patient driven care/choice
- Personal responsibility
- Incentives to carefully use health care resources, with an emphasis on primary care
- Fair compensation for providers
- Efficient, effective administration
- Effective use of technology
- Improved patient outcomes
- Effective communication
- Efficient use of resources

General Findings of the Task Force

- Medicaid expenditures have more than doubled in the last seven years and the current structure is going to continue to drain state resources;
- The existing Medicaid program is a bureaucracy-centered system;
- The current Medicaid structure is a one-size-fits-all system;
- Medicaid meets a fundamental need in society; however, given the potential for uncontrolled growth of the program in the future, elected officials will need to be especially prudent when devoting taxpayer dollars to the program;
- There are too few deterrents for improper utilization of the healthcare system by Medicaid recipients and too few incentives for proper utilization, including use of the emergency room;
- Comprehensive disease management programs have been shown to hold down long-term costs in the program and improve outcomes for patients;
- Improvements in program oversight and accountability can be made in the management, eligibility and verification processes;
- The current system lacks an educational component that teaches recipients how to properly and responsibly utilize the health care system;
- There exists an opportunity to make better use of technology in the Medicaid program, for example, electronic medical records and e-prescribing;
- There is a critical lack of health care providers in certain areas of the state;
- Overall, provider rates are insufficient to attract physicians to the Medicaid program;
- Current accountability measures are inadequate to ensure that health care providers who agree to be Medicaid providers actually see their Medicaid patients;
- With regard to long-term care, there has been insufficient focus on developing a continuum of services for the aging population that ranges from home-based care to quality care in nursing facilities;

- The current system contains loopholes that allow individuals to move assets around in order to qualify for Medicaid long-term care.

Task Force Recommendations

Recommendation 1: Patient Empowerment

Adopt a patient empowerment reform model, which will introduce competition and consumer choice into the Medicaid program. The new program will be phased in within an appropriate period of time and will move us to a patient-centered system. Recipients will be able to select a benefit package that best meets their needs. Components of the existing state Medicaid program will provide a safety net for those who are otherwise uninsurable. In addition, program participants will be able to opt out of Medicaid and use their state allocated Medicaid "premium" to participate in an employer-sponsored health care plan.

Recommendation 2: Health Savings Accounts

Include in the reform effort the establishment of health savings accounts for program participants. Money in the account would be used to defray health care related costs and pay for certain wellness activities.

Recommendation 3: Electronic Medical Records/E-Prescribing

To help improve the quality of care for patients and reduce inefficiencies in the system, require the Oklahoma Health Care Authority to design a implement a database of clinical utilization information or electronic medical records and a program of electronic prescribing for Medicaid providers.

Recommendation 4: Disease Management

To improve the quality of care for Medicaid recipients and allow the state to better manage the cost of care, develop a comprehensive disease management program.

Recommendation 5: Purchasing Pools

Form cooperative purchasing pools to negotiate better pricing for supplies and services.

Recommendation 6: Emergency Room Utilization

Develop a program that will encourage the timely and appropriate use of primary care services in lieu of emergency room utilization through the implementation of educational strategies, technology-based monitoring, increased use of primary care clinics and health centers and co-payments.

Recommendation 7: Tiered Reimbursement for Nursing Facilities

To incentivize and reward high quality care, develop a graduated Medicaid reimbursement rate plan for nursing facilities.

Recommendation 8: Long-Term Care Medicaid Lookback Period

The asset lookback period for determining long-term care Medicaid eligibility should be increased from three to five years.

Recommendation 9: Planning for Future Long-Term Care Needs

Develop a plan for the implementation of a continuum of care–ranging from community-based options to quality nursing facility care–to meet the long-term care needs of the aging baby boom generation. Reform the state's tax structure and provide incentives for Oklahomans to plan their long-term care needs, including purchasing long-term care insurance.

Recommendation 10: Accountability Measures

Establish a method to deter abuse and reduce errors in Medicaid billing, payment and eligibility through the use of technology and accountability measures for the Health Care Authority, providers and recipients.

Recommendation 11 *(as amended)*: Phase Out Medicaid Benefits

Develop a system in which Medicaid benefits are phased out in accordance with income to avoid the "cliff effect."

Recommendation 12: Funding

Provide a stable source of state revenue that can be matched with federal funds in order to ensure adequate compensation for providers, provide additional support to rural and other financially vulnerable medical facilities and finance the necessary reforms of the Medicaid system.

Recommendation 13: Extend Medicaid Benefits to Certain Persons

Extend Medicaid benefits to age 23 if recipient is a full-time student.

Recommendation 14 *(as amended)*: Preventive Wellness Programs for Children

Implement a pilot pediatric weight management and physical activity program for children on Medicaid.

INDEX TO APPENDICES:

Appendix A

House of Representatives

STATE OF OKLAHOMA

August 1, 2005

TO: Members of the House Medicaid Reform Task Force and Advisory Board Members

DATE: Wednesday, August 10, 2005

TIME: 9:00 a.m. - 12:00 p.m.

PLACE: Room 432A, State Capitol Building

AGENDA:

1. Call to Order
2. Welcome and Introductions - Chairman Steele
3. Presentation by Representatives of the Oklahoma Healthcare Authority Regarding the Agency's Programs and Activities with Regard to:
   - A. Patient Empowerment-Increased Access for the Working Poor
   - B. Chronic Disease Management Programs
   - C. Primary-Prevention Care
4. Questions and Discussion - Task Force and Advisory Board Members
5. Other Business
6. Adjournment

House of Representatives

STATE OF OKLAHOMA

August 15, 2005

TO: Members of the House Medicaid Reform Task Force and Advisory Board Members

DATE: Wednesday, August 24, 2005

TIME: 9:00 a.m. - 12:00 p.m.

PLACE: Room 432A, State Capitol Building

AGENDA:

1. Call to Order
2. Welcome and Introductions - Chairman Steele
3. Presentation by Representatives of the Oklahoma Health Care Authority Regarding the Agency's Programs and Activities with Regard to:
   - A. Long-term care and alternatives to institutional care (presentation in conjunction with Department of Human Services)
   - B. Prescription drugs
   - C. Provider reimbursement
4. Questions and Discussion - Task Force and Advisory Board Members
5. Other Business
6. Adjournment

House of Representatives

STATE OF OKLAHOMA

August 29 2005

TO: Members of the House Medicaid Reform Task Force and Advisory Board Members

DATE: Wednesday, September 7, 2005

TIME: 9:00 a.m. - 1:00 p.m.

PLACE: Room 432A, State Capitol Building

AGENDA:

1. Call to Order
2. Welcome and Introductions - Chairman Steele
3. Presentations by:
   - A. Ron Lindsey, former Director of the Texas Human Services Commission
     - Managing Disease and Risk through Competition
   - B. Christie Raniszewski Herrera, American Legislative Exchange Council
     - Florida Medicaid Reform (SB838)
     - South Carolina Medicaid Waiver
4. Questions and Discussion - Task Force and Advisory Board Members
5. Other Business
6. Adjournment

Chair: Representative Kris Steele
Vice-Chair: Representative Doug Cox

Members: Representative Dan Sullivan
Representative John Auffet
Representative Thad Balkman
Representative Lee Denney
Representative Pam Peterson
Representative R.C. Pruett

House of Representatives

STATE OF OKLAHOMA

REVISED

September 13, 2005

TO: House Medicaid Reform Task Force Members and Advisory Board

DATE: Wednesday, September 21, 2005

TIME: 9:00 a.m. - 12:00 p.m.

PLACE: Room 432A, State Capitol Building

AGENDA:

1. Call to order
2. Presentation: Medicaid Strategies for Improving Health Outcomes While Reducing Utilization - Pam Fromelt, Vice President for Government Relations, Lifemasters
3. Establish guiding principles - Task Force Members
4. Other Business
5. Adjournment

Chair: Representative Kris Steele
Vice Chair: Representative Doug Cox

Members: Representative Dan Sullivan
Representative John Auffet
Representative Thad Balkman
Representative Lee Denney
Representative Pam Peterson
Representative R.C. Pruett

Q:\meetings\medicaidtf-mtg
MG\tdk

House of Representatives

STATE OF OKLAHOMA

REVISED

October 4, 2005

TO: House Medicaid Reform Task Force Members and Advisory Board

DATE: Wednesday, October 5, 2005

TIME: 9:00 a.m. - 12:00 p.m.

PLACE: Room 432A, State Capitol Building

AGENDA:

1. Call to order
2. Presentation: Jerry Appleby, Executive Director, Reaching Our City (A faith-based free clinic)
3. Presentation: Dr. John Crouch, In His Image Family Practice
4. Presentation: Jim Greene, CEO, MedEncentive (For information on MedEncentive visit: www.saxumcommunications.com/medencentive/summer05.htm)
5. Discussion regarding emergency department utilization versus primary-preventive care and begin to formulate solutions - Task Force Members and Advisory Board Members
6. Other Business
7. Adjournment

Chair: Representative Kris Steele
Vice Chair: Representative Doug Cox

Members: Representative Dan Sullivan
Representative John Auffet
Representative Thad Balkman
Representative Lee Denney
Representative Pam Peterson
Representative R.C. Pruett

Q:\meetings\medicaidtf-mtg
MG\tdk

House of Representatives

STATE OF OKLAHOMA

REVISED

October 12, 2005

TO: House Medicaid Reform Task Force Members and Advisory Board

DATE: Wednesday, October 19, 2005

TIME: 9:00 a.m. - 12:00 p.m.

PLACE: Room 432A, State Capitol Building

AGENDA:

1. Call to order
2. Response to request for information by advisory board member Barry Smith - Representatives of the Health Care Authority and State Health Department
3. Presentation by a representative of the Health Care Authority regarding contract with EDS
4. Continued discussion regarding emergency department utilization versus primary-preventive care and possible solutions - Task Force and Advisory Board members
5. Discussion regarding Florida's Medicaid Waiver Application - Task Force and Advisory Board members (materials mailed prior to last meeting)
6. Other Business
7. Adjournment

Chair: Representative Kris Steele
Vice Chair: Representative Doug Cox

Members: Representative Dan Sullivan
Representative John Auffet
Representative Thad Balkman
Representative Lee Denney
Representative Pam Peterson
Representative R.C. Pruett

Q:\meetings\medicaidtf-mtg
MG\tdk

House of Representatives

STATE OF OKLAHOMA

October 24, 2005

TO: House Medicaid Reform Task Force Members and Advisory Board

DATE: Wednesday, November 2, 2005

TIME: 9:00 a.m. - 12:00 p.m.

PLACE: Room 432A, State Capitol Building

AGENDA:

1. Call to order
2. Presentation regarding results of a study of long-term care services in Oklahoma - Representative of the National Academy for State Health Policy
3. Advisory Board member presentations and discussion
4. Other Business
5. Adjournment

Chair: Representative Kris Steele
Vice Chair: Representative Doug Cox

Members: Representative Dan Sullivan
Representative John Auffet
Representative Thad Balkman
Representative Lee Denney
Representative Pam Peterson
Representative R.C. Pruett

Q:\meetings\medicaidtf-mtg
MG\tdk-nl

House of Representatives

STATE OF OKLAHOMA

REVISED

November 8, 2005

TO: House Medicaid Reform Task Force Members and Advisory Board

DATE: Wednesday, November 16, 2005

TIME: 9:00 a.m. - 12:00 p.m.

PLACE: Room 432A, State Capitol Building

AGENDA:

1. Call to order
2. Presentation regarding the Indiana Chronic Disease Management Program – Melanie Bella, Vice-President for Policy, Center for Health Care Strategies
3. Presentation regarding the Asheville, N.C. disease management program – John Miall, consultant, American Pharmacists Association
4. Presentation regarding Department of Mental Health and Substance Abuse Services – Dr. Terry Cline and Terri White
5. Private Providers of Behavioral Health Services Perspective – Mary Maple, Counseling Center of SE Oklahoma; Milton Evans, SE Oklahoma Family Services, Inc.
6. Other Business
7. Adjournment

Chair: Representative Kris Steele
Vice Chair: Representative Doug Cox

Members: Representative Dan Sullivan
Representative John Auffet
Representative Thad Balkman
Representative Lee Denney
Representative Pam Peterson
Representative R.C. Pruett

Q:\meetings\medicaidtf-mtg
MG\tdk-nl

House of Representatives

STATE OF OKLAHOMA

November 28, 2005

TO: House Medicaid Reform Task Force Members and Advisory Board

DATE: Wednesday, December 7, 2005

TIME: 9:00 a.m. - 12:00 p.m.

PLACE: Room 432A, State Capitol Building

AGENDA:

1. Call to order
2. Presentation by Dana Davis, Executive Director of the Oklahoma Dental Association
3. Presentation by Lisa LaTray, Oklahoma Network of Community Options and Resources
4. Advisory Board member presentations and discussion
5. Presentation by Dr. Bill Jackson, Pediatric Cardiologist
6. Other Business and Adjournment

Chair: Representative Kris Steele
Vice Chair: Representative Doug Cox

Members: Representative Dan Sullivan
Representative John Auffet
Representative Thad Balkman
Representative Lee Denney
Representative Pam Peterson
Representative R.C. Pruett

Q:\meetings\medicaidtf-mtg
MG:tdk

House of Representatives

STATE OF OKLAHOMA

December 16, 2005

TO: House Medicaid Reform Task Force Members and Advisory Board

DATE: Wednesday, January 4, 2006

TIME: 9:00 a.m. - 1:00 p.m.

PLACE: Room 432A, State Capitol Building

AGENDA:

1. Call to order
2. Presentations by:
   - A. Phil Woodward and Lonny Wilson, Oklahoma Pharmacists Association
   - B. Karl Nigg, CEO, Doctor on Call
   - C. Tom Coble, Oklahoma Association of Healthcare Providers
   - D. Scott Pilgrim, White House Conference on Aging
   - E. Dr. Bill Jackson, Pediatric Cardiologist
   - F. Jim Best, CEO and Dr. John Harvey, Chief Medical Officer, Oklahoma Heart Hospital
3. Other Business and Adjournment

Chair: Representative Kris Steele
Vice Chair: Representative Doug Cox

Members: Representative Dan Sullivan
Representative John Auffet
Representative Thad Balkman
Representative Lee Denney
Representative Pam Peterson
Representative R.C. Pruett

Q:\meetings\medicaidtf-mtg
MG:tdk

House of Representatives

STATE OF OKLAHOMA

January 6, 2006

TO: House Medicaid Reform Task Force Members and Advisory Board

DATE: Tuesday, January 17, 2006

TIME: 1:00 - 3:00 p.m.

PLACE: Room 412C, State Capitol Building

AGENDA:

1. Call to order
2. Discussion regarding financing of the Oklahoma Medicaid Program Task Force and Advisory Board Members
3. Other Business and Adjournment

MEETING NOTICE

Chair: Representative Kris Steele
Vice Chair: Representative Doug Cox

Members: Representative Dan Sullivan
Representative John Auffet
Representative Thad Balkman
Representative Lee Denney
Representative Pam Peterson
Representative R.C. Pruett

Q:\meetings\medicaidtf1-17-mtg
MG:tdk

House of Representatives

STATE OF OKLAHOMA

January 17, 2006

TO: House Medicaid Reform Task Force Members and Advisory Board

DATE: Wednesday, January 25, 2006

TIME: 1:30 - 3:30 p.m.

PLACE: Room 412C, State Capitol Building

AGENDA:

1. Call to order
2. Discussion regarding final recommendations of the Task Force - Task Force and Advisory Board members
3. Vote on final recommendations - Task Force members
4. Other Business and Adjournment

Chair: Representative Kris Steele
Vice Chair: Representative Doug Cox

Members: Representative Dan Sullivan
Representative John Auffet
Representative Thad Balkman
Representative Lee Denney
Representative Pam Peterson
Representative R.C. Pruett

Q:\meetings\medicaidtf1-25-mtg
MG:tdk

House of Representatives

STATE OF OKLAHOMA

January 24, 2006

TO: House Medicaid Reform Task Force Members and Advisory Board

DATE: Wednesday, February 1, 2006

TIME: 9:00 - 11:00 a.m.

PLACE: Room 432A, State Capitol Building

AGENDA:

1. Call to order
2. Discussion and vote on final recommendations - Task Force members
3. Other Business and Adjournment

Chair: Representative Kris Steele
Vice Chair: Representative Doug Cox

Members: Representative Dan Sullivan
Representative John Auffet
Representative Thad Balkman
Representative Lee Denney
Representative Pam Peterson
Representative R.C. Pruett

Q:\meetings\medicaidtf2-1-mtg
MG:tdk

Appendix B

Medicaid Fact Finding Tours

Summary of Comments

Medical Providers

Assigned primary care physician often lives in a different town than the patient;

Patients often encounter delays in getting an appointment with their physician;

Some physicians don't see the patients in their panels even though they are being paid to do so;

Medicaid clients over-utilize the emergency room;

ER physicians act as primary care providers for recipients;

Need to provide incentives for physicians to offer after-hours, nonemergency care for Medicaid clients;

Transportation to medical appointments is problematic for recipients, and many don't understand or know about the SoonerRide program;

Serious lack of specialists who accept Medicaid;

Medicaid patients are very often complex and difficult cases;

Should require mandatory education programs for Medicaid recipients regarding proper utilization of the health care system, recognizing true emergencies, etc.;

Impose premiums and co-pays on recipients to help reduce abuse of the system, particularly the ER;

Should require more personal responsibility on the part of recipients;

Need to establish a gatekeeping system for patients who come to the ER for nonemergency treatment;

Don't cut eligibility guidelines–doing so will harm hospitals;

Cut the program. Limit benefits to the most needy groups; then you could increase provider rates and adequately meet recipients' needs;

Medi*care* reimbursement is inadequate; don't measure adequacy of Medic*aid* reimbursement levels by comparing them to Medicare;

Need to enact the provider tax.

DHS Workers

May be certifying applicants who are not in the country legally;

Lack of transportation in rural areas is a barrier to accessing medical care;

Social services aren't very good at transitioning people off of Medicaid;

Lack of employers who offer affordable health insurance;

Quit expanding services at the expense of those who are truly needy;

Clients view the SoonerCare program as their "insurance." They don't think of it as a government program.

Need to increase the income guidelines for determining eligibility for Medicaid long-term care–it should be increased to better reflect the monthly cost of care;

Eliminate the ability of individuals to hide or transfer assets in order to qualify for Medicaid long-term care;

Concerned that requiring co-pays for services will result in children not getting the care they need.

Medicaid Recipients

Experience problems getting an appointment with their physician;

Experience problems with auto assignment–reassigned to a different physician without their knowledge;

Problems with the limited hours of certain services (i.e physical therapy) that are reimbursable. Need to have a maintenance level of service;

Lack of physician specialists;

Need education on what programs and services are available and on what Medicaid covers;

An educational program would be helpful after being certified. It would help supplement the information packet sent out by the Health Care Authority;

Have to turn down raises so they don't lose Medicaid eligibility.

Appendix C

Medicaid Task Force –
Topic: Primary Preventive Care

Overview for August 10, 2005

PRIMARY CARE SERVICES
Overview

Access to primary health care services encompasses multiple factors:

- Health care is available to beneficiaries
- Beneficiaries know how to access services
- Beneficiaries appropriately access services

PRIMARY CARE SERVICES
Overview

Primary care services are provided by all SoonerCare providers/clinics and certain specialty Fee-For-Service (FFS) practitioners. The provider types and specialties include:

Provider types:

- Physician
- PA-C
- Nurse Midwives
- Certified Nurse Practitioner

Provider specialties:

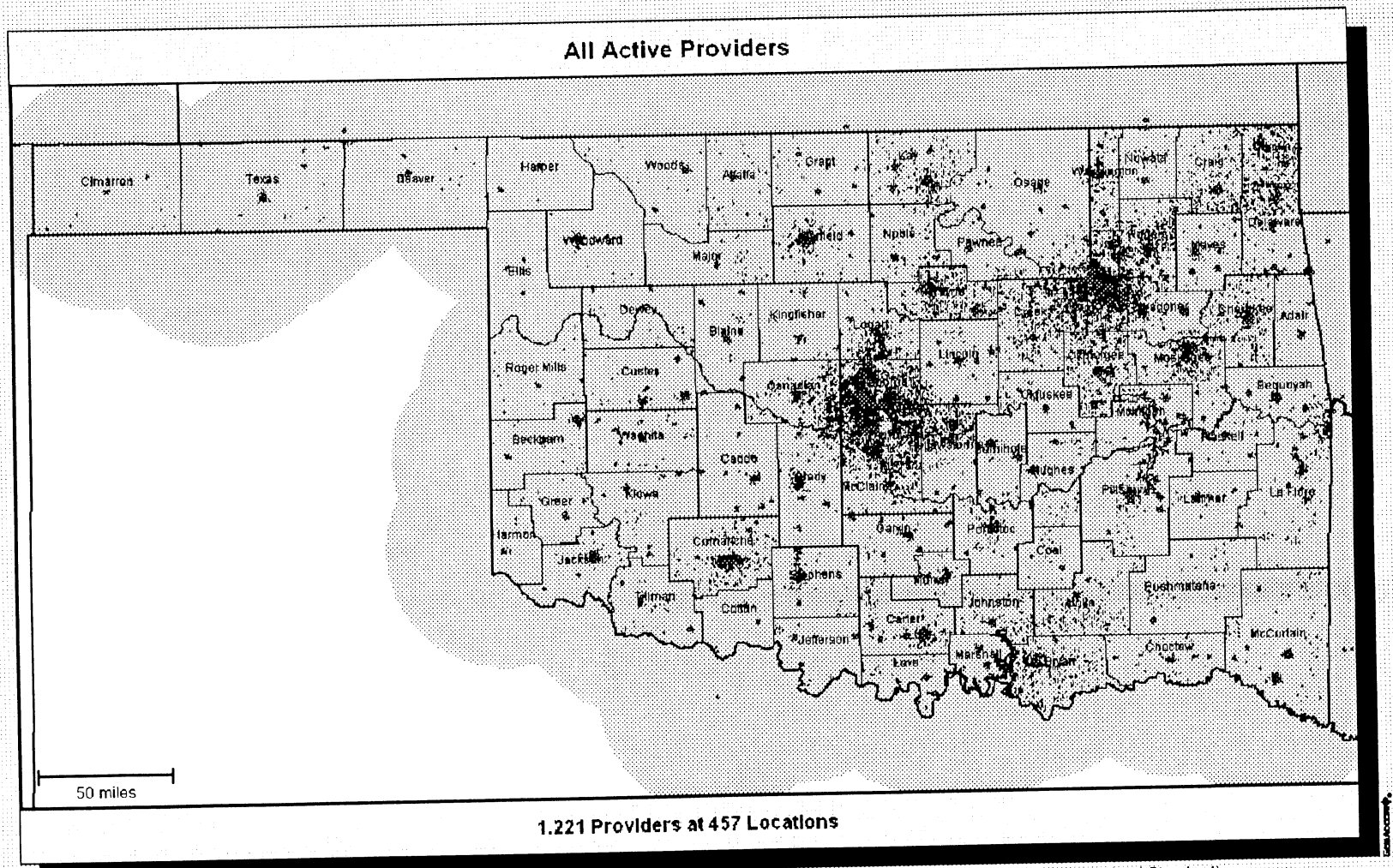
- Pediatrics
- Family practice
- Internal medicine
- OB-GYN
- General practitioners

PRIMARY CARE SERVICES
Overview

SoonerCare staff has the following mechanism in place to monitor and address enrollee access to the assigned provider:

- Routine assessment of the distance between each SoonerCare enrollee and the assigned provider. Although the federal standard is for each enrollee to reside within 45 miles of the assigned provider, the state goal is within 25 miles.

SOONERCARE PROVIDER LOCATIONS



Single Provider Locations (233)

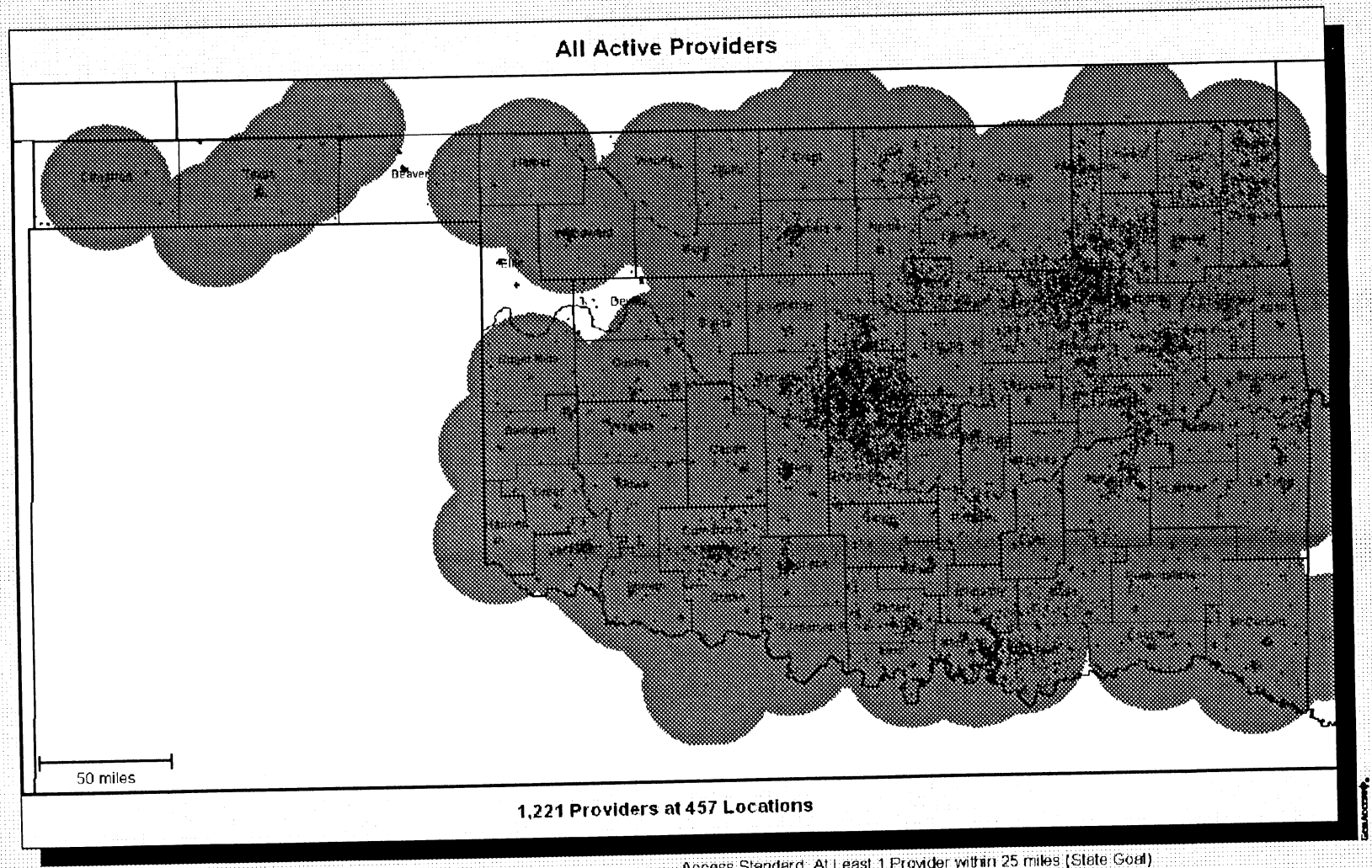
Multiple Provider Locations (224)

Access Standard: At Least 1 Provider within 45 miles (Federal Standard)

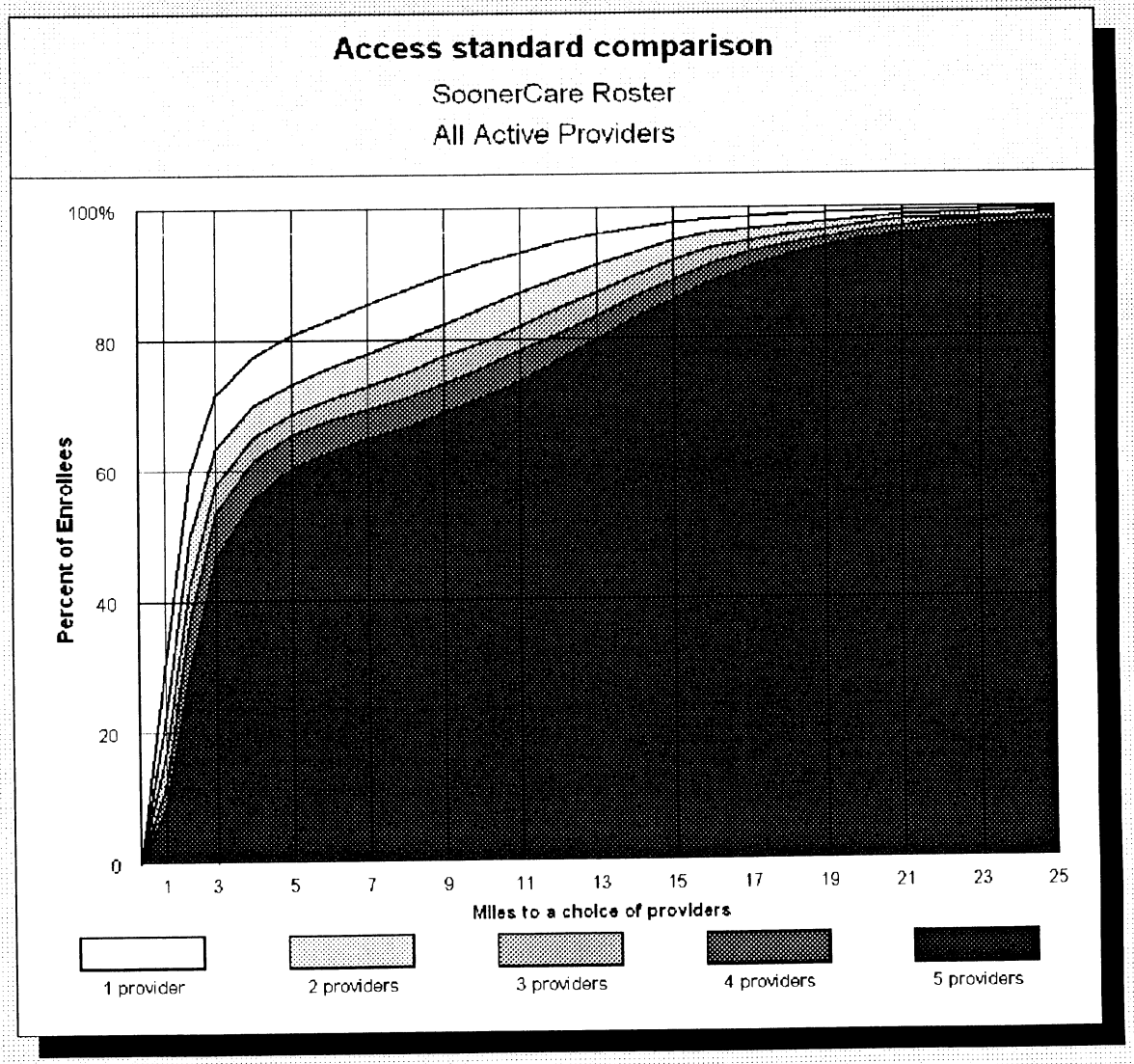
Service area: Oklahoma

45 mile radius

SOONERCARE PROVIDER LOCATIONS



ACCESS STANDARD COMPARISON



Average distance to a choice of providers

Number of providers	Miles
1	3.2
2	4.4
3	5.2
4	5.9
5	6.9

PRIMARY CARE SERVICES
Overview

SoonerCare staff also monitors access and utilization through the following mechanisms:

- On-site audits of *SoonerCare* providers
- Daily monitoring of reports such as dire medical, enrollee complaints, and Nurse Advice Line
- Monitoring of provider education activities
- Annual performance monitoring (e.g., HEDIS, CAHPS)

PRIMARY CARE SERVICES
Overview

SoonerCare staff conducts the following enrollee outreach activities:

- New member packet which includes information about the Help Line, Nurse Advice Line, and transportation
- Calls to new enrollees and at 90 days after date of enrollment to provide:
  a. education related to services available including the Help Line, Nurse Advice Line, and transportation services
  b. assistance with any other issues identified

PRIMARY CARE: Services Provided, Populations Served and Costs

For consistency of reporting, all utilization and cost data that follows was calculated using the amount ***paid*** **by OHCA** in SFY 2005 for services ***utilized*** in SFY 2005. This caused a slight variance to actual services provided and associated costs due to claim lag.

PRIMARY CARE: Services Provided, Populations Served and Costs

Services provided in the primary care office setting

Program Payments	Average Number of Beneficiaries per Month SFY 2005	Average monthly cost of services provided in the primary care office SFY 2005	Average Cost per member per month for Primary Care Services SFY 2005
SoonerCare Capitation	531,709	$5,793,961	$14.26
Fee-For-Service		$1,789,009	

PRIMARY CARE ACCESS
Outcomes

HEDIS® Measurement (OHCA paid claims and encounter data)	*SoonerCare**				Nat'l. Medicaid Average	Natl. Commercial Average
Measure	2001 Data	2002 Data	**2003 Data**	2004 Data	**2003****	2003**
Children's access to PCP						
12-24 months	88%	90%	**91%**	91%	**87%**	96%
25 months - 6 yrs	74%	77%	**79%**	78%	**76%**	87%
7-11 yrs	77%	79%	**79%**	77%	**77%**	87%
12-19 yrs (New category for 2003)	N/A	N/A	**77%**	77%	**N/A**	N/A
Adult Access to Prev./Amb. Health Services	2001 Data	2002 Data	**2003 Data**	2004 Data	**2003****	2003**
20-44 yrs	68%	69%	**70%**	72%	**75%**	92%
45-64 yrs	80%	82%	**81%**	82%	**82%**	94%

* *SoonerCare* Choice 2001- 2003; *SoonerCare* 2004

** Most recent average available

PRIMARY CARE ACCESS
Outcomes

To evaluate people's experiences in getting needed care, the following areas are evaluated as part of the CAHPS survey:

- How much of a problem it was to get a provider the respondent was happy with.
- How much of a problem it was to see a needed specialist.
- How much of a problem it was to get the care that the doctor believed necessary.
- How much of a problem were delays in health care while awaiting approval.

PRIMARY CARE ACCESS
Outcomes

CAHPS® Survey Results*	*SoonerCare***	National Medicaid Average	*SoonerCare***	National Medicaid Average
Specific survey composite (each of these composites includes 4 questions to calculate rate)	**2003 Adult Survey**	**2003 Adult Survey**	**2004 Child Survey**	**2004 Child Survey**
Getting needed care (not a problem/small problem)	79%	86%	89%	89%
Getting care quickly (always/usually)	67%	72%	72%	76%

* Adult and Child Surveys are alternated each year

** *SoonerCare* Choice 2001-2003; *SoonerCare* 2004

PRIMARY CARE ACCESS
Outcomes

The CAHPS survey evaluates the following areas to rate people's experiences in getting care quickly:

- When the respondent called the provider's office during regular hours, how often was the help or advice needed received.
- Not counting times when health care was needed right away, how often was an appointment scheduled as soon as requested.
- When care was needed right away, how often was care available as soon as requested.
- How often was the respondent taken to the exam room within 15 minutes of the appointment time.

EMERGENCY ROOM UTILIZATION
Overview

Emergency Room Utilization Initiative:

- *SoonerCare* provider profiling of ER utilization by assigned enrollees (including provider education)
- Care Management outreach to beneficiaries with high ER utilization
- Care Management follow-up on Nurse Advice Line calls that directed beneficiary to the ER
- Care Management follow-up on external referrals

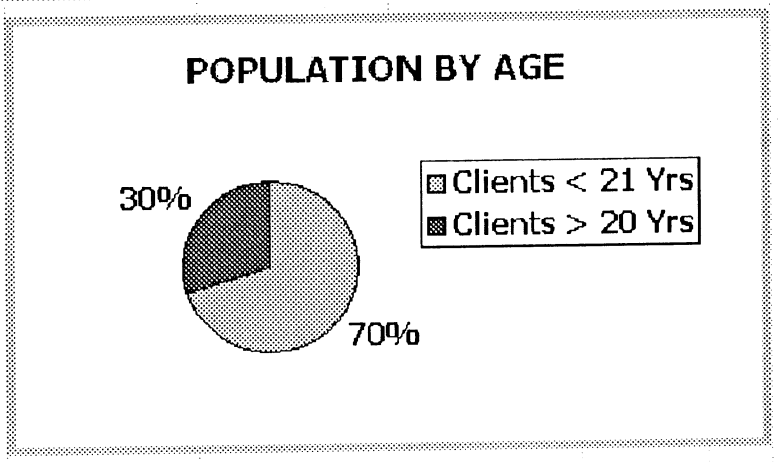
ER UTILIZATION: Services Provided, Populations Served And Costs

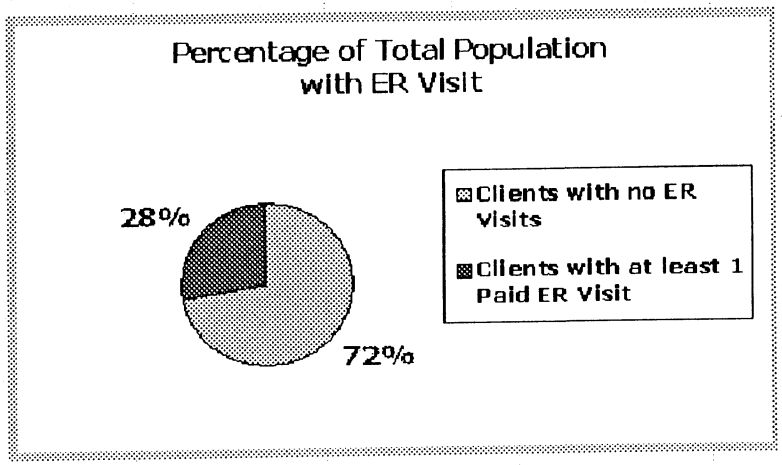
For consistency of reporting, all utilization and cost data in this section was calculated using the amount *paid* by OHCA in SFY 2005 for services *utilized* in SFY 2005. This caused a slight variance to actual services provided and associated costs due to claim lag.

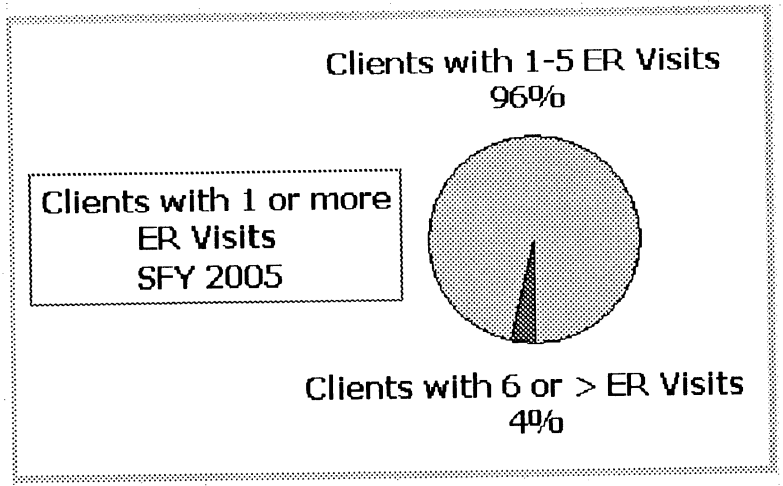
Services provided in the emergency room setting

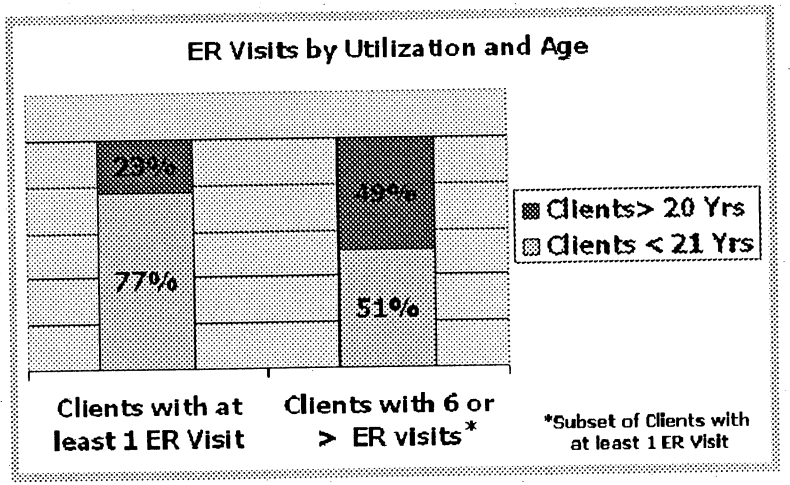
# of ER visits Paid (facility)	Unique # of clients served	Cost of services provided in the ER (facility)	Cost for services provided in the ER (physician)	Total Cost SFY 2005	Average Cost per ER Visit
373,911	189,830	$21,468,108	$14,076,090	$35,544,198	$95.06

ER UTILIZATION: Services Provided, Populations Served And Costs









ER UTILIZATION
Outcomes

Emergency Room Utilization	*SoonerCare** HEDIS® RATE		National Medicaid Average**
Measure	**2003**	2004	**2003**
Rate/1000 member months	**59.8**	48.1	**49.4**

* *SoonerCare* Choice 2003; *SoonerCare* 2004

** Most recent average available

- 1,965 ER Utilization referrals have been made to Care Management for assessment of beneficiary needs and related education for ER visits that occurred in SFY 2005
- 1,295 ER Utilization Provider Profiles have been mailed to providers over the course of 3 data refreshes

PRIMARY CARE SERVICES
Next Steps

- ✓ Continue with current member and provider outreach and education activities
- ✓ Continue with current ER Utilization Initiative
- ✓ Continue with current HEDIS® measures and CAHPS® surveys
- ✓ Complete an analysis of ER utilization and Care Management interventions for dates of service 07/01/2005 – 06/30/2005
- ✓ Evaluate the results of ER Utilization Study completed by Oklahoma Foundation for Medical Quality upon completion (results pending)

Appendix D

Medicaid Task Force-Topic – Chronic Disease Management Programs

Overview for August 10, 2005

What's the difference?

- **Disease management**
  - Population based interventions
- **Therapy management**
  - Pharmacy focus
- **Care management**
  - Access and coordination care

Disease Management

- Definition: (63 O.S. Sec. 5030.4A)
  - *an integrated system of interventions, measurements and refinements of health care delivery that include*
    - *Patient education and self-care techniques*
    - *Clinical policies/best practices*
    - *Outpatient drug management*
    - *Clinical information systems to identify, classify and track defined patient populations*
    - *Informed support of physicians*
    - *Team-oriented multidisciplinary approach*
    - *Feedback or continuous review*

A New Way of Thinking

- Treatment paradigm is now focused at one on one level
  - One patient: One doctor
- Disease management steps back to focus on a larger population and then targets certain members of the population for more intense management
  - All diabetics : all caregivers

Goals of Disease Management

- Make the patient more aware of their health status
- Educate the patient about self-monitoring and self-care techniques
- Encourage the patient to begin to take responsibility for the appropriateness and quality of their own care and to take responsibility for their health status

Types of Disease Management Programs

- Physician vs. Patient Orientation
  - Patient oriented programs are based on face-to-face, telephone, or postal contact between a provider (or payer) and the patient.
  - Physician oriented programs are based on interventions targeted to primary care providers. These interventions generally consist of education, peer comparison, or compliance with best practices based on claims review.

Disease State Selection

- Prevalence
- Established National Treatment Standards
- Evidence of non-compliance with standards
  - Providers and clients
- Return on investment
  - ROI generally estimated to be 1.6 to 1 for disease management programs

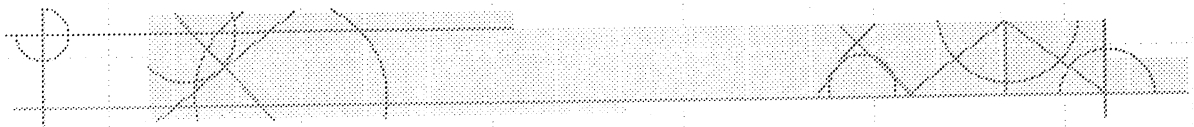
Commonly Managed Disease States

- Diabetes
- Asthma
- Congestive Heart Failure
- Chronic Obstructive Pulmonary Disease
- Hypertension
- AIDS
- Hemophilia, Sickle Cell, Cystic Fibrosis

Special Considerations for the Medicaid Population of Clients

- Age – Very Old and Very Young
- Caregiver intermediary
- Education level
- Language
- Frequent change of residence
- Lack of contact information
- Gaps in enrollment and eligibility
- Multiple co-morbidities

OHCA Disease Management Snapshot



Sooner PSYCH

Prescription

Solutions for

Your

Cognitive

Health

Project Coordination

- Public – Private Partnership
- Managed jointly by OHCA and ODMHSAS
- Project is funded by Eli Lilly
- Comprehensive NeuroSciences, Inc. is the contracted vendor

Sooner PSYCH GOALS

- **Improve the quality of prescribing practice for behavioral health medications based on best-practice guidelines**
- **Improve patient adherence to medication plans**
- **Improve the effectiveness of dollars spent by Medicaid for behavioral health drugs**
- **Not a "cost saving" project, but savings may result**

Communication with Prescribers

- **Monthly profiles of behavioral health claims that do not meet Best Practice Guidelines**
- **Targeted messages to outlier physicians**
- **Alert all prescribers to patients who:**
  - **Fail to refill BH meds on time**
  - **Fill same-class BH drugs by multiple doctors**

Most Significant Changes Observed*

- Children on 3 or more BH meds
  - Patients identified decreased by 85%
  - Prescribers identified decreased by 57%
- Multiple prescribers of same class
  - Patients identified decreased by 85%
  - Prescribers identified decreased by 68%

*for quarter ending June 30, 2005

Pediatric Diabetes Project

- Interagency Agreement between Oklahoma Health Care Authority and Board of Regents of the University of Oklahoma – Endocrinology Group
- Program for Insulin-dependent diabetic children

Program interventions

- Sick day management
- Referral to ER
- CDE assessments/education as ordered by the pediatric endocrinologist
- One-on-one education (pumps, special needs)
- Pattern management consultation
- Consults with patients/families/school
- Diabetes supplies and prescription issues
- Contact with the family to increase compliance with diabetes management

Sick Day Management

- Each "sick day" represents a 24 hour time period where the team is in close contact with the family to manage, by telephone, the diabetes medical care
- Typical communication is every 2-3 hours, 24 hours a day, until the illness is resolved

Outcomes

- Population Served: about 100 Insulin-dependent diabetic children
- Cost: $400 per patient, up to $50,000 per year
- Outcomes: 66 hospital admissions or emergency room visits prevented over an 18 month period
- Savings estimate: $ 1 million

Best Clinical & Administrative Practice Program (BCAP)

SoonerCare
Quality Improvement Initiative (BCAP)

The focus of the *SoonerCare* BCAP project is on improving the effectiveness and level of care for adult Native American enrollees identified with diabetes. These enrollees are provided health care services through the traditional *SoonerCare* program as well as through the Indian Health Service (IHS) program.

Through the course of this project, *SoonerCare* staff is evaluating the diabetic services of Native Americans cared for through both systems.

Project Data

- Eligibility Criteria - *SoonerCare* enrollee, 18-74 years of age, Native American, Diabetic
- Benefit Package - *SoonerCare*
- Provider Rates - Screening services paid at FFS rates
- Clients Served - 1,020 clients included in initial intervention group
- State, Federal and Total Money Spent - Not applicable

BCAP Project Data

Intervention Activity	Intervention Cycle 1 Rate (SFY 2005 Qtr 3)
Contact by Care Mgmt Staff – clients with phone	93%
Letter by Care Mgmt Staff – clients without phone	99%
Provider notification of screening needs	100%

HEDIS Rates
Comprehensive Diabetes Care

Measure	CY 2003	CY 2004
HbA1c	44.4%	49.2%
LDL-C	34.7%	39.4%
Eye Exam	14.1%	20.7%

Administrative (claims) data only.

Diabetic Care - Next Steps

- Continue BCAP project as designed making modifications to interventions as indicated.
- Consider extension of project to include all racial/ethnic groups.
- Continue annual HEDIS measurement for Comprehensive Diabetic Care.
- Evaluate results of OFMQ study of *SoonerCare* Comprehensive Diabetic Care when available.

Therapy Management

- Started 1-1-04
- Client selection
  - HCB Waiver (Advantage)
  - More than 3 branded Rx and/or 10 generics
- Review current therapy
  - Duplicate
  - Drug/disease or drug/drug interactions
  - Adverse effects
  - Dosage

Outcomes

- FY 05
  - Over 3500 letters, 800 calls to physicians and other caregivers and providers
  - More than 1,600 clients screened
  - Average 3 interventions per client
    - Therapy change
    - Medication authorization

Next Steps

- Focus on asthma, hypertension, HIV/AIDS, hemophilia
- Adult diabetes project
- Goal of the agency is to partner with pharmaceutical companies for unrestricted funding of pilot projects

Appendix E

Medicaid Task Force – Topic: Patient Empowerment

Overview for August 10, 2005

Background –
Barriers to Patient Empowerment

- Current Federal Medicaid Law –
  - In order for a state to receive federal financial participation (FFP), a state must agree, to a certain set of regulations

Background –
Barriers to Patient Empowerment

- Minimum State Requirements -
  - Cover a mandatory population
  - Provide a mandatory set of benefits for all beneficiaries
    - Any added optional benefit must be provided to all beneficiaries
  - Have no enrollment caps or waiting lists

Background –
Barriers to Patient Empowerment

- No cost-sharing for the following services:
  - Children's services
  - Pregnancy related services
  - Family planning services

- In most other cases, only "nominal" cost sharing is permitted:
  - $2 per month deductibles per family
  - Co-pays ranging from $.50 - $3.00 per service

Federal Law Constraints

+

High Rates of Uninsured

=

Problems for Policymakers

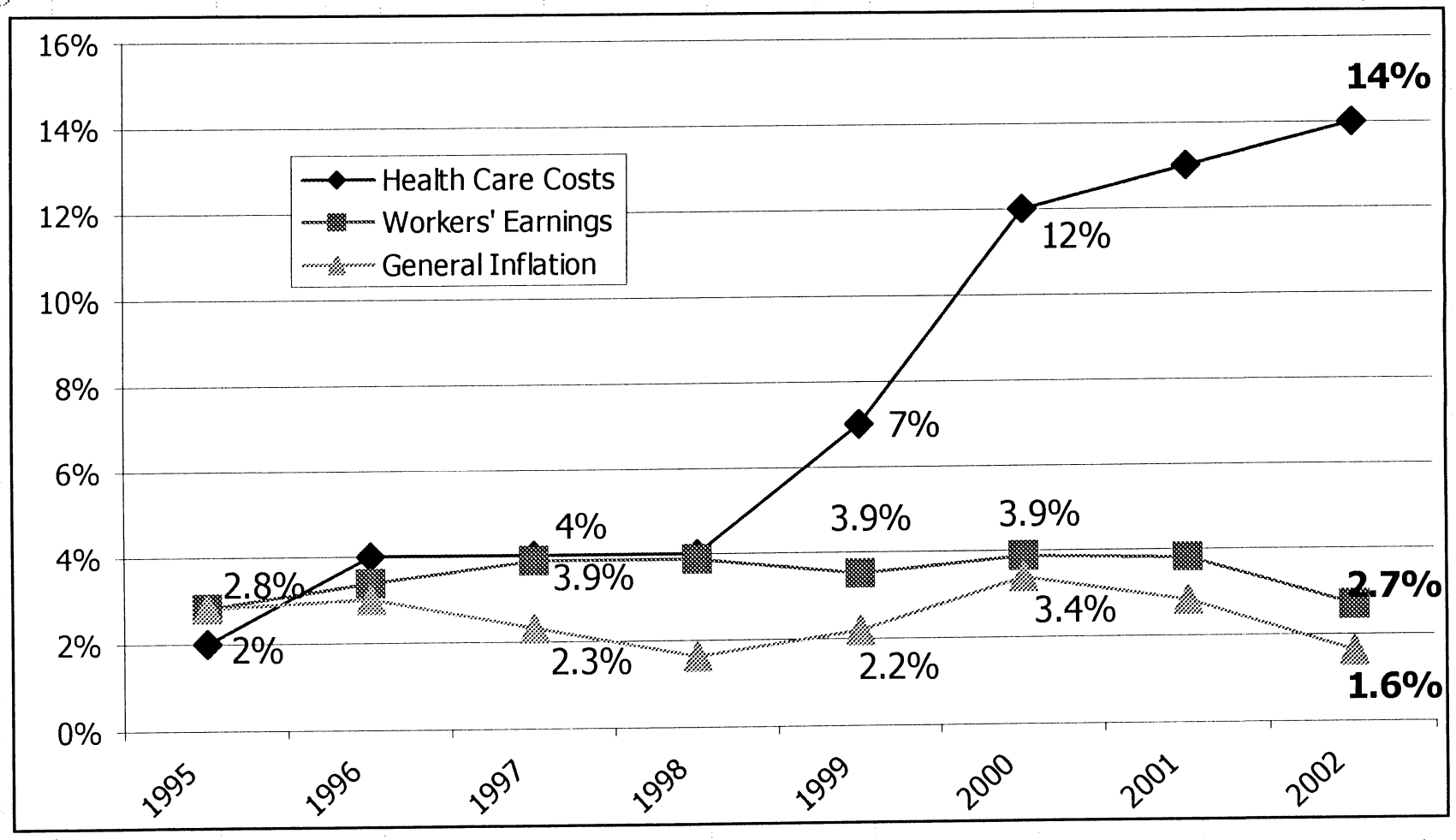
Oklahoma's Uninsured

- Estimated 650,000 uninsured Oklahoman's
  - **Of these nearly 75% are employed or dependents of an employed individual**
  - Just over 75% of the uninsured are between the ages of 19-64
  - An estimated 60% fall below 200% of federal poverty

Possible Causes for the Uninsured

- For 2004, employers reported a **16%** increase in insurance premiums
  - Employers cannot financially afford to provide health insurance to their employees
- Since 2001, the share of the employee's premium has increased by **50%**
- Worker's earnings have not kept up with the pace of increase in health insurance premiums

Increases in Health Insurance Premiums Compared to Other Indicators, 1995 - 2002



Problems Recognized By

- Bush Administration
- Governor Henry
- Oklahoma Legislators
  - House Medicaid Reform Task Force

Federal Government Response

HIFA – Health Insurance Flexibility and Accountability Waiver: an 1115 Demonstration Initiative with the following objective:

To allow states to increase the number of individuals with health insurance coverage within current-level Medicaid and SCHIP resources.

Why is this waiver so revolutionary?

- States are allowed to provide for, or assist in the payment of:
  - Coverage of "non-traditional" groups
    - (ie, working poor)
  - Flexible benefit packages

- *States are allowed to establish enforceable, meaningful cost-sharing*

Oklahoma's Response

O-EPIC

Oklahoma Employer / Employee Partnership Insurance Coverage

(Waiver submitted to CMS - January 2005)

Oklahoma's Plan to Cover the Uninsured (O-EPIC)

- Targets small employers, covering between 50,000 – 70,000 individuals initially

- Multiple funding sources:
  - Employers
  - State / Federal dollars (thru HIFA waiver)
  - Individuals / Families / Employees

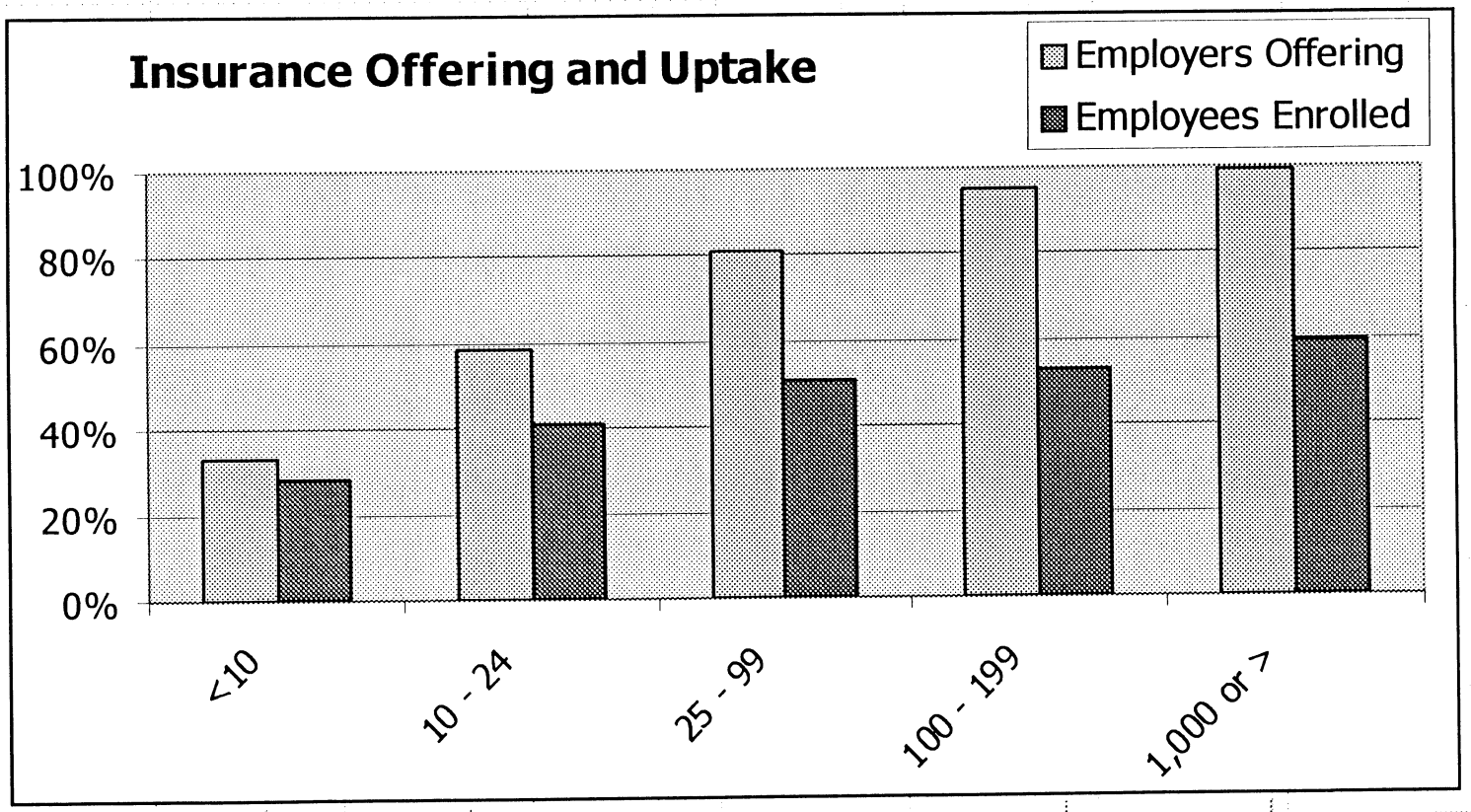
General Eligibility Criteria – Step #1

- Employment –
  - 25 employees or less; or
  - Self-employed; or
  - Un-employed (seeking work)

- Employer must be Oklahoma-based

Employer Offerings and Employee Uptake by Employer Size

	<10	10 - 24	25 - 99	100 - 199	1,000 or >
Employers Offering	33%	58%	81%	95%	99%
Employees Enrolled	28%	41%	51%	53%	59%



General Eligibility Criteria – Step #2

- Individual
  - Annual income at or below 185% FPL; and
  - Oklahoma resident

Family Size	100% FPL	150% FPL	185% FPL
1	$9,310	$13,965	$17,224
2	$12,940	$18,735	$23,107
3	$15,670	$23,505	$28,990
4	$18,850	$28,275	$34,873

Program Implementation Phases

- Phase #1
  - Employer Sponsored Insurance
    - (Fall 2005)
- Phase #2
  - Introduction of Public Product
    - (Early Calendar Year 2006)

Program Design

- How will the program be designed?
  - Employer Already Offers Coverage: Employees and their families eligible for a voucher used to purchase health insurance (sent directly to the employer)
    - **Effect: Should reduce both the employee and employer contribution towards the premium amount.**
  - Employer Does Not Offer Coverage: Employer obtains coverage on the open market – see above
  - Self-Employed or Non-Working: Allowed to purchase health insurance on the private market

How will employers / employees know if their health care product qualifies?

- Currently working with insurance companies to "pre-approve" products.

- Insurance products will be required to include (at a minimum):
  - Outpatient physician services;
  - Inpatient hospital care;
  - Pharmaceuticals; and
  - Minimum deductible

Payment Arrangement Facts

- Employers will be required to contribute 25% of the premium amounts for the worker.
- Individuals will pay up to 15% of the monthly premium.
  - (capped at 3% of monthly household income).
- State dollars will be matched with federal dollars at the current program match rate.
  - (FFY2005 – 70.18%; FFY2006 – 67.91%).

Example

Family of four:
(husband, wife, two children)

Annual household income:
($34,000 / 180% FPL)

Employer Sponsored Ins Premium:
($300 for individual / $600 for individual & spouse)

Distribution of Premium Contributions – For Example

Payer	Individual	Spouse	Total
Employer	$75	0	$75
Employee	$45	$40	$85
State Share	$54	$78	$132
Federal Share	$126	$182	$308
Totals	$300	$300	$600

Potential Program Design

- For those individuals and families without access to ESI, AND no other affordable health insurance alternative is available:
  - The individual or family contacts the state (or contracted agent of the state)
  - Payment plan is set up with individual for public product, individual pays their portion directly to contracted agent

Budgetary Controls

- How will the program be managed to ensure costs are controlled?
  - Phase in of the program, starting with the smallest employers (1-25 workers), then expanding when budget projections are met
  - Adjustment of the size of the premium assistance, or voucher payment if need arises

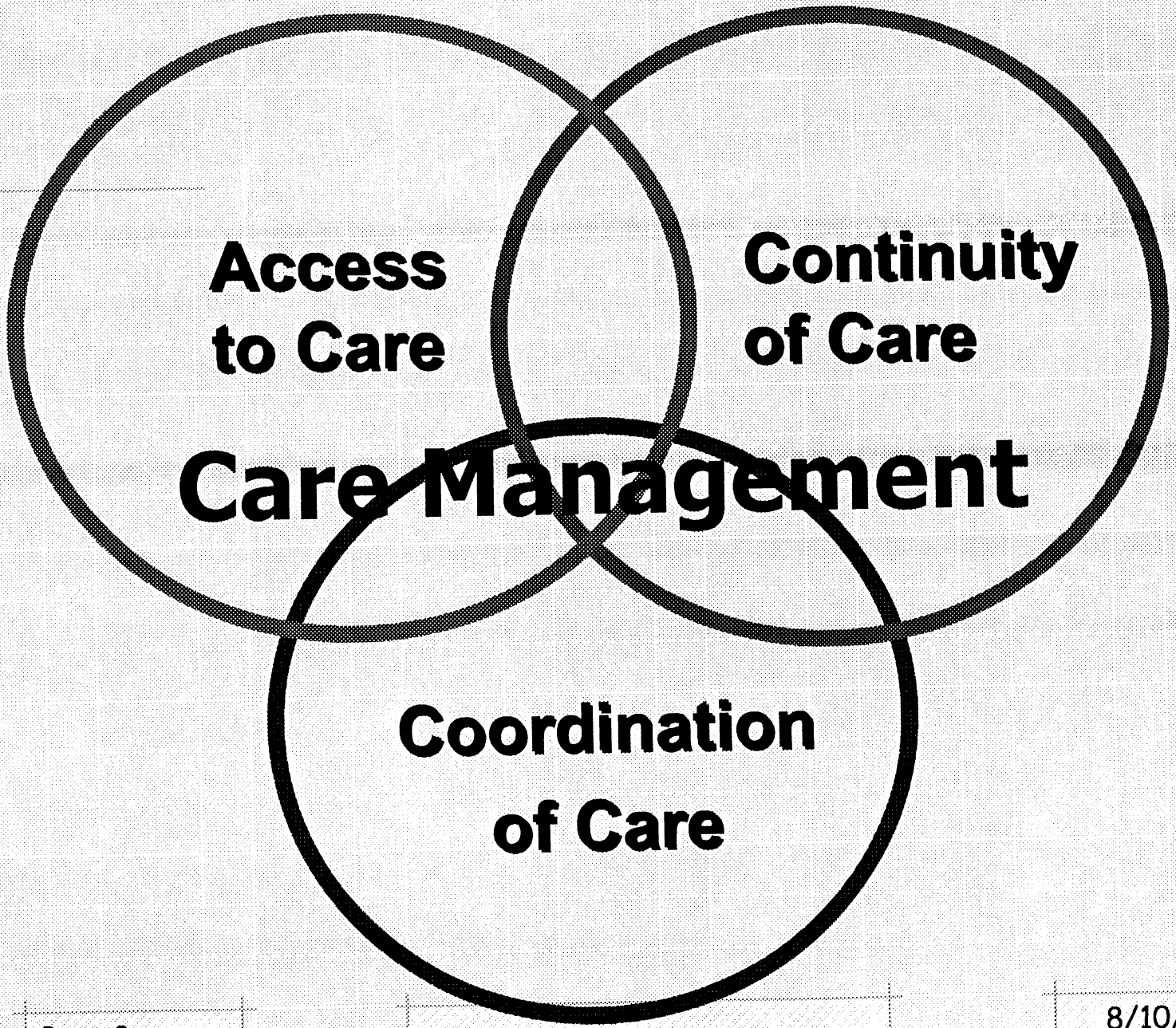
Appendix F

Care Management in Action

Dedicated to providing and improving health care access for Oklahomans.

Population Served

- ***SoonerCare*** Managed Care Members
  - Pregnant women
  - Children
  - Persons categorized as disabled
  - Women with breast &/or cervical cancer
- Fee-for-service beneficiaries


Access
to Care
Continuity
of Care
Care Management
Coordination
of Care

Care Management Staff

- Director and 2 RN supervisors
- 2 administrative assistants
- 21 RN Exceptional Needs Coordinators
- 6 LPN ENC Associates
- Total of 32 health care professionals

What We Do

Facilitate and coordinate care for:

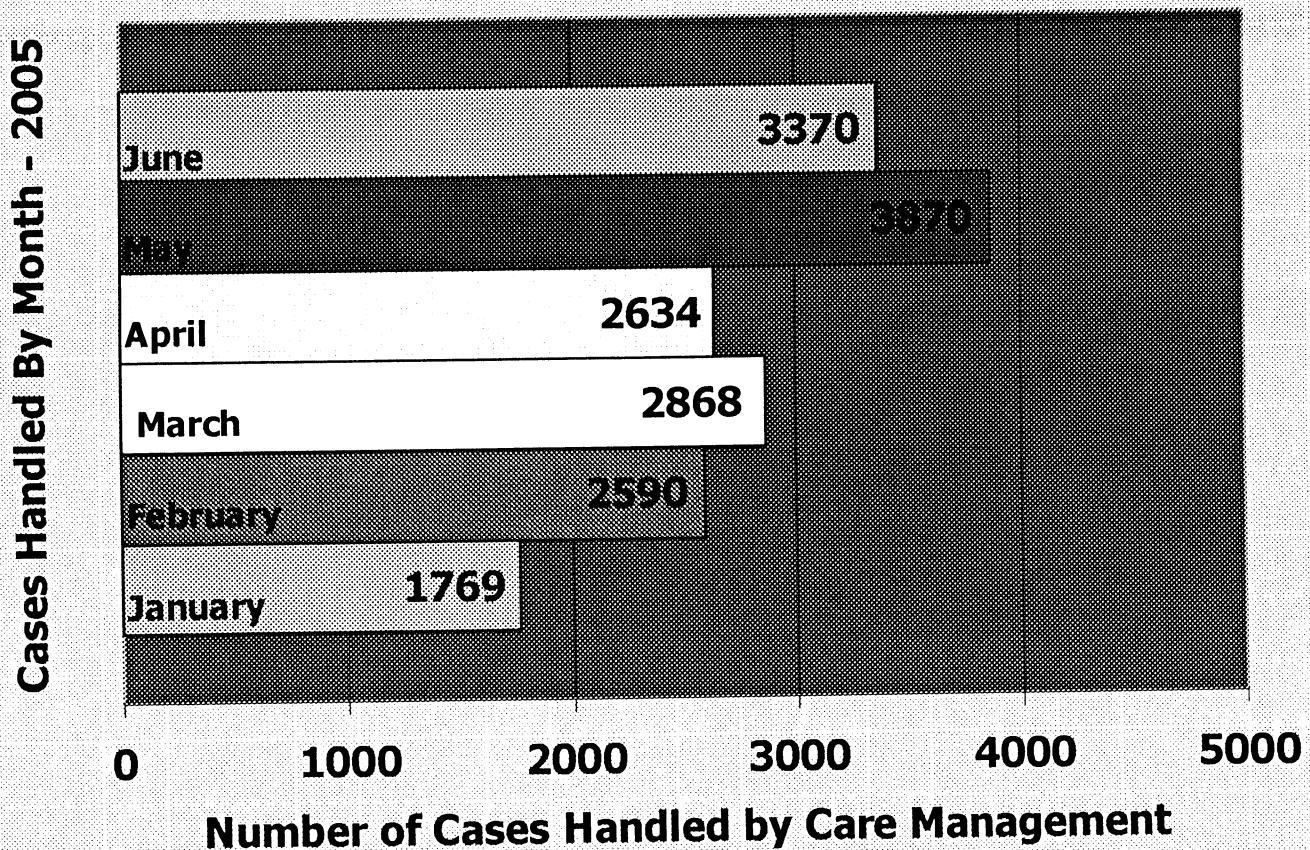
- Children receiving private duty nursing in the home
- High risk pregnancies
- Organ transplant candidates
- Women in the Breast and Cervical Cancer Treatment program
- Persons with both medical and behavioral health diagnoses

Assist members and providers with locating specialty providers

Perform educational outreach for targeted populations

Coordinate out-of-state health care when comparable in-state services are not accessible

Care Management at a Glance



Vignette 1

One-year-old female with congenital heart disease (referred by ***SoonerCare*** PCP)

- March 16, 2005 - St. Louis Children's Hospital for heart transplant, inpatient
  - Transportation, coordination of services, special approval for device
- April 20, 2005 - External, artificial heart pump
- June 2, 2005 - Heart transplant
- Coordination of child's pregnant mother's return to Oklahoma for delivery

Vignette 2

Nine-year-old female, terminal diagnosis, seizures, pain (referred by ***SoonerCare*** PCP)

- Private duty nursing in the home
- March 2004 – Start of ENC, in-home visits
- April 2004 - Parents request hospice services
- Sept. 2004 - Hip fracture, collapsed lung
- Oct. 2004 - Hospitalization
- May 2005 - Private duty nursing hours increased to 16hr/day
- June 2005 - Private duty nursing hours increased to 24hr/day
- Staff advocated for hospice services through EPSDT
- Hospice services initiated and remained in place until child's death on death July 7, 2005

Vignette 3

14-year-old with stroke, emergency hospitalization in Tulsa

- **July 28, 2005 -** Large mass found in heart
- 3 hour turnaround to coordinate with *SoonerCare* PCP, approve out-of-state treatment, arrange transportation, verify contract in place
- Pediatric cardiologist, neurosurgeon, neurologist and nephrologist (15 specialists) required for treatment
- Transported to Texas Children's Hospital, Houston for evaluation
- **July 29, 2005 -** Child returned by Medi-Flight to OU Children's Medical Center for treatment

"Wonderful... appreciated the teamwork at OHCA"
~ Referring Specialist

Next Steps

- October 2005: Implementation of TEFRA Program for Children

- Management of ***SoonerCare*** members identified with high utilization by claims analysis

Appendix G

Medicaid Task Force –

Topic: Provider Reimbursement

Oklahoma Health Care Authority

Overview for August 24, 2005

Provider Reimbursement Overview

Physician reimbursement & adequacy

Hospital reimbursement & adequacy

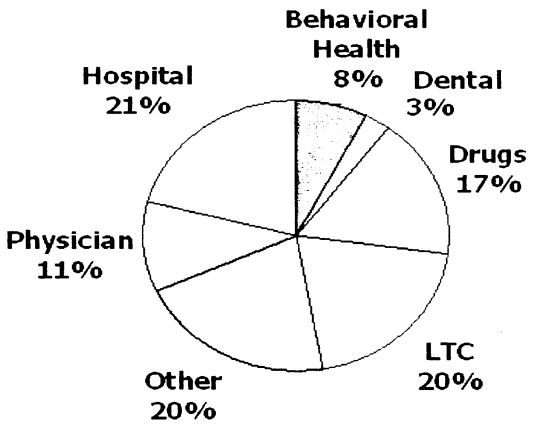
Impact of payment rates on uninsured

OHCA Goals:

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

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

Where Medicaid dollars were spent in SFY05



Medicaid provider payment rates should be...

consistent with efficiency, economy and quality of care

adequate enough to ensure provider participation

Payment Considerations

States generally have great flexibility in setting payment rates

Physicians ~

- payments limited to a maximum of usual and customary charges or Medicare fee schedules (e.g. laboratory services)
- for measurement, rates are generally compared to Medicare rates (percent of Medicare)

Hospitals ~

- payments limited to costs, known as the upper payment limit (UPL) which is a reasonable estimate of what would be paid to a group of facilities under Medicare payment principles
- for measurement, payments are generally compared to costs (payment to cost ratio)

Physician Reimbursement

A brief history....

Physician Payment Methods

Fee-For-Service

In SFY2000, Oklahoma adopted the Medicare Resource Based Relative Value Scale (RBRVS) methodology as a benchmark for establishing fee-for-service payments to physicians and other providers

The RBRVS, developed at Harvard University, emphasizes the benefits of primary and preventive care. Each physician procedure code has a relative value unit (RVU) which is multiplied by a dollar conversion factor to determine the payment rate

Fees were established at approximately 76% of Medicare

Capitated Rates

Must be calculated and certified as actuarially sound

Average percent of Medicare allowed charge compared to states in our region

At 76.2%, Oklahoma Medicaid ranked 30th nationally in physician payments in 2000

Physician Services Average Medicaid Fee as % of Medicare Allowed Charge 2000		
State	% of Medicare	National Rank
New Mexico	110.7%	2
Arkansas	88.9%	21
Louisiana	80.8%	25
Texas	77.6%	28
Oklahoma	**76.2%**	**30**
National Median	**80.8%**	

Average fees ranged from a low of 35.9% in New York to 126.8% in Alaska

Average payment per recipient for physician services FFY01

Physician Services Average Payment Per Recipient FFY2001			
State	Payment per Recipient	Regional Rank	National Rank
Arkansas	$ 446	1	10
Texas	432	2	13
Louisiana	339	3	28
Oklahoma	**315**	**4**	**29**
New Mexico	297	5	33
National Average	**$ 391**		

Changes in physician payment since 2000

Due to budgetary constraints, Medicaid rates have not always kept up with the annual Medicare updates

In 2003 the state increased university affiliated physicians payment rates to 140% of Medicare

In 2004 the evaluation and management codes for all providers were increased to 90% of the Medicare schedule

Court finds rates inadequate

Court found that Oklahoma Medicaid was not providing equal access to children

Specialty rate study must be performed

House Bill 1088 provided $63 million to improve physician and hospital rates in order to assure access to care

In August 2005, all RVU based procedure codes were increased to 100% of Medicare

Oklahoma physician rates now rank 2nd in a survey of 27 states

Hospital Reimbursement

A brief history....

Hospital Payment Methods

Inpatient –

- Prospective per diem system, by level of care - implemented in 1990 to encourage efficiency
- Payments periodically updated for inflation
- The average payment per day is $648
- 24 day limit for adults

Supplemental Payments -

- Graduate medical education payments to teaching hospitals
- In SFY05, supplemental payments were made to Non-State Government Owned Hospitals for inpatient and outpatient services

Outpatient –

- Fee schedules for ancillary & diagnostic services
- Ambulatory surgery paid @ percent of Medicare fee
- ER Rate = $50 per case

Disproportionate Share (DSH)

Graduate Medical Education

Direct Medical Education Payments to Hospitals (17 hospitals)	$54 million
Indirect Medical Education Payments to Hospitals (3 hospitals)	$24 million
Direct payments to * medical schools (3 schools)	$51 million
Total	$129 million

Disproportionate Share Hospital (DSH) Payments

This payment provides additional funding to those hospitals which provide an extraordinary amount of their services to the state's Medicaid and low income citizens.

Qualifying Criteria

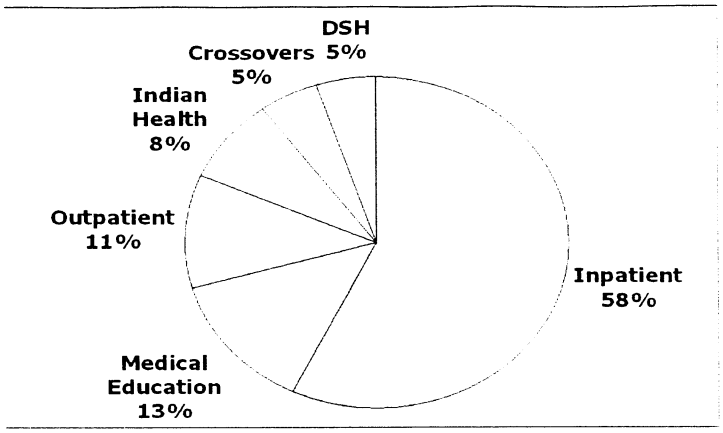
- the hospitals Medicaid inpatient utilization rate is above average; or
- the hospitals calculated low income rate exceeds 25 percent

Oklahoma specific limits for DSH

- Allotment for FFY05 was $31.1 million
- This allotment increases 16% annually until 2008
- Payment cannot exceed 100% of a qualifying hospitals costs of serving Medicaid and the uninsured

In FFY05, there were 16 qualifying hospitals

Oklahoma Hospital Expenditures by Category, SFY2005



Average payment per recipient for inpatient hospital services FFY01

Inpatient Hospital Services Average Payment Per Recipient FFY2001			
State	Payment per Recipient	Regional Rank	National Rank
New Mexico	$ 5,231	1	12
Oklahoma	**4,327**	**2**	**21**
Texas	3,966	3	28
Louisiana	3,450	4	36
Arkansas	2,495	5	40
National Average	$ 4,642		

Are these payments adequate?

Payment to cost ratios (PCR) are used to indicate the relative degree to which payments by each payer cover the costs of treating its patients

$$PCR = \frac{\text{Total Payments}}{\text{Total Costs}}$$

Oklahoma Medicaid hospital payment-to-cost ratio compared to national levels

According to OHCA data, SFY05 hospital payments covered 80 percent of cost, (excluding DSH)

	Payment to cost ratio with DSH	Payment to cost ratio without DSH
Inpatient	100.00	0.95
Outpatient	0.48	0.46
Total	0.85	0.80

Nationally, average Medicaid payments covered 96 percent of hospital costs in 2002

Outpatient payment disparity

Payments for outpatient services are substantially below cost (48%)

Low outpatient cost coverage creates disincentives for treating patients in the most cost efficient setting

Creates additional financial pressures on hospitals as the trend to move more patients from the inpatient to the outpatient setting continues

Next Steps

Improve hospital payments by converting to a DRG methodology and eliminate hospital day limit for adults

Expand the number of disproportionate share hospitals

Address the disparity in outpatient payments

- Proposed changes:
  - Increase outpatient ER payments under a tiered approach by trauma level
  - Increase ambulatory surgery fees to 100% of Medicare

These changes will result in an overall 25% increase in hospital payments

- 14% increase in inpatient payments
- 96% increase in outpatient payments

Impact of Payment Rates

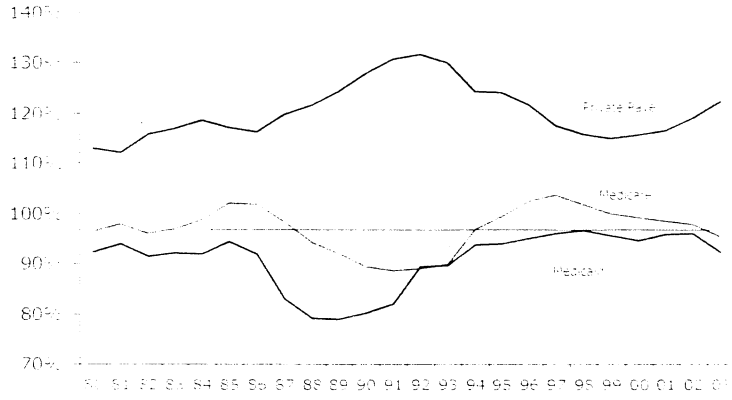
on uninsured and private payers

What is cost shifting?

The subsidizing of unpaid costs of care delivered to one patient population through above cost-revenue collection from other patient populations

For hospitals, the historical cause of cost shifting has been attributed to below-cost reimbursement rates paid by public programs and uncompensated care losses from charity care or bad debt

Aggregate Hospital Payment-to-Cost Ratios for Private Payers, Medicare, and Medicaid 1980 - 2003



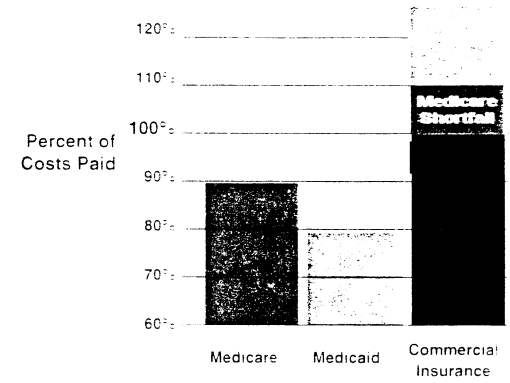
Does cost shifting matter?

It matters to consumers who face higher costs...

Employers who face escalating premiums and a limp economy are not absorbing the latest round of escalating health care costs. Instead, they are reducing their level of coverage, asking employees to share more costs, and some are ceasing to provide coverage altogether

When providers prices rise and public payers do not follow suit, the result is that people lose coverage

Inadequate Government Payments Lead to Higher Insurance Rates



The $63 million investment

Medicaid is jointly funded by the state and the Federal government

Currently, Oklahoma has a favorable match rate. For every $1 in spending, the state receives $2.12 in Federal matching funds

By increasing physician and hospital rates, the state actually increases the Oklahoma health care economy by over $200 million

This investment will hopefully slow down increases in private insurance premiums

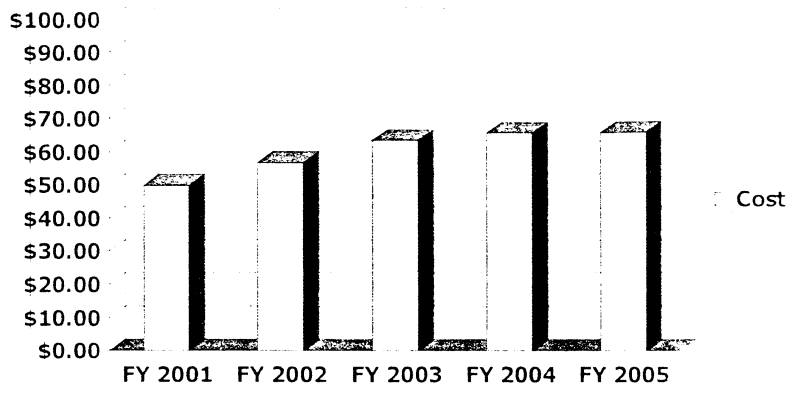
Appendix H

Medicaid Task Force
Topic – Prescription Drugs
August, 24 2005

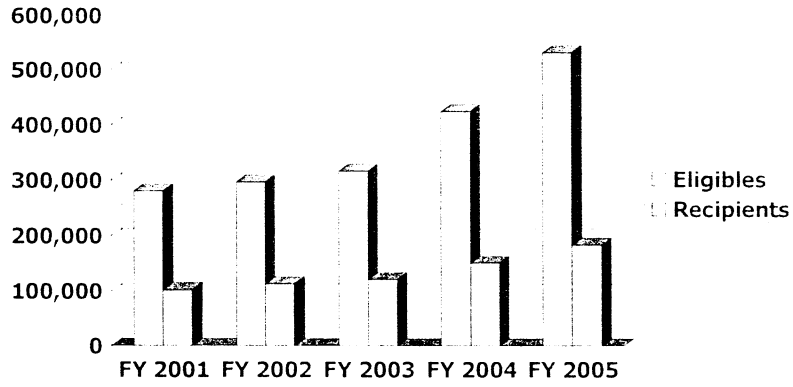
SFY 2005 Drug Benefit Stats

- $**467 million** in expenditures
- Monthly cost per Rx user- $**171.00**
- 7 million paid Rx claims
- Average monthly Rx Clients – 183,000
- Average Rx cost - $65.85
- Average Claims per client – 3.2

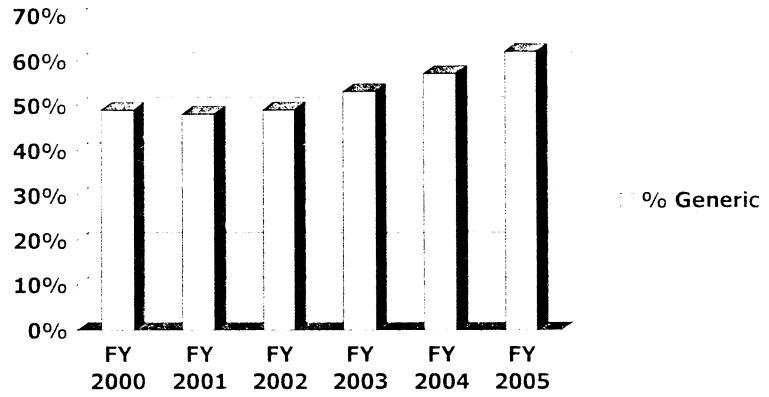
Average Cost per prescription



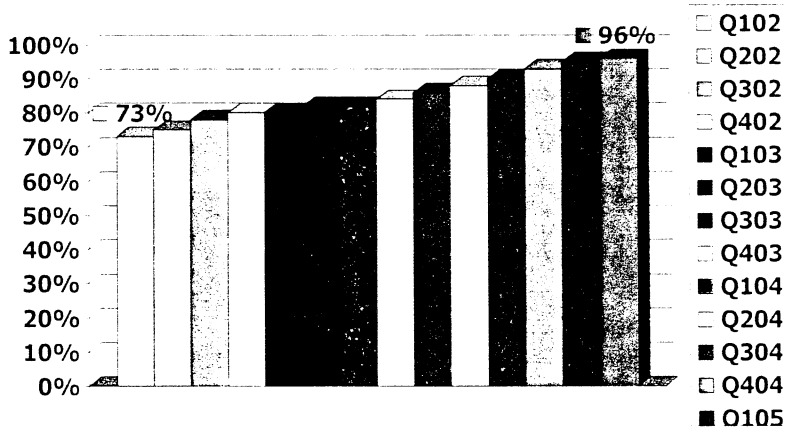
Eligibles and Recipients



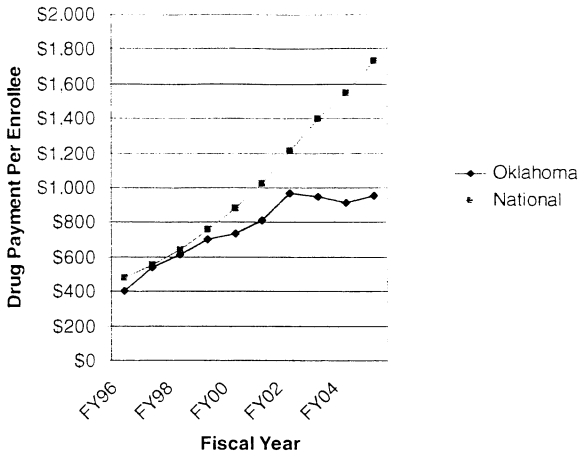
Generic Dispensing Rate



Generic Substitution Rate



10 Year Retrospective



Cost Containment Initiatives

- Script limits
- Mandatory Generic
- Reimbursement
  - SMAC
  - EAC, Disp Fee
- Prior authorization
- Quantity limits

Script Limits

- Until Jan 1, 2004, adults limited to 3 prescriptions per month
- Now 6 per month with 3 brand limit
- LTC, Children have no limits
- HCB Waiver – additional 7 generics plus therapy management

Reimbursement Issues

- Ingredient cost + dispensing fee
- Ingredient cost – lower of
  - Estimated Acquisition Cost
  - State Maximum Allowable Cost
  - Federal Upper Limit
  - Usual and customary charge to the general public

Reimbursement Issues

- State Maximum Allowable Cost
  - Limits reimbursement for generics
  - Based on Oklahoma pricing/availability
  - Savings
    - 2003 - $5.6 million
    - 2004 - $30 million
    - 2005 - $62 million
  - Many blockbusters coming off-patent
    - Prozac, Paxil, Prilosec, Cipro, Augmentin

Reimbursement Issues

- Dispensing fee – Maximum $4.15
- Should cover fixed costs
  - Salaries
  - Utilities
  - Supplies (labels, containers)
- Professional service fee

Prior Authorization

- Scope
  - Right time, right reason, right patient
- Utilization
  - Dosing amount
  - Duration of treatment
- Product
  - Step therapy
  - Preferred Drug List

Product Based Prior Authorization Program

- Savings Estimate: $18.7 million FY 2005
  - Total estimated savings since inception: **$91m**
- Categories
  - NSAIDs
  - Anti-Ulcer
  - Anti-hypertensives
  - Treatments for ADHD and Narcolepsy
  - Statins (cholesterol)
  - Antidepressants

Supplemental Rebates

- Works with Prior Authorization Program
- Collected $1.6 million in FY 2005
- Expect to collect over $6 million CY 05
- 100% participation
  - Statins
  - SSRI antidepressants
  - Proton Pump Inhibitors (anti-ulcer)

Statistics

- 18 companies participating
- Over 30 products included
- First quarter invoicing $425,000
- Second quarter projected $1 million +
- All contracting and invoicing done in-house – no fees lost to vendors

Federal Drug Rebates

FY 2005

- Collected over $96 million in rebates
- Approximately 20% of drug spend
- Federal share is returned to CMS
- If a company participates in the federal rebate program, their drugs must be made available to Medicaid clients

Medicare Part D Prescription Drug Benefit

New Medicare drug benefit starts January 2006

New "Part D" offers optional drug coverage to all Medicare beneficiaries

Rx coverage provided through private drug plans or Medicare HMOs (Medicare Advantage)

Limited to private plan's formulary

Changes Medicaid coverage for Medicare beneficiaries with Medicaid Rx coverage

Medicaid Changes

Medicaid Changes effective January 1, 2006

New law prohibits states from drawing federal funds for drugs for dual eligibles

Rx coverage for dual eligibles will be discontinued 1/1/06

Medicare will facilitate enrollment of dual eligibles into Part D plans.

States make monthly payment to Medicare

Who are the dual eligibles?

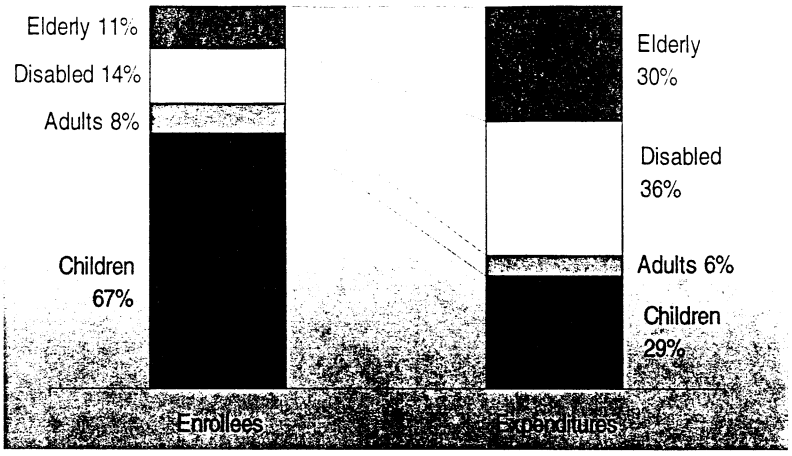
Dual Eligibility refers to individuals who are:

- Medicare eligible (aged or disabled);
- Low income; and
- Also eligible for some level of Medicaid coverage

There are different types of dual eligibility, but generally, they fall into two categories:

- Full dual eligibles – Medicaid Pharmacy Benefit
- Other dual eligibles

Oklahoma Medicaid Enrollees and Expendtiures by Enrollment Group, SFY2004



How Will The Duals' Access to Prescription Drugs Be Protected?

CMS will "auto-enroll" these individuals into PDP plans in their region (random)

Premiums for dual eligibles are paid by the federal government

Dual eligibles have a continuous open enrollment period and may change plans at any time

Subsidies For Full-Benefit Duals

Dual Eligibles under 100% FPL –

this group includes ABD's

pay no premium

never pay more than $1 generic/$3 brand

Dual Eligibles over 100% FPL

This group includes some HCBW clients

pay no premium

never pay more than $2 generic/$5 brand

Duals in LTC never pay a copay

What drug coverage continues for dual eligibles?

Medicaid may continue to cover and receive FFP for optional categories of drugs excluded from Part D. Oklahoma will continue to pay for:

- OTC Prilosec
- OTC Claritin
- Barbiturates
- Benzodiazepines

Medicaid cannot pay for a drug whose category is included in Part D, but not covered by a particular plan's formulary

CLAWBACK

Phased Down State Contribution

- Designed to reflect the amount states currently contribute for Rx benefit for dual eligibles
- CMS' formula includes inflationary factor that does not give the states credit for recent cost-containment measures

Budget Impact

OHCA estimates for FY 2006 we will require $5 million more state dollars than if we paid for the benefit (6 months)

OHCA estimate is that Medicaid will not financially benefit from Part D "savings" until 2009 without modifications to the formula for calculating the state contribution

Projections and Dates

Oklahoma will have 4-5 regional PDP's

There will be several national PDP's

Plans will be announced September 15

Plan marketing begins October 1

Open enrollment: Nov 15 through May 15

Comparison of Top 10 Drug Classes of Spending

Dual Eligibles	Non-Duals
Antipsychotics	Antipsychotics
Antidepressants	Antidepressants
Narcotic analgesics	Hemophilia Factors
Anticonvulsants	*Bronchial dilators*
Cholesterol reducers	Anticonvulsants
Diabetes treatments	*Antivirals*
Anti-ulcer (H2/PPI)	Narcotic analgesics
Hemophilia factors	*Contraceptives*
Anti-hypertensives	Diabetes treatments
NSAID/Cox-2's	Anti-ulcer (H2/PPI)

Categories currently included in Prior Authorization Program

Dual Eligibles	Non-Duals
Antidepressants	Antidepressants
Cholesterol reducers	Anti-ulcer (H2/PPI)
Anti-ulcer (H2/PPI)	
Anti-hypertensives	
NSAID/Cox-2's	

Categories for study

- Hemophilia Clotting Factor – pricing issues
- Asthma Treatments – Combine with disease mgmt
- Anticonvulsants – diagnostic criteria
- Narcotic analgesics – limitations/duplications
- Contraceptives – preferred list
- Diabetes treatments – combine with disease mgmt
- Antibiotics – step therapy based on national treatment guidelines

Automated Prior Authorization

- Approved for 90/10 match funding
- Based on Delaware's system
- ~20 types of checks for any one drug
  - Diagnosis
  - Prescriber specialty
  - Step therapy
  - Quantity limits
  - Therapeutic duplication

Appendix I

Medicaid Task Force
Topic: Long Term Care

Overview for August 24, 2005

Medicaid
The Major Public Financing Source for Long Term Care

- Nationwide, Medicaid paid for 50 percent of all nursing home care in 2002.
- In Oklahoma, Medicaid pays for more than 70 percent of all nursing home care.

Medicaid Long Term Care Facilities

- Nursing Facilities
- Private Intermediate Care Facilities for the Mentally Retarded (ICF/MR)
- Public Intermediate Care Facilities for the Mentally Retarded (ICF/MR)

Page 3

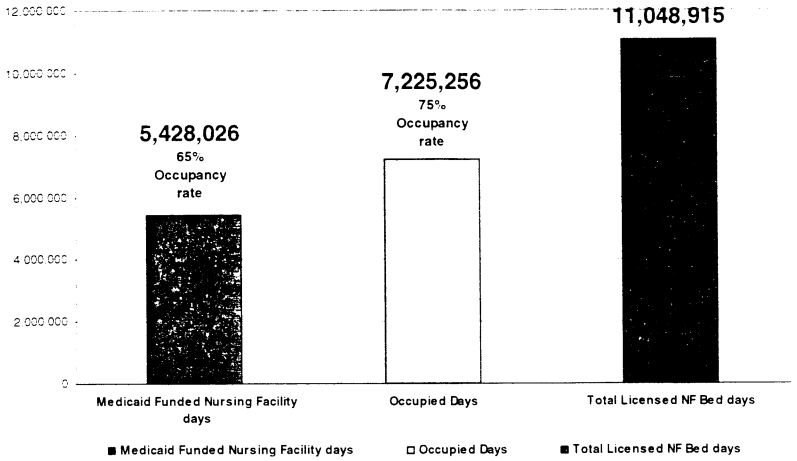
Pre-Admission Screening and Resident Review (PASSR)

- Federally required
- Pre-admission screening
- Appropriate admissions

Page 4

Nursing Facility Data – State FY 2005

Source: MAR MR [illegible] Quality Care Report, OK State [illegible] Health



Page 5

Long Term Care Facility Data

Facility (Current Rate)	Unduplicated Recipients	Days	Reimbursement	Average Per Person	Average Per Day
Nursing Facilities ($103.20)	22,705	5,428,026	$448,467,167	$19,751.91	$82.62
ICFs/MR (Private) ($102.87) ($133.59) ≤16 bed (B)	1,545	475,226	$48,062,192	$31,108.21	$101.14
ICFs/MR (Public) ($405 interim pymt)	442	151,067	$65,028,850	$147,124.10	$430.46
Totals	24,692	6,054,319	$561,558,208		

Page 6

Basic Medicaid Eligibility Criteria for Long Term Care

Medical Necessity

Income Limits

Asset or Resource Limitation

Page

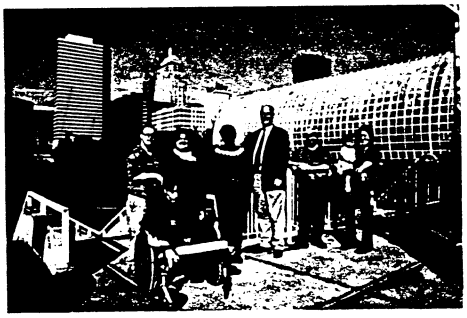
WHAT IS A DEVELOPMENTAL DISABILITY?

- Developmental disability happens in the developmental years (before the age of 22).
- Developmental disabilities are life-long and chronic.

Examples of developmental disabilities include, but are not limited to:

- mental retardation
- epilepsy
- cerebral palsy
- autism
- Down Syndrome
- PraderWilli Syndrome

Developmental Disabilities Services



- Serves children and adults, ages 3 and older,
- Primary diagnosis of mental retardation (IQ of 70 or below).
- Other disabilities can co-exist with mental retardation

Developmental Disabilities Services Division

The division's Medicaid funded long-term care services are available in two basic categories:

- Public ICF-MR (institutions)
- Community Waiver Programs

Public ICFs-MR

DDSD operates three public ICFs-MR (institutions)

- Northern Oklahoma Resource Center in Enid (NORCE)
- Southern Oklahoma Resource Center (SORC) in Pauls Valley
- Robert M. Greer Center (on the campus of NORCE). Specialized facility for persons with a dual diagnosis of mental retardation and mental illness.
- There are currently 420 residents at the three facilities.

What are "Waiver" Programs?

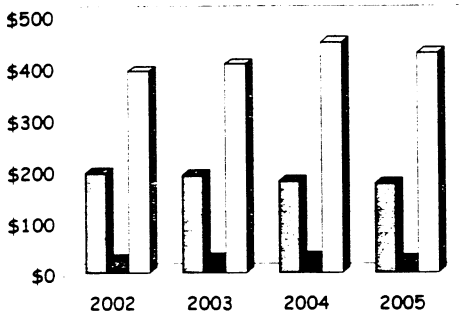
- Oklahoma's first Home and Community Based Waiver Program began in 1985.
- Medicaid funding for alternatives to institutional care.
- Meets Medicaid categorical and financial eligibility requirements.
- Meets level of need comparable to ICF-MR care.
- Expands services beyond traditional Medicaid coverage.
- Services must be less costly than institutional care.
- Consumers have written plan of care.
- Monitored by CMS and state quality assurance programs

Oklahoma's Home and Community-Based Waivers for People with Mental Retardation

DDSD offers four Medicaid waiver programs:

- In-Home Supports Waiver (IHSW) for Children – ages 3-21 whose needs can be met within the capitated amount of $12,360 annually.
- In-Home Support Waiver (IHSW) for Adults – people over age 21 whose needs can be met within the capitated amount of $18,540 annually.
- Community Waiver – persons ages 3 and older who have critical support needs that cannot be met by IHSWs.
- Homeward Bound Waiver – members of the Homeward Bound vs. the Hissom Memorial Center class-action lawsuit. There are currently 804 class members receiving waiver services.

Average Daily Expenditure For DDSD Medicaid Programs



DDSD Waiver services help clients to:

- become involved in their communities.
- build personal relationships.
- develop decision-making skills.
- live as independently as possible.

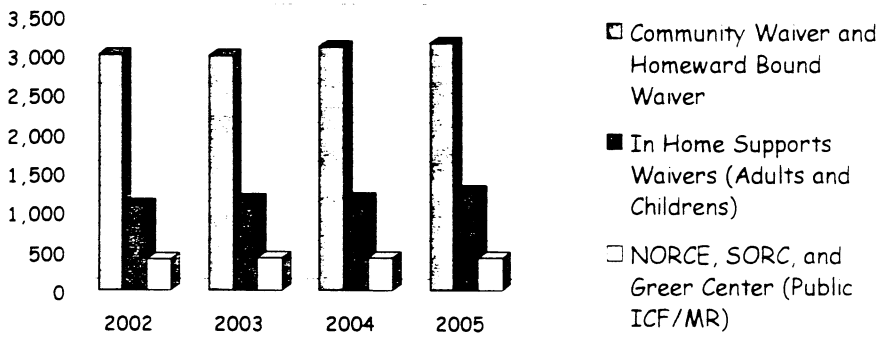
Services Available through the DDSD Waiver Programs:

- Adaptive equipment
- Adult day services
- Architectural modifications to the home
- Audiology exams and treatment
- Dental exams
- Employment training and services
- Family counseling and training
- Guardianship assessments and services
- Habilitation training specialists
- Medical services and supplies
- Nursing/skilled nursing services
- Nutritional services
- Occupational, physical and speech therapies
- Psychological services
- Residential services
- Respite services
- Transportation

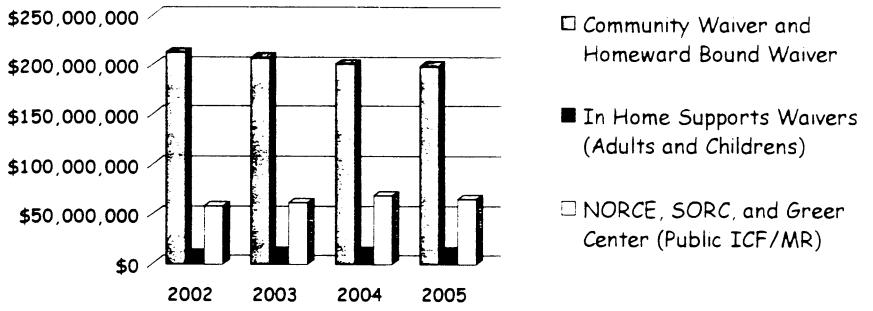
DDSD Waiver Consumer Demographics

• Male	57%
• Children	15%
• Young Adults (18 to 21)	8%
• Adults (21-65)	76%
• Over Age 65	1%
• Residential Services (supporting people to live outside the family home)	53%
• Non-ambulatory	56%
• Seizure Disorder	59%
• Significant health risks and needs	26%

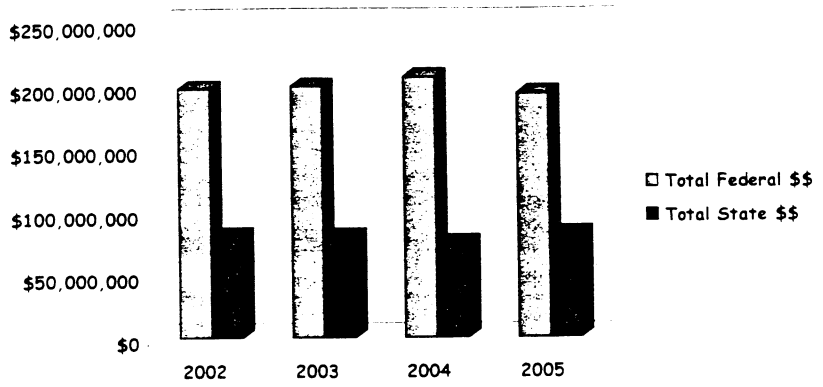
DDSD Medicaid Programs Clients Served



Total Expenditures for DDSD Medicaid Services



State & Federal $$ Spent on DDSD Medicaid Programs



Waiting List for DDSD Waiver Services

Year	Waiting list count
FY02	2,783
FY03	3,494
FY04	4,064
FY05	3,853

Length of stay on waiting list (as of 6/30/2005)

Over 3 years	1,516	39%
Over 2 years	828	22%
Over 1 year	730	19%
Within 1 year	799	20%

Support from Legislature

FY04 $2 M
FY05 $1.6 M

Served from Waiting List

408
325 projected

Aging Services Division

Oklahoma Department of Commerce Census Projections

Aged 65-84

1980	2000	2005	2010	2020	2030
362,078	398,775	420,300	457,900	609,500	776,400

Aged 85+

1980	2000	2005	2010	2020	2030
33,981	57,175	65,300	76,400	94,000	123,200

Aging Services Division

AD*vantage* waiver eligibility requirements:

- Meets Medicaid categorical and financial eligibility requirements
- Able to remain safely in home
- Costs less than nursing facility placement
- Level of need comparable to nursing home care

Aging Services Division

AD*vantage* demographics

•Average Age:	71.3
•Minority consumers	22.9%
•Female	75.2%
•Consumers living alone	48.3%
•Diverted from nursing home	98.4%
•De-institutionalized	1.6%
•Average Length of stay	974 days
•Oldest consumer	105 years old
•Youngest consumer	21 years old

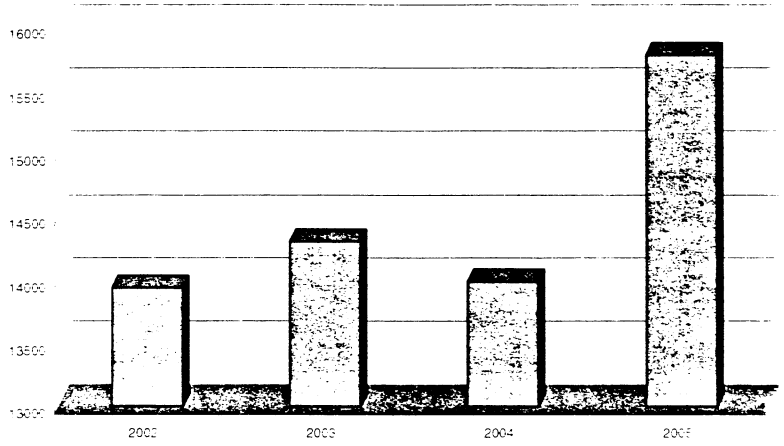
Aging Services Division

AD*vantage* Waiver Benefits

- •Personal Care
- •Advanced Personal Care
- •Consumer Directed Personal Assistance Services
- •Skilled Nursing Care
- •Case Management
- •Environmental Modifications
- •Medication
- •Medical Equipment/Supplies
- •Adult Day Health
- •Home Delivered Meals
- •Occupational, Physical, and Speech Therapies

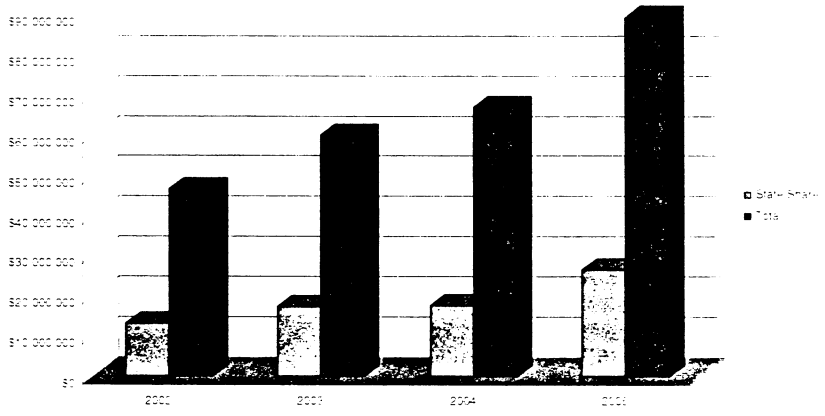
Aging Services Division

ADvantage Clients Served



Aging Services Division

State & Federal Dollars Spent for ADvantage Waiver Clients



Aging Services Division

Comparative costs

One day of basic nursing home care:	$83
One day of basic AD*vantage* service	$22*

* For services that DHS maintains the state share.

State Plan Personal Care

<u>Eligibility Requirements</u>

- Meet Medicaid financial eligibility requirements
  - Individual income cannot exceed $776 a month
  - Couple income cannot exceed $1,041 a month
  - Resources cannot exceed $2,000
- Need assistance in home

State Plan Personal Care

Personal Care Benefits (non-technical)

Bathing assistance	Meal preparation
Chore service	Laundry
Light housekeeping	Errands

State Plan Personal Care

2005 Program Data

- Served 6,739 individuals
- Expended $16.9 million (state share $5 million)

Aging Services Division

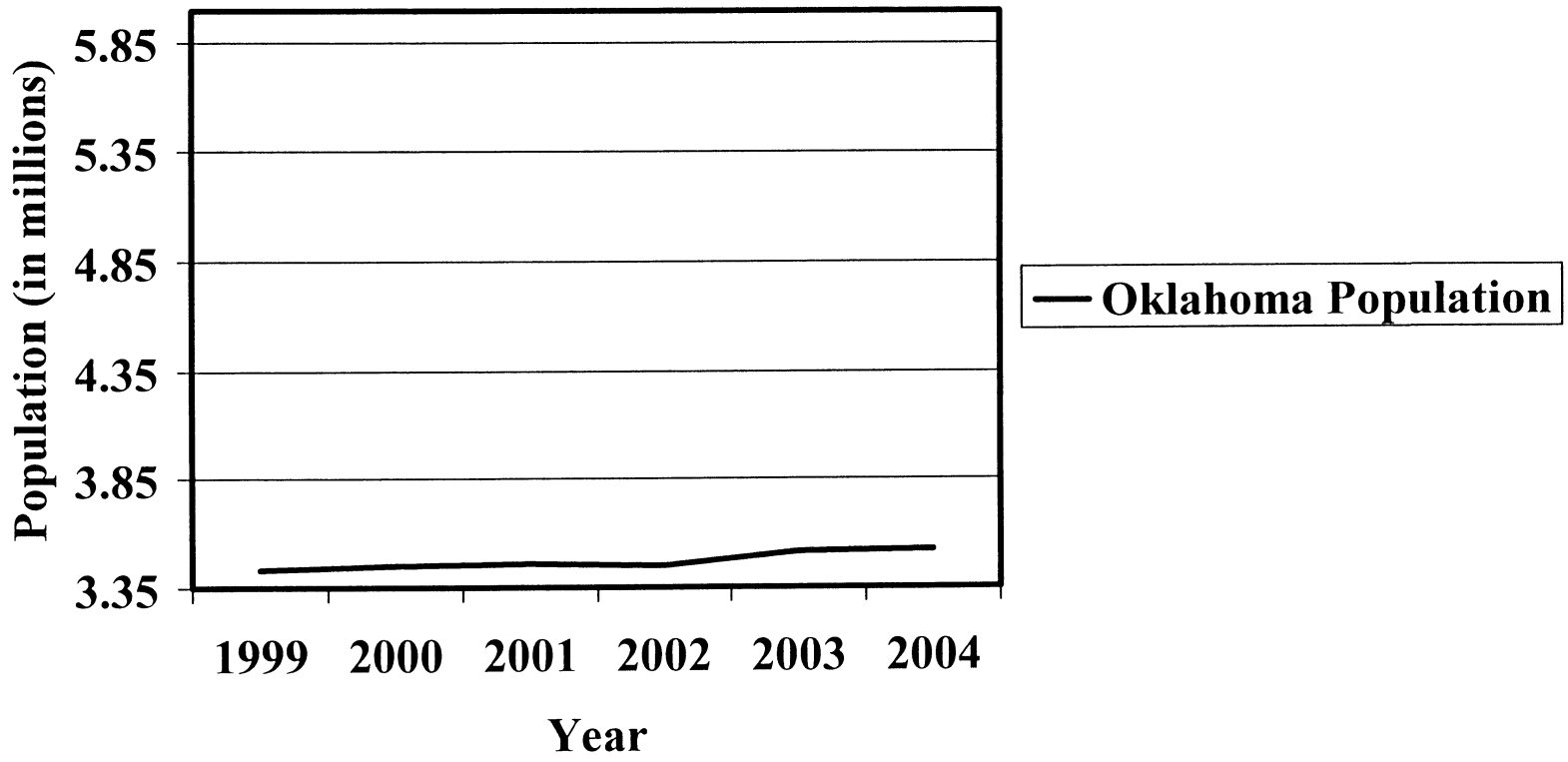
Appendix J

Reforming Medicaid

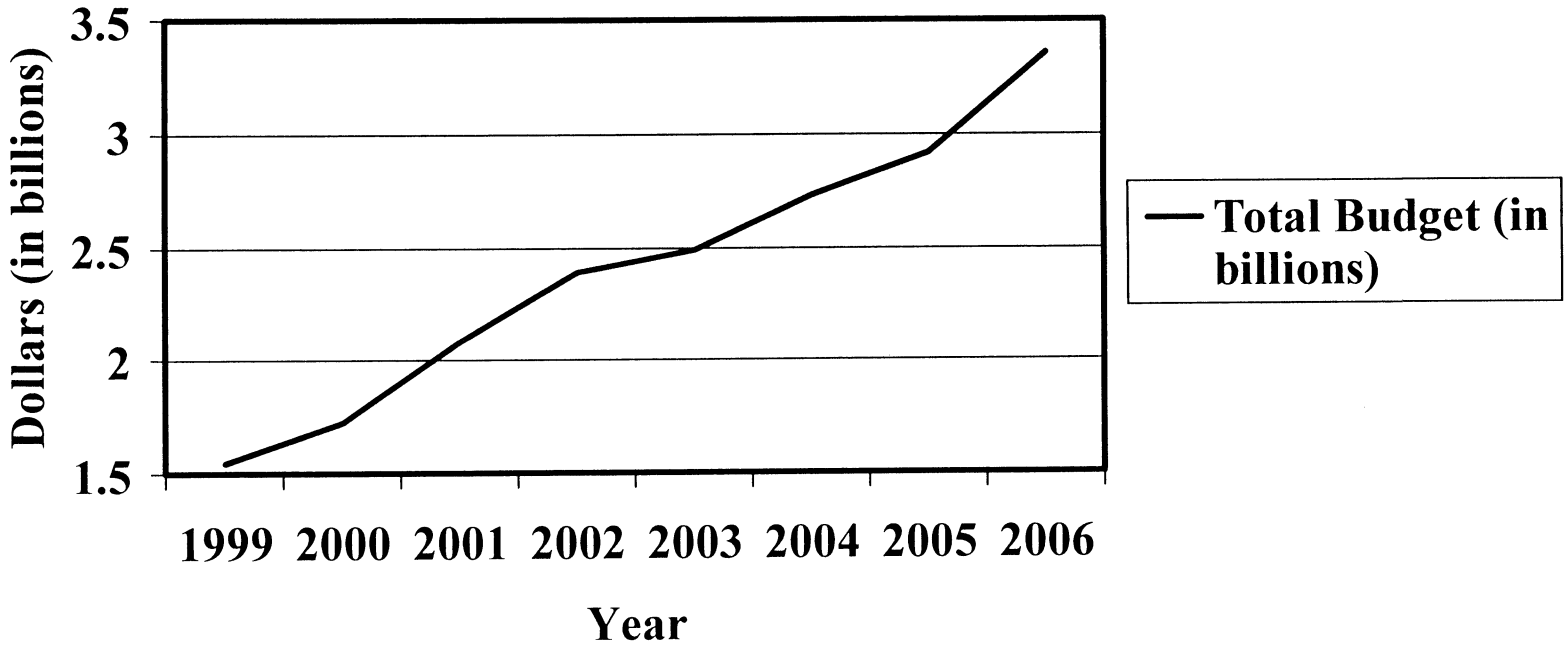
Managing Disease and Risk through Competition

By
Ron Lindsey

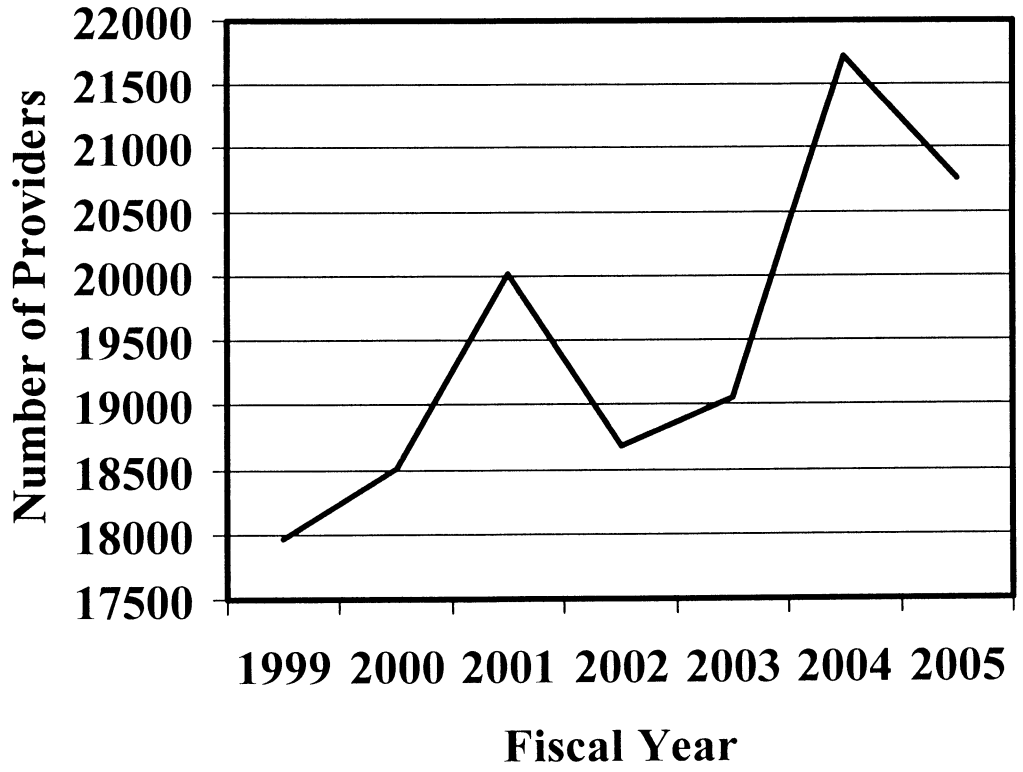
Oklahoma Population 1999-2004



Oklahoma Medicaid Budget 1999-2006



Total Number of Providers 1999-2005



[redacted]

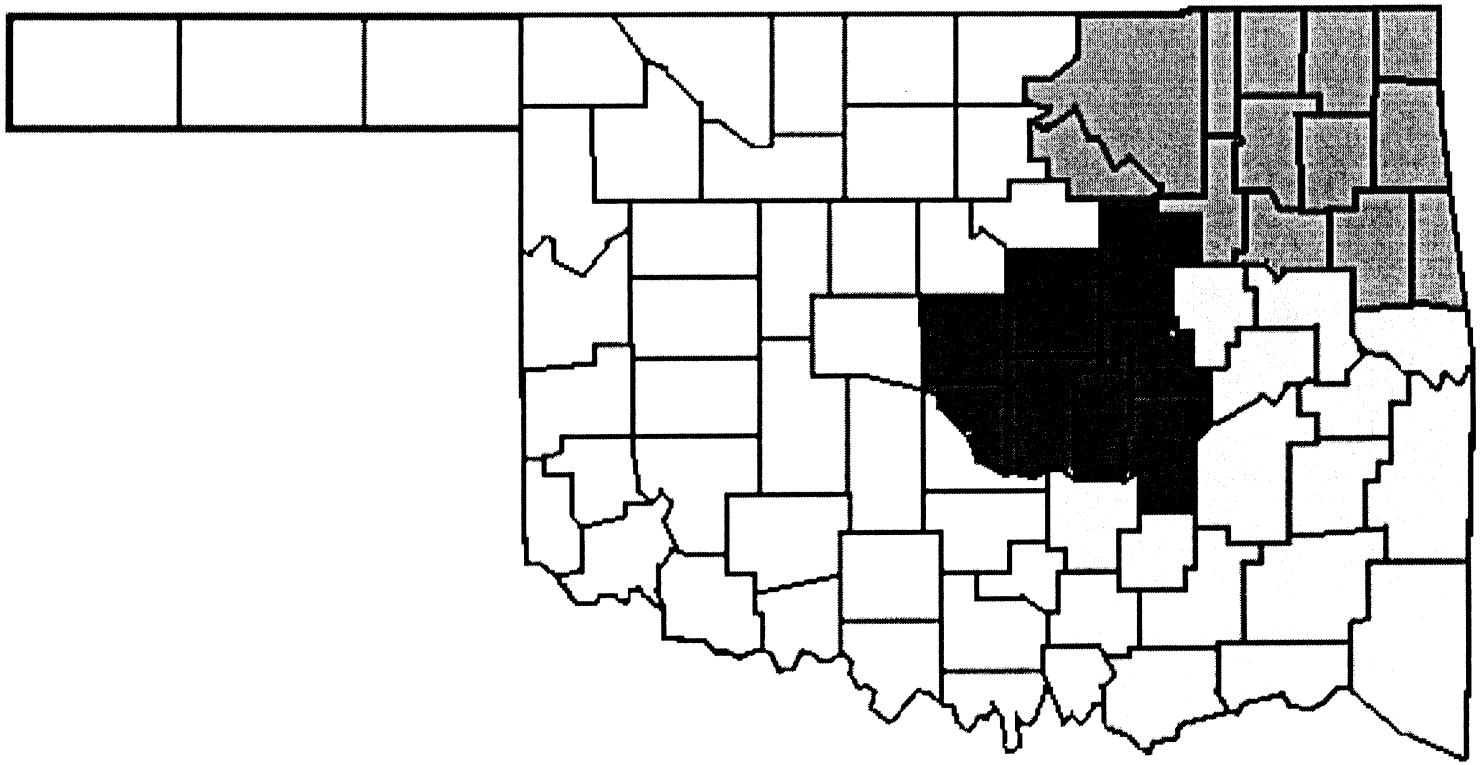
Medicaid Economics

- Services can be provided profitably by providers –or--
- Providers receive value and marginal utility by offsetting fixed costs serving Medicaid patients
- Provider shortages are due to price setting by government rather than optimal pricing being set in the open market

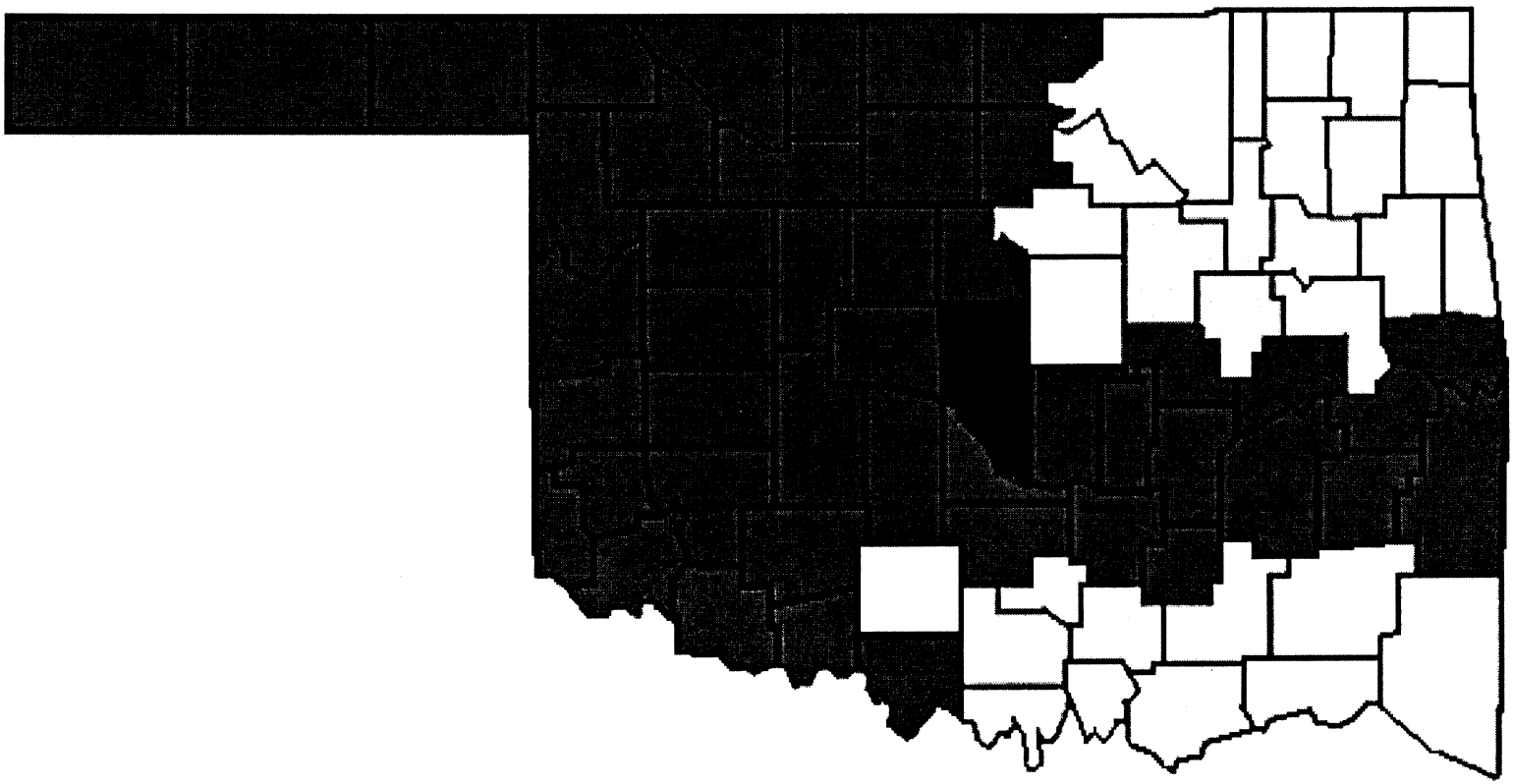
Pursue Broad HIFA Waiver(s)

- Allow bidders to propose consumer choice models
- Seek approval to allow bidders to propose pricing based upon different levels of deductibles and eligibility criteria
- Deregulate bureaucratic constraints to reduce costs on providers

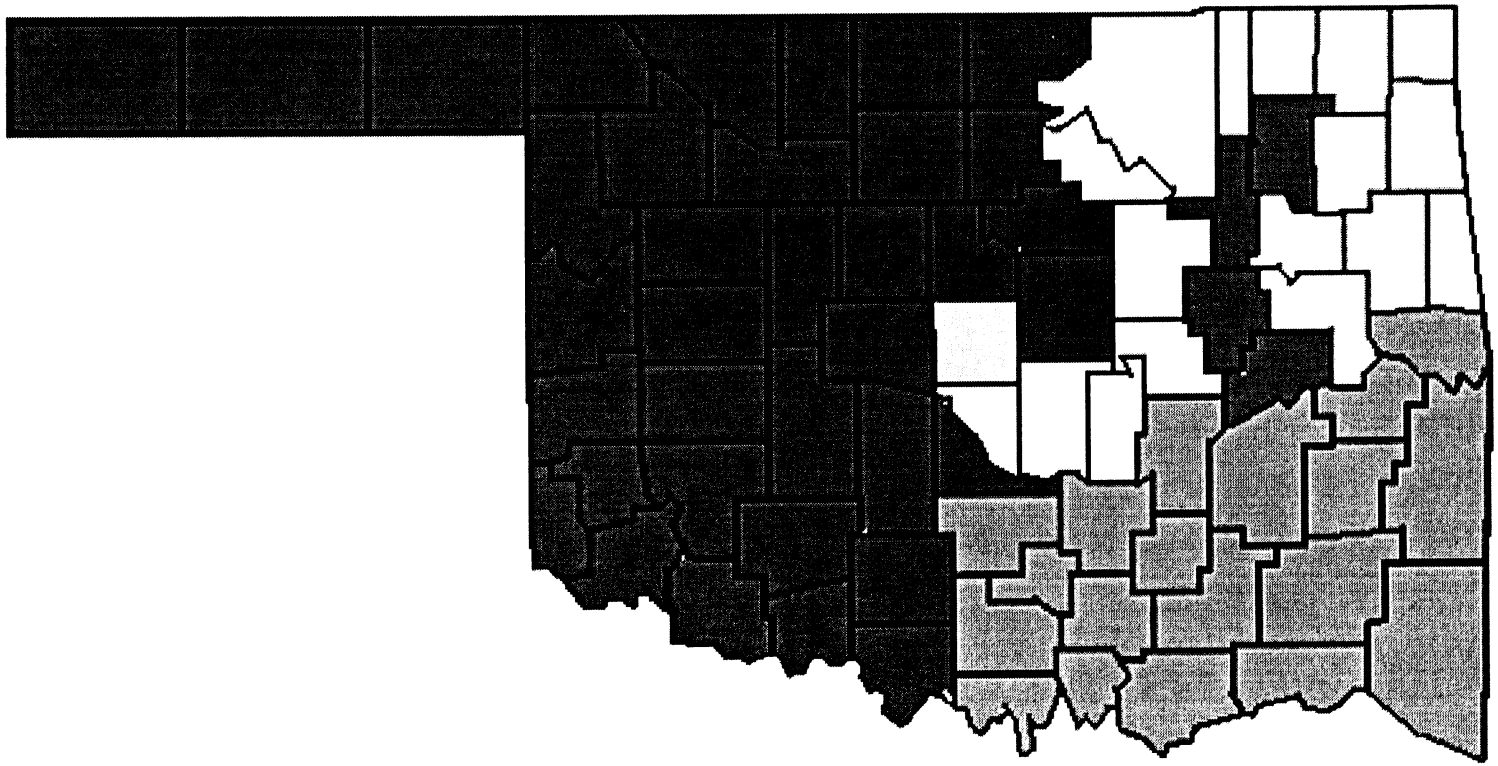
Blind and Disabled Carve-Out



Aged Carve-Out



TANF-Families Carve-Out



Controlling Costs

- Constant competition between bidders
- Two health performance plans per geographic region
- Fixed cost bids regardless of population with higher cost bidder receiving default patients rather than the winning low bidder per region
- Dollars only follow the patient when a patient changes health plans

Managing Performance

- Establish performance outcomes for each eligibility category with advocates, providers, and policy makers establishing criteria
- Quantitatively measure performance through an objective performance evaluation
- Pay for incentives to high performers by penalizing poor performers
- Gradually consolidate the market to high performing providers with minimal disparity from top performer to low performer
- Difference from prior managed care plans is constant competition

Improving Patient Health Care

- Reformed system encourages providers to make patients healthier rather than sicker
- Competition and market forces yield the true cost of quality care
- Clear choices on eligibility and patient responsibility are presented to policy makers
- Poor performers must improve or exit the business

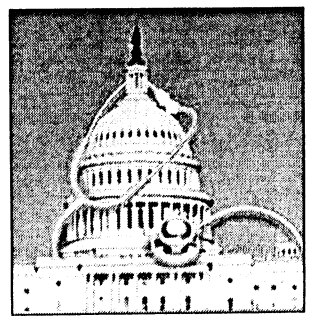
Conclusion

- Seek and obtain the broadest HIFA waiver possible
- Parallel to that process carve the Medicaid budget into manageable yet scaled "chunks"
- Bid out on a fixed cost basis with risk based reserving requirements
- Develop quantitative performance measures that benefit the best "disease managers" for each eligibility category carve out

Appendix K

The Free-Market Road to Medicaid Reform

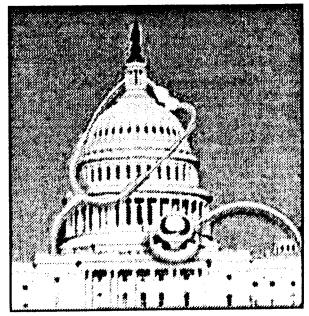
Christie Raniszewski Herrera
Director, Health and Human Services Task Force
American Legislative Exchange Council
Washington, D.C.



About ALEC

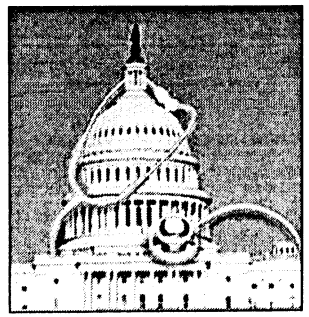
• ALEC is the nation's largest nonpartisan individual membership organization of state legislators, with nearly 2,400 members across the country.

•Our mission is to promote the Jeffersonian principles of limited government, free markets, federalism, and individual liberty.



Medicaid: Key Facts and Statistics

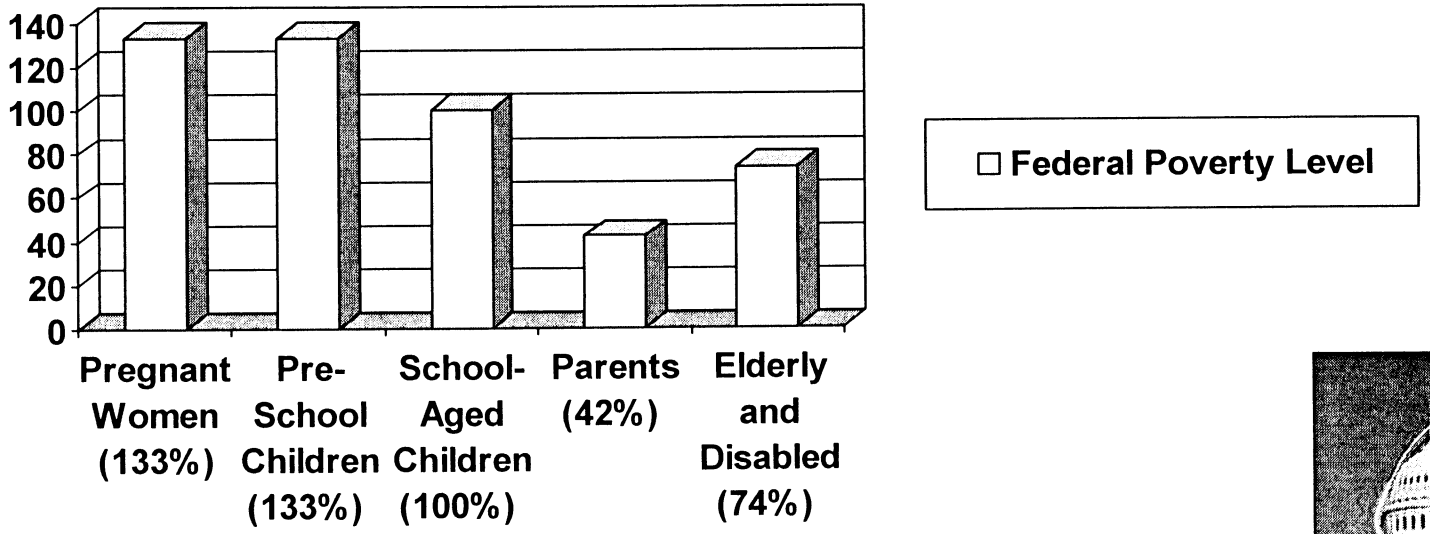
- Congress established Medicaid in 1965 under Title XIX of the Social Security Act.
- Medicaid targets the welfare population: single parents with children, the aged/blind/disabled.
- States must provide federally-defined benefits to a federally-defined population.



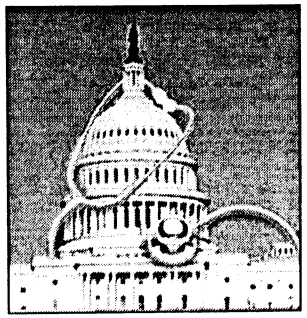
Medicaid: Key Facts and Statistics

The Federal Poverty Level (FPL):
$9,310 for a single person
$15,670 for a family of three

MINUIMUM MEDICAID FEDERAL ELIGIBILITY LEVELS (2004)
Income eligibility levels as a percent of FPL:



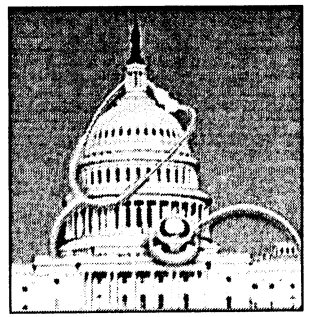
Source: Diane Rowland, Kaiser Commission on Medicaid and the Uninsured



Medicaid: Key Facts and Statistics

Federally-Mandated Services Include . . .

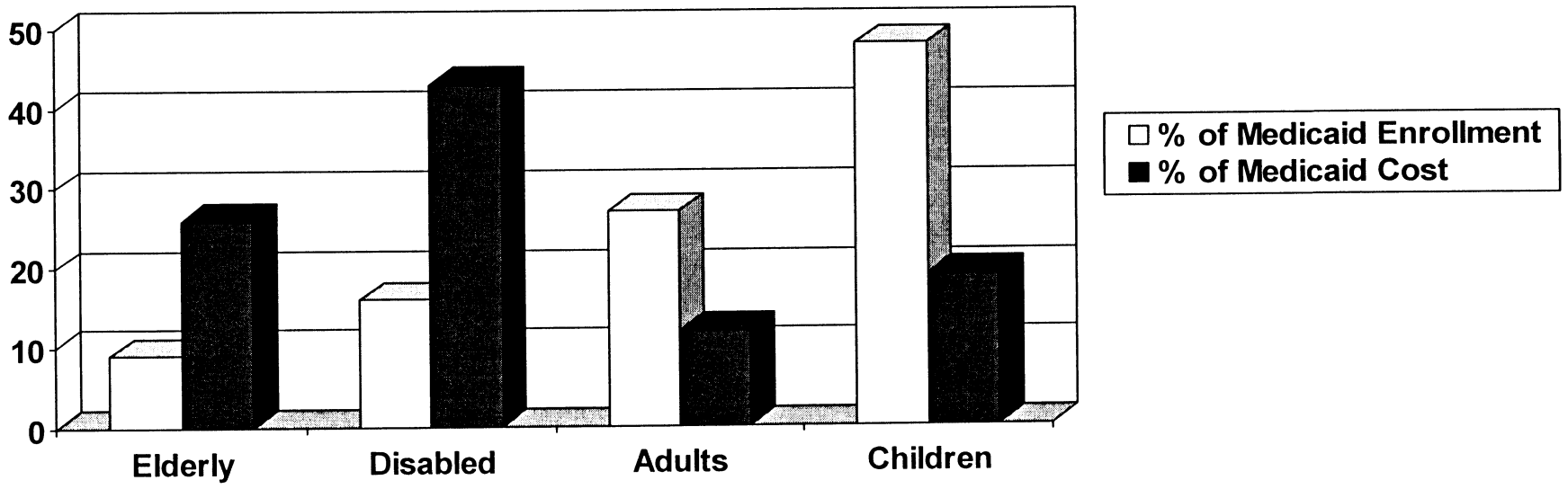
- Physician services
- Laboratory and x-ray services
- Inpatient/outpatient hospital services
- EPSDT (early and periodic screening, diagnostic, and treatment services) for those under 21
- Family planning
- FQHC (rural and federally-qualified health center services)
- Nurse midwife services
- Nursing facility services for adults



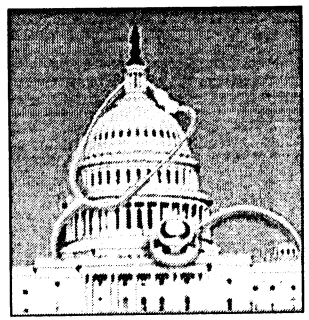
Source: Diane Rowland, Kaiser Commission on Medicaid and the Uninsured

Medicaid: Key Facts and Statistics

MEDICAID COSTS BY ENROLLMENT GROUP (2003)

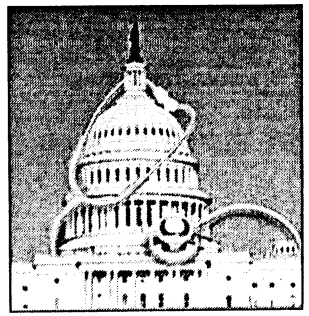


Source: Diane Rowland, Kaiser Commission on Medicaid and the Uninsured



Perverse Incentives: The Federal Match

- Federal Medical Assistance Program (FMAP) pays for more than half of Medicaid spending.
- It's a guaranteed return-on-investment for state Medicaid dollars.
- Average federal match: 57%.
- Oklahoma's federal match: 60%.



Sources: Cato Institute, Oklahoma Council of Public Affairs

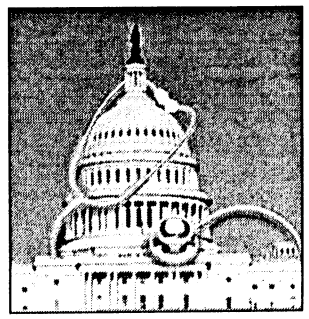
Perverse Incentives: The Federal Match

- Open-ended, dollar-for-dollar federal match means that states tend to milk the system for all it's worth, using creativity to define Medicaid "spending."

- **The problem: federal money isn't "free"!**

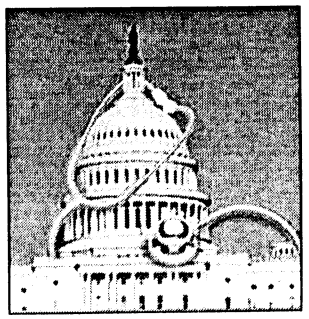
  - Your own taxpayers pay federal, state, and local taxes. They don't distinguish which branch of government takes their money—they just know they're worse off because of it.

  - Skyrocketing Medicaid spending—in the form of higher taxes—could hurt the recipients that Medicaid is supposed to help.



Perverse Incentives: Providers

- Medicaid's "command-and-control" reimbursement system tells providers what they're paid for services, regardless of market value.
- Medicaid reimbursement = about 62% of what Medicare pays.
- Medicare reimbursement = only 80% of what private markets pay.
- Oklahoma Hospital Association: Oklahoma providers get only 62 cents for every dollar of Medicaid treatment.



Sources: American Legislative Exchange Council, Oklahoma Council of Public Affairs

Perverse Incentives: Patients

- Medicaid's beneficiaries have little or no cost-sharing requirements, making Medicaid virtually "free." There's no reason for them to be prudent health care consumers.

- Removing price sensitivity induces patients to consume more medical care by as much as 43%.

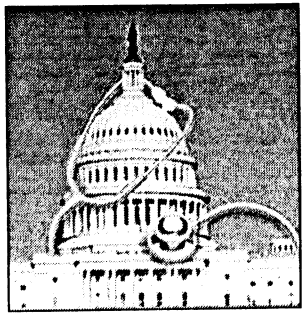
- **The problem: Overconsumption affects the private market as well as Medicaid.**

Increased demand for medical services

=

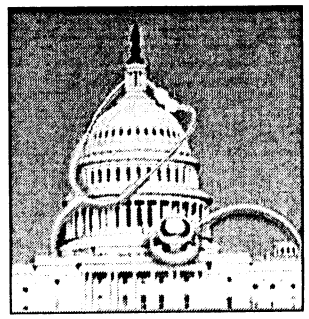
Higher prices for everyone

Source: RAND Health Insurance Group



Perverse Incentives: Eligibility

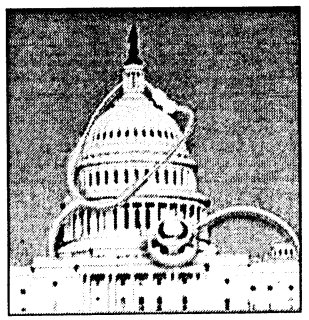
- The federal match led to an explosion of eligibility in the 1990s, which took away funds from the truly needy.
- Optional coverage is the rule, not the exception.
- Only 39% of Medicaid spending is spent on mandatory coverage.
- 21% of adults and 27% of children who qualified for Medicaid were eligible for private insurance.
- Almost a quarter of Medicaid eligibles actually had private coverage.



Sources: Pacific Research Institute, Urban Institute

Perverse Incentives: Eligibility

Instead of expanding eligibility, the goal of Medicaid reform should be to return as many people as possible to the private market.



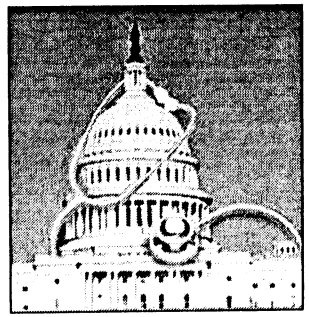
The Moral Case for Medicaid Reform

- The example of welfare reform leads the way for Medicaid reform.

- Both programs conferred a legal right to benefits, both got funding in an open-ended federal match, and both programs were micromanaged from Washington.

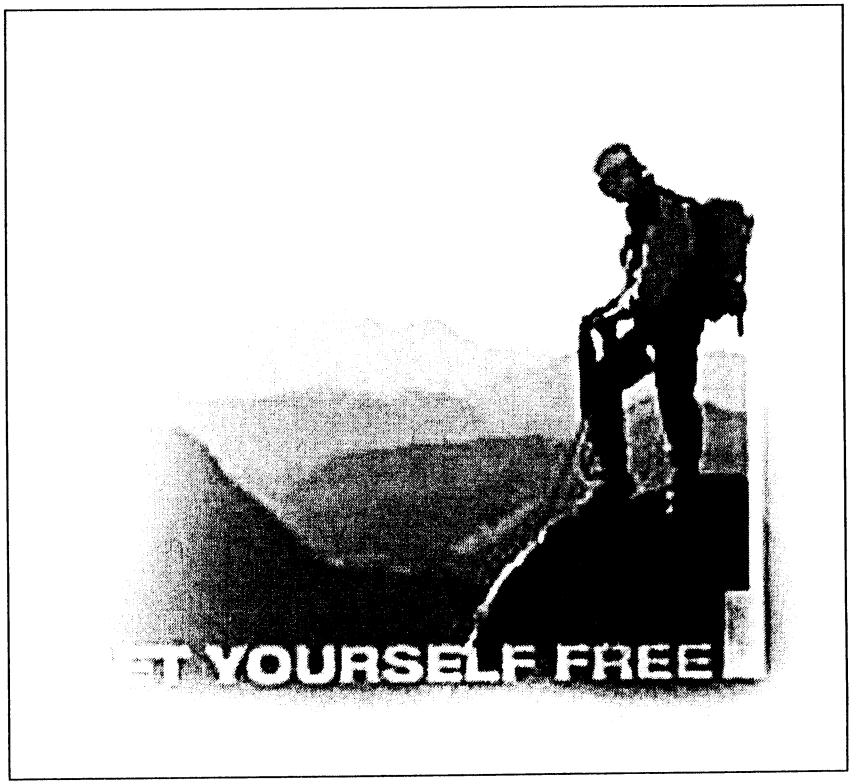
- When government tries to "do good," there are always unintended consequences.

- The difference between Medicaid and welfare: states took matters into their own hands to "end welfare as we know it" and empower welfare recipients to become self-sufficient.



The Moral Case for Medicaid Reform

THE "CLIFF EFFECT"



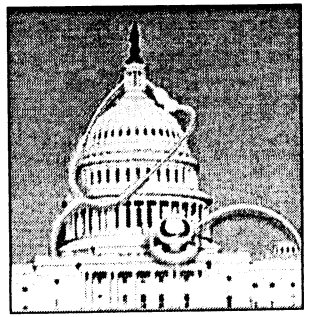
Source: Jenifer Zeigler, Welfare Policy Analyst, Cato Institute

The Moral Case for Medicaid Reform

DISCOURAGES SAVING

- Poor families might be hesitant to accumulate wealth, because they know they'll have to spend it down in order to qualify for benefits.

- As a result, recipients consume more instead of save more, which eliminates self-sufficiency.



Source: Jenifer Zeigler, Welfare Policy Analyst, Cato Institute

The Moral Case for Medicaid Reform

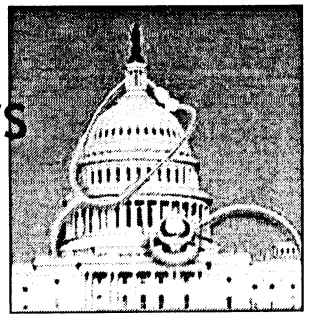
"CROWD-OUT"

- When the government begins to provide a service, it crowds out other alternatives.

- Robert Wood Johnson Foundation: More than half of the expansion in public health care coverage is accompanied by reductions in private health care coverage.

- There's no incentive for companies to provide health insurance if they know some of their employees will qualify for public assistance.

- Borjas: When forced to find private coverage, workers sought employment that provided for health care.



Source: Jenifer Zeigler, Welfare Policy Analyst, Cato Institute

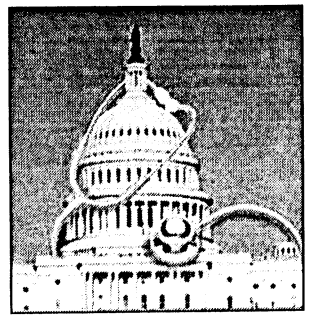
What Works: Key Elements

- Devolving Medicaid to the state level will allow Oklahoma to use Medicaid funds to care for its own citizens—without many federal strings attached.

- Your mission: Transition as many people as possible to self-sufficiency through private market coverage, rather than expanding enrollment.

- Medicaid should be private and portable. It should not be a disincentive to work or save.

- **Medicaid must be overhauled to a defined contributions structure, rather than a defined benefits structure.**



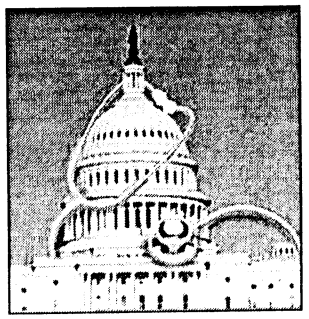
What Works: Key Elements

THE NON-ELDERLY POOR

- Health Savings Accounts (HSAs) will make beneficiaries more responsible for their health care dollars and decisions.

- The state should provide information on providers, benefits, and pricing so that HSA owners make sound and informed decisions.

- The state could also provide case management support, which has been proven successful in Medicaid "Cash and Counseling" pilot programs.



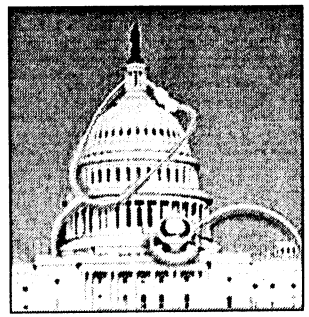
What Works: Key Elements

THE DISABLED

- Need flexibility in alternative coverage and treatment.

THE ELDERLY

- Lowest enrollment, but most expensive. Long-term care = 70% of all Medicaid spending.
- Medicaid discourages 66-90% of seniors from buying long-term care insurance.
- Long-term care insurance market should flourish.
- Eligibility exemptions should be reviewed.



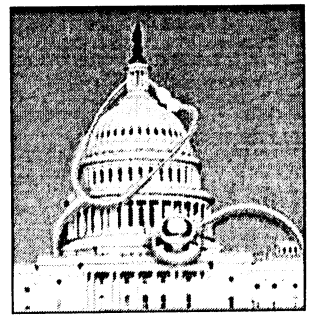
Sources: American Legislative Exchange Council, University of Illinois/National Bureau of Economic Research

The South Carolina Medicaid Choice Plan

"The systematic hiding of health care costs from those who pay them gives rise to the ultimate 'moral hazard': allowing politicians to spend the public's money on health care in ways the public would never choose for itself either in the marketplace or in the voting booth."

--Duke University Health Care Law Professor Clark Havighurst

Source: Wall Street Journal, *10/14/2004 (via the FY 04-05 South Carolina budget)*

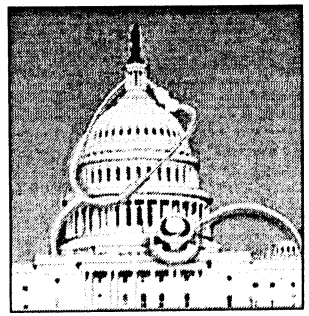


The South Carolina Medicaid Choice Plan

- South Carolina Medicaid has always operated in a "fee-for-service" manner, in which a provider delivers a service to a patient and then bills Medicaid.

- Under this arrangement, both patients and providers are isolated from market forces that drive down costs and waste—and increase quality.

- The South Carolina waiver proposal provides comprehensive, market-based reform for general and acute care.



SC Medicaid Choice: How It Works

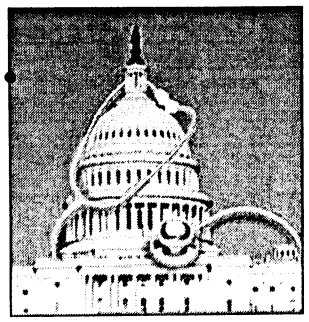
- All Medicaid beneficiaries—except for dual-eligibles—would be given a Personal Health Account (PHA) to pay for health care services from any provider.

- Quarterly PHA deposits:

  - Actuarially-determined based on current fee-for-service structure.

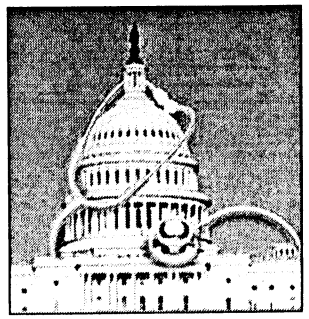
  - Risk-adjusted for both age and gender.

  - **Will not be an "average" amount for everyone.**



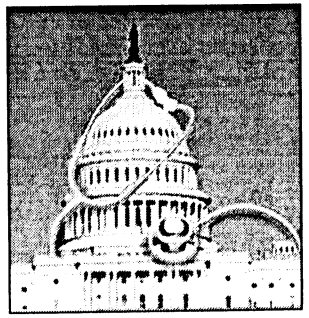
SC Medicaid Choice: How It Works

- Unspent PHA funds roll over into the following year.
- When beneficiaries are no longer eligible for Medicaid, they can use some of the unspent funds to purchase private health insurance or other medical services.
- SC Medicaid Choice will provide financial incentives for healthy living and saving.
- **These kinds of incentives would do more to encourage healthy living and fiscal fitness than existing government mandates.**



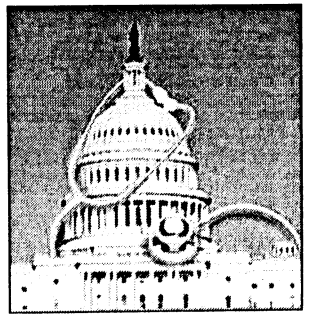
SC Medicaid Choice: How It Works

- In addition to the PHA, beneficiaries would be provided with catastrophic and preventive coverage.
- Children's coverage will remain the same under current State Children's Health Insurance Program (SCHIP) rules.
- Adults' coverage must include the federal minimum of mandatory services.



SC Medicaid Choice: Self-Directed Care

- The beneficiary purchases a limited major medical benefits plan that includes certain preventive services.
- The "premium" is deducted from the PHA using an actuarial estimate of preventive service expenses.
- Beneficiaries will have to pay a co-payment for preventive services, which can be paid from the PHA.
- PHA owners can use their funds to buy services directly from any provider using their debit card.

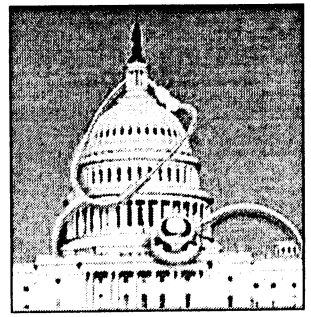


SC Medicaid Choice: Self-Directed Care

The Limitations:

- No history of "unstable expensive acute care crises."
- Must have a "medical home," or primary care physician.
- Must have a reasonable understanding of their family's health care needs and how they are met.

Enrollment counselors will help PHA owners with options, helping them become savvy health care consumers.



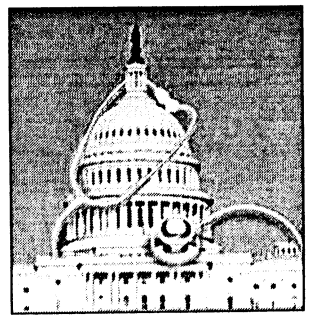
SC Medicaid Choice: Managed Care

- Beneficiaries use their PHA funds to buy an insurance plan from a Managed Care Organization (MCO) or any plan that combines standard insurance with a pharmacy or dental plan.

- Medicaid will pay the premium directly to the insurance company.

- The beneficiary can use leftover PHA funds for co-payments or to directly purchase services not covered by their plan.

- **The goal: Plans will compete for beneficiaries' business by creating an array of low-cost coverage packages that can specialize in what their customers are looking for.**



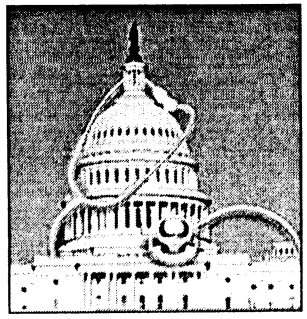
SC Medicaid Choice: MHNs

- Beneficiaries would have a "medical home," or primary care physician, who coordinates their care under the existing fee-for-service model.

- Because of its similarity to the existing fee-for-service structure, the premium for this plan would require the full amount of the PHA.

- **The advantage: If a beneficiary's costs exceed the original estimate, then both the provider and the state share in the loss. When a beneficiary's costs are less than expected, both share in the savings.**

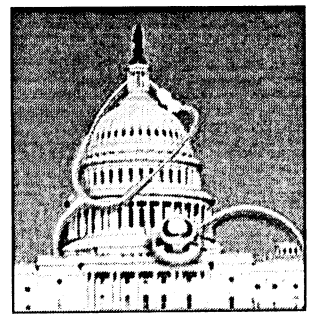
- **Everyone has a financial stake in savings and quality.**



SC Medicaid Choice: Alternative Coverage

- Beneficiaries who have access to group-based health insurance may "opt out" of Medicaid.

- In this case, Medicaid pays the beneficiary's premium up the amount it would otherwise pay—and the beneficiary is responsible for the remainder.



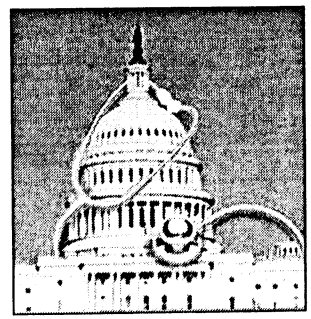
SC Medicaid Choice: The Concept Paper

- Before South Carolina submitted its waiver request in June, it authored a "concept paper" that broadly outlined its Medicaid reform plan.

- South Carolina's waiver request included the concept paper's outline for reforming Medicaid acute and general care.

- South Carolina's waiver request did not include reform plans for community-based and long-term care.

- South Carolina Medicaid officials will submit separate waiver requests for these areas.



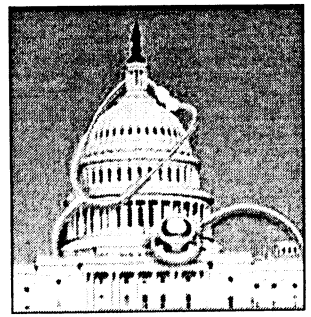
SC Medicaid Choice: Community Care

- Currently, the disabled and elderly choose from a pre-approved list of Medicaid services.

- **The problem: They can only get what Medicaid gives—and this rigid set of services often isn't tailored to meet individual needs.**

- The disabled and elderly should receive a PHA that—in addition to normal PHA deposits—would include additional funds for additional services.

- Enrollment counselors would help every step of the way.

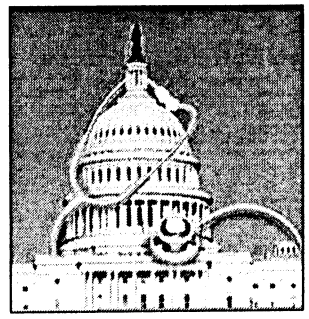


SC Medicaid Choice: Long-Term Care

- Offers different purchasing options, since the most common unit states buy is a day of care.

- Because links to payment and quality are limited, South Carolina has proposed changing its broken system to a more competitive bidding approach.

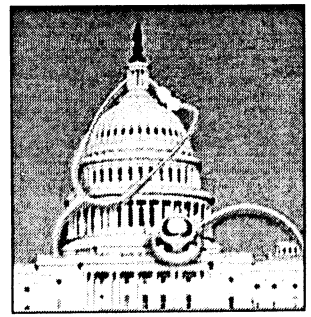
- Medicaid beds would be bid on the open market. Beds could be allocated from the lowest bid up until all of the Medicaid funding is spent.



SC Medicaid Choice: Long-Term Care

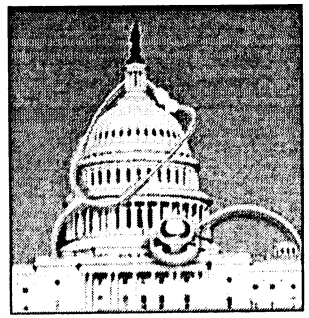
The Limitations:

- Beds must be distributed based on the lowest bid.
- Adequate quality must be assured by enforcing survey and certification standards.
- Bids will accepted for three years at a time to stabilize the system.
- Quality will be improved by tying rate increases to quality performance standards for each nursing home.



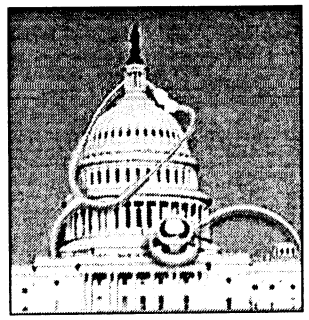
The Florida Plan: Why Reform?

- Budget constraints
- Patient care
- Simplification of an already-complex Medicaid system of 47 covered services, 11 managed care plans, five case management plans, and 20 existing Medicaid waivers (!)
- Fraud and abuse: 2/3 of Florida's enrollees are still in fee-for-service plans, where fraud and abuse is rampant.



The Florida Plan: Guiding Principles

- Patient Responsibility and Empowerment
- Marketplace Decisions
- Bridging Public and Private Coverage
- Sustainable Growth Rates



The Florida Plan: Benefits

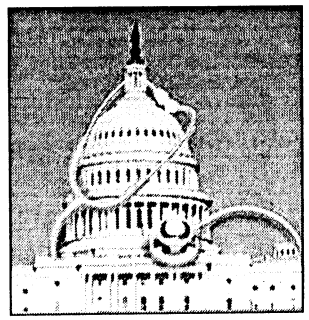
BENEFITS

=

Core set of federally-mandated benefits

+

"Customized Benefit Packages"
that include most optional Medicaid services



The Florida Plan: Who Assumes Risk?

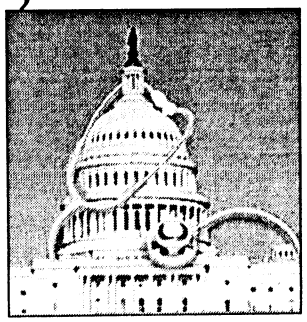
- **Core set of required benefits + "customized benefit package" = COMPREHENSIVE CARE.**

- Participating plans would assume full risk for comprehensive care expenses up to the maximum dollar amount of the state-provided premium.

- **Comprehensive care expenses more than the maximum = CATASTROPHIC COVERAGE.**

- Participating plans could choose not to assume the financial risk for catastrophic coverage—and if that's the case, the state assumes that risk.

- **Opt-Out/Cost-Sharing/Enhanced Benefit Accounts**

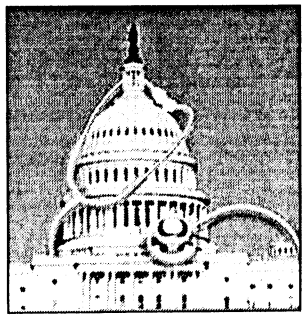


For more information on "The Free Market Road to Medicaid Reform," visit:

American Legislative Exchange Council
http://www.alec.org

South Carolina's Medicaid Choice Plan
http://www.dhhs.state.sc.us/dhhsnew/HealthyConnections/Related.asp

Florida's "Empowered Care" Medicaid Reform Plan:
http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml



Appendix L

Home and Community Based Services in Oklahoma: A Systems Review
A Report Completed by the National Academy for State Health Policy (NASHP)
September, 2005

Recommendations Overview

Goal of NASHP Recommendations
Improve the balance in Oklahoma long term care spending among community, residential and institutional services - shifting resources to create balance.

NASHP Recommendations
Recommendation A: Oklahoma should include a long term care philosophy and mission statement in statue and regulation.

- Philosophy is a starting point for developing a road map or strategic plan for long term care.
- Philosophy facilitates changing the balance between institutional and community care.

Current System Structure: NASHP found no written statement of the state's philosophy for its long term care program in statute, regulations or policy materials.

Rationale: Philosophy guides policy, budget and program decisions. Especially during revenue shortfalls, philosophy can allow states to avoid reductions in its community based services because of its commitment to reducing the nursing home caseload and expanding HCBS waiver spending.

Recommendation B: Budgets for nursing home and ADvantage should be linked to one another. Establish a single Medicaid LTC line item within one state agency.

- Creates the infrastructure necessary for shifting funds from institutional to community services.
- Allows state to purchase LTC services based on the needs of individuals not their Medicaid entitlement (Money Follows the Person).

Current System Structure: Nursing Facility funding is in OHCA budget, State Plan Personal Care and ADvantage funding is in OkDHS budget. While agency officials and staff work collaboratively, the separation of responsibilities makes it difficult for the state to improve management and policy development of the long term care system

Rationale: One long term care line item allows a state to expand home and community-based services by reducing Medicaid nursing home spending. It allows a state to track Medicaid utilization and shift funds to HCBS programs rather than create waiting lists or temporarily suspend waiver enrollment.

Recommendation C: Through the public – private partnership established in the ADvantage waiver, streamline access to long term care for consumers using comprehensive entry points (CEP). In Oklahoma, CEP would include options counseling, preadmission screening for nursing home and nursing home relocation planning, expedited eligibility for ADvantage waiver services and state plan personal care and service planning and authorization.

- Reduces fragmentation by consolidating access functions currently performed by multiple agencies.
- Increases visibility of single access point.
- Creates seamless access to consumers and families based on their eligibility and preferences.

Current System Structure: In 1992 the state made a strategic decision to build the ADvantage management and service delivery system outside of state government. ADvantage waiver administration and waiver management are out contracted to LTCAs of Enid and Tulsa (dba LTCA-Oklahoma). Case management and service delivery are provided by private sector agencies including not for profit, for profit and faith-based agencies. A nursing home transition pilot program, funded by the Real Choices federal grant is in operation in Tulsa County.

Rationale: Presently an institutional bias exists in access to Oklahoma long term care services. A consumer can enter a nursing home prior to Medicaid eligibility determination. Should a nursing home provider choose, a consumer can immediately be admitted into a nursing home. To access HCBS, Medicaid eligibility must be completed prior to a consumer accessing services - a process that can take months. Delays in determining eligibility may adversely affect a consumer's access to HCBS, especially in instances of hospital discharge which account for nearly half of all nursing home admits.

Recommendation D: Establish a comprehensive array of services to maximize consumer choices and building HCBS capacity to prevent unnecessary and premature nursing home placements.

- Fills gaps in existing in home support services across the state.
- Adds residential options to ADvantage waiver services.

Current System Structure: Services in adult foster homes and assisted living settings are not covered under the ADvantage waiver or under the Medicaid personal care state plan service. One of the activities of the Real Choices Systems Change federal grant is modeling affordable assisted living in Oklahoma.

Rationale: Developing residential settings as an additional setting in which ADvantage waiver can be delivered allows the state to defer nursing home placement for consumers

that do not have caregivers and may have higher needs than other consumers without informal supports. It also allows the state to relocate nursing home residents who do not have housing.

Recommendation E: Promote consumer direction in service delivery.

- Consumers control the services they receive, the providers who supply them and the manner in which services are delivered.
- Consumer may also have increased employer responsibilities including worker hiring, training, recruitment and dismissal.

Current System Structure: Consumer direction is a new development in Oklahoma. In 2005 the state's first consumer directed program was established in the ADvantage waiver. The pilot program is currently only available in Tulsa County.

Rationale: AARP surveys document that older adults favor self-directed home care over agency-directed home care, with more than 75 percent of respondents preferring to have control over the money allocated for these services and the supervision of aides providing such services. CMS is supporting consumer direction philosophy through it recent CD-PASS grants awarded to states wanting to initiate consumer directed services.

Recommendation F: Develop an integrated structure for conducting quality oversight

- Increase quality assurance and improvement activities.
- Coordinate quality oversight between OHCA, OkDHS and LTCA-Oklahoma.
- Strengthen consumer directed options.
- Quality management structure must comply with CMS quality guidelines.

Current System Structure: Oklahoma's unique long term care organizational structure diffuses responsibility for quality management across multiple entities. Quality management is not well coordinated between OHCA, LTCA-Oklahoma and OkDHS.

Rationale: The ultimate test of quality is found in positive outcomes among consumers. States must set up prospective conditions that enhance the likelihood of positive outcomes down the road. CMS identifies six primary areas:

- Is there clear leadership for quality management?
- Are there agreed to measures?
- Are discovery methods timely and consistent?
- Are there remediation systems?
- Is there a process for analyzing trends and identifying and acting on opportunities for systems improvement?
- Is there a meaningful system engagement with stakeholders in the quality management process?

Appendix M

Care Management as a Vehicle for Getting Value in Medicaid

Melanie Bella
Center for Health Care Strategies

State of Oklahoma
Medicaid Reform Task Force
November 16, 2005

Health Care System Pressures

- Roughly 50% of Americans not receiving evidence-based care (Quality Chasm)
- Increasing complexity and prevalence of co-morbidities and disabilities
- Primary care and behavioral management increasingly complex
- Most consumers receiving inadequate support for self-management and health promotion
- Crowd-out/"crowd-in"
- Policymakers and purchasers tend to resort to short-term, budget driven actions

Importance of Long Term Solutions in Medicaid

- 80 percent of Medicaid resources are spent on people with chronic conditions.
- 39 percent of Medicaid enrollees have one or more chronic conditions.
- Eleven million non-institutionalized Americans with chronic conditions have only Medicaid coverage.

Source: http://www.partnershipforsolutions.com/dms/files/chronicbook2002.pdf

Managing Care in Medicaid

- Goals of Care Management:
  - Create medical home and coordinate care
  - Improve health outcomes
  - Control costs
- States use a variety of care models:
  - Primary Care Case Management (PCCM)
  - Enhanced Primary Care Case Management (EPCCM)
  - Risk-Based Managed Care (RBMC)
  - Disease/Care Management (DM)
  - Medicaid-Medicare Demos (Medi-Medi)

Care Management Trends: Disease/Care Management

- Over 30 states have a FFS/PCCM DM program*
- Some states contract with a commercial vendor (Florida, Washington, Mississippi)
- Some states make or assemble a program "in house" (North Carolina, Indiana)
- Considerable innovation in CM/DM is occurring in the safety net system (FQHCs, safety net hospitals)
- Single disease focused programs recognize the need to evolve to address the significant co-morbidities of Medicaid consumers

*"Disease Management in Medicaid." 2004. California Healthcare Foundation . 08 Jul. 2005 <CHCF.org>.

State Options: Make, Buy, Assemble

- Make / Assemble
  - Develop "in house", typically as part of Primary Care Case Management (PCCM) program
  - Majority use the Chronic Care Model framework
  - Examples: North Carolina, Vermont, Indiana
- Buy
  - Outsource to commercial vendor
  - According to LifeMasters Supported SelfCare, 11 states have outsourced and several more are releasing RFPs
  - Examples: Washington, Oregon, Mississippi

One State's Experience

Indiana Chronic Disease Management Program (ICDMP)

ICDMP Key Principles

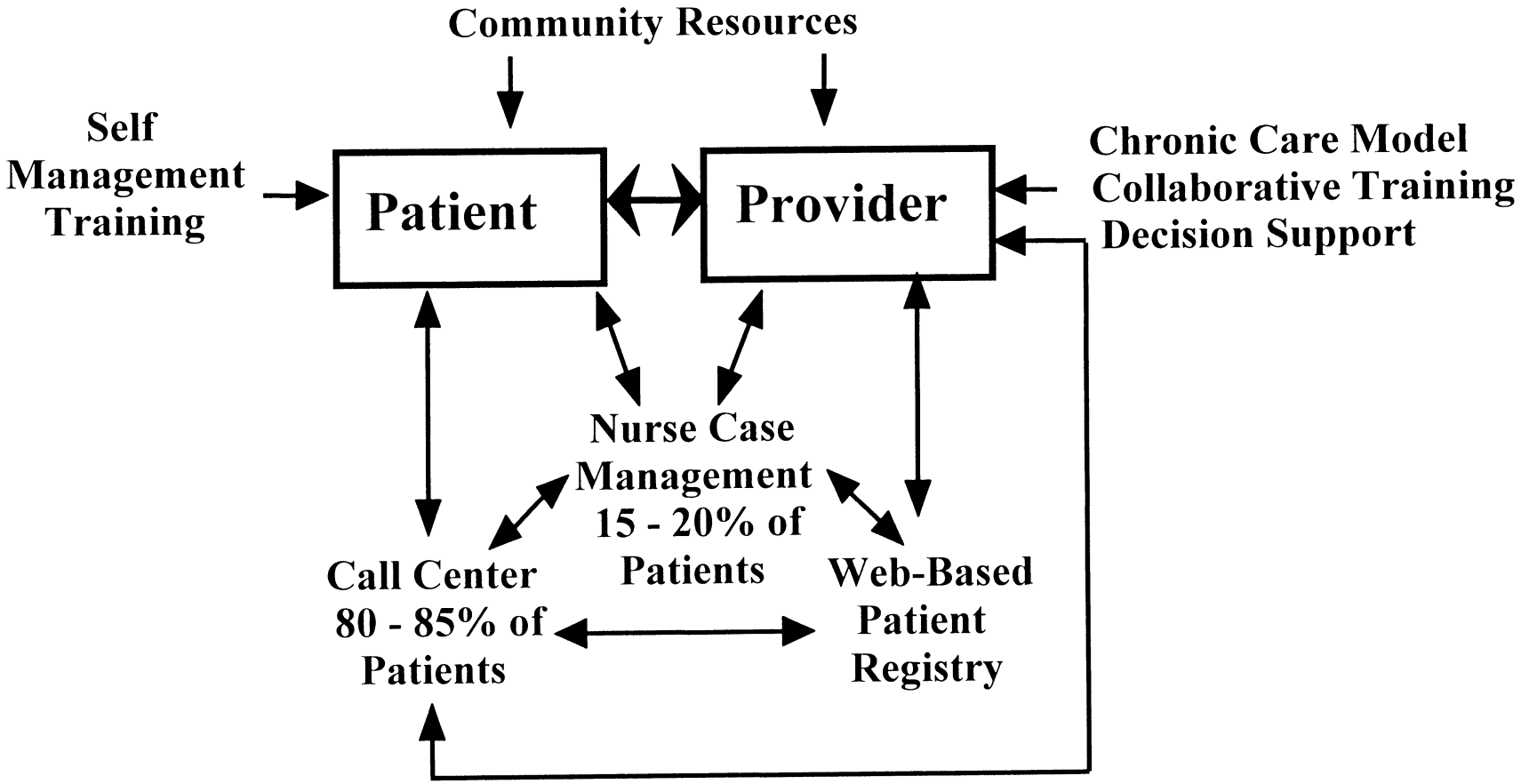
- Creates a comprehensive, sustainable community based infrastructure
- Connects care management & primary care
- The ICDMP infrastructure supports chronic care, quality improvement efforts statewide –

for all patients, providers, payers and disease states

ICDMP Program Summary

- Target Population: Aged, Blind, Disabled Adults (including dual eligibles); Children with Asthma
- Chronic Conditions: Diabetes, Congestive Heart Failure, Asthma, Chronic Kidney Disease
- Statewide Implementation
- State-Assembled Program Components:
  - Chronic Care Provider Collaboratives: 4 Regional
  - Evidence Based Guidelines: Statewide Dissemination
  - Patient Self Management
  - Nurse Care Managers
  - Centralized Call Center
  - Electronic Patient Data Registry
  - Measurement & Evaluation: RCT & Time-Series Evaluation

ICDMP Program Component Flow



Measurement & Evaluation:
Randomized Controlled Trial & Overall Statewide Evaluation

IN: Results of Preliminary Independent Evaluation

- Regenstrief Institute conducting two prong evaluation:
  - Randomized Controlled Trial (RCT) – Central Indiana
  - Time-series Evaluation – Statewide
- Preliminary Evaluation Findings*
  - RCT
    - CHF: $720 PMPM net cost savings
    - Diabetes: $41 PMPM net cost increase (increased costs in high-risk, decreased costs in low-risk)
    - Overall ROI: $29 M estimated net savings annually
  - Time series
    - There may be a slowing in the rate of growth of expenditures with the advent of the program

*Presented by Regenstrief Institute 9/28/05. Prepublication findings – please do not cite, distribute, quote.

IN: Clinical Outcomes Early Data

- CHF patients are experiencing fewer and shorter hospitalizations
- Hemoglobin A1C blood test reflects average blood sugar control for the past few months
- Medical record data captured by nurse care managers showed HbA1C decreased about 0.3 percentage points
  - Clinically significant: compares to 0.25 in intensive interventional studies of lifestyle change
- Electronic clinical record data from RCT, while still substantially incomplete, showed:
  - 2%-6% more likely to have A1C<7 (excellent control)
  - 0%-5% less likely to have A1C>9 (terrible control)

*Presented by Regenstrief Institute 9/28/05. Prepublication findings – please do not cite, distribute, quote.

Critical Success Factors

- NGA Policy Academy & Resources
- Technical Assistance from National Experts

  (MacColl Institute, Institute for Healthcare Improvement, Center for Health Care Strategies, National Initiative for Children's Healthcare Quality)
- Chronic Care Model Foundation
- Integration of Health & Medicaid
- Legislative Support
- CMS Support
- Long Term View.....short term investment

Summaries of Two Other States

- Washington
- North Carolina

Washington: Program Summary

- In 2001 session, Washington's Legislature directed DSHS to implement Disease Management (DM), in order to improve outcomes and save between 5% and10% of medical expenses in current fiscal cycle
- Target Population:
  - Fee-For-Service: SSI (aged, blind or disabled) clients, not on Medicare
  - About 125,000 clients can use the Nurse Advice Line
  - Estimated 30,000 are eligible for DM because of diagnosis; 17,000 clients actively participate
- Chronic Conditions: Asthma, Diabetes, HF, COPD, ESRD, CKD
- Statewide Implementation
- Two contractors: McKesson Health Solutions and Renaissance Health Care

WA: Results of Independent Evaluations

- First Year Study by University of Washington found:
  - Significant increase in asthma action plans
  - Significant increase in eye exams and HgA1c test for diabetics
  - Increase in ER utilization for three conditions
  - Drop in high-risk asthma length-of-stay in hospital compared to controls
  - Lower hospital and ER use by ESRD clients

- Milliman USA found that, compared to baseline expenses:
  - ESRD saved $300,000 in first year, $400,000 in second year in excess of fees paid for DM services. Exceeded the contractual guarantee.
  - Asthma, CHF, and Diabetes lost money in the first year, saved $560,000 in second program year in excess of fees paid for DM services. Did not meet the contractual guarantee.

North Carolina: Program Summary

- Target Population: TANF, MIC, Aged, Blind, Disabled
- Chronic Conditions: Asthma, Diabetes, CHF (2006)
- Statewide Implementation via Community Networks
  - Local Network QI Infrastructure: Local Medical Director, dedicated case managers, physician buy-in, practice level system change
  - State CCNC QI Infrastructure: Clinical staff for technical assistance, QI performance reports, claims data reports, annual chart audit reviews
- Responsibilities of Networks Include:
  - Managing Medicaid members' care
  - Developing quality improvement initiatives
  - Implementing cost containment initiatives
  - Creating systems to improve care

NC: Results of Independent Evaluation

- Cecil G. Sheps Center for Health Services Research Findings (April 2004):
  - Both CCNC Asthma & Diabetes Interventions resulted in reduced ED visits and inpatient hospital admissions
  - Cost savings for diabetes care for 3 year period approximately $2.1 million
  - Cost savings for asthma for calendar year 2002 approximately $1.58 million
- Chart audit results show improvement in diabetes and asthma process measures

Medicaid: Turning Challenges into Opportunities

- Managing Co-morbidities
- Consumer Self Direction
- Special Needs Plans (SNPs)
- Medicare Chronic Care Demonstrations
- State and Federal Reform Efforts
- "Scoreable" Savings

How Do We Get There… Medicaid Quality Building Blocks

The next step is to get more states (and those considering reform at the federal level) to focus on the Building Blocks for Quality

1. Evidence-Based Practices
2. Measures/Outcomes
3. Information Technology
4. Continuous Quality Improvement
5. Pay for Performance
6. Care Management
7. Integrated Care
8. Consumer Direction

Medicaid Quality Solutions

BUILDING BLOCK	EXAMPLE
1. Evidence-Based Practice	New York State is implementing standardized asthma guidelines. Indiana is adopting standardized consensus guidelines for select chronic conditions.
2. Measures/Outcomes	Virginia developed a Managed Care Performance Report to guide improvement efforts. California designed the "Dashboard" report for an "at-a-glance" view of targeted performance measures.
3. Information Technology	Indiana Medicaid developed an electronic patient data registry for the state's chronic disease management program. Numerous health plans developed asthma registries.
4. Continuous Quality Improvement	More than 150 managed care entities have participated in CHCS' Best Clinical and Administrative Practices (BCAP) initiative to improve care for targeted groups of consumers. Many states, e.g. Wisconsin and California, are working with health plans to implement and track CQI.
5. Pay for Performance	New York is distributing up to $13 million to plans through its incentive program. Seven plans in California are paying a provider bonus to improve HEDIS well-visit rates for babies and teens. Many states, e.g., Michigan, New Mexico, are using auto-assignment to reward high-performing plans.
6. Care Management	North Carolina's PCCM program assigns nurse care managers to local practices to assist with chronically ill, high-risk patients. Oklahoma, Oregon, Washington, and Pennsylvania have developed requirements for special/exceptional needs coordinators based at the state or health plan level.
7. Integrated Care	Commonwealth Care Alliance, a specialized plan for dual eligibles in Massachusetts, uses a comprehensive care coordination approach to address members' physical, behavioral and social needs. Massachusetts, Minnesota and Wisconsin have established comprehensive integrated care programs
8. Consumer Direction	Cash and counseling demonstration programs, e.g., in Arkansas, Florida, and New Jersey, offer preliminary evidence for how consumers might manage their own care. West Virginia Medicaid and other states seek to create health investment accounts that will reward consumers for healthy choices.

Closing Thoughts: Keys to Success

- Manage Care vs. Manage Costs
  - Opportunity Costs of Poor Policy Decisions
- Make the Case for Quality
  - Business Case
  - Economic Case
  - Social Case
- Front-end Investments = Long Term Gain

Questions??

ICDMP Resources

For More Information, such as

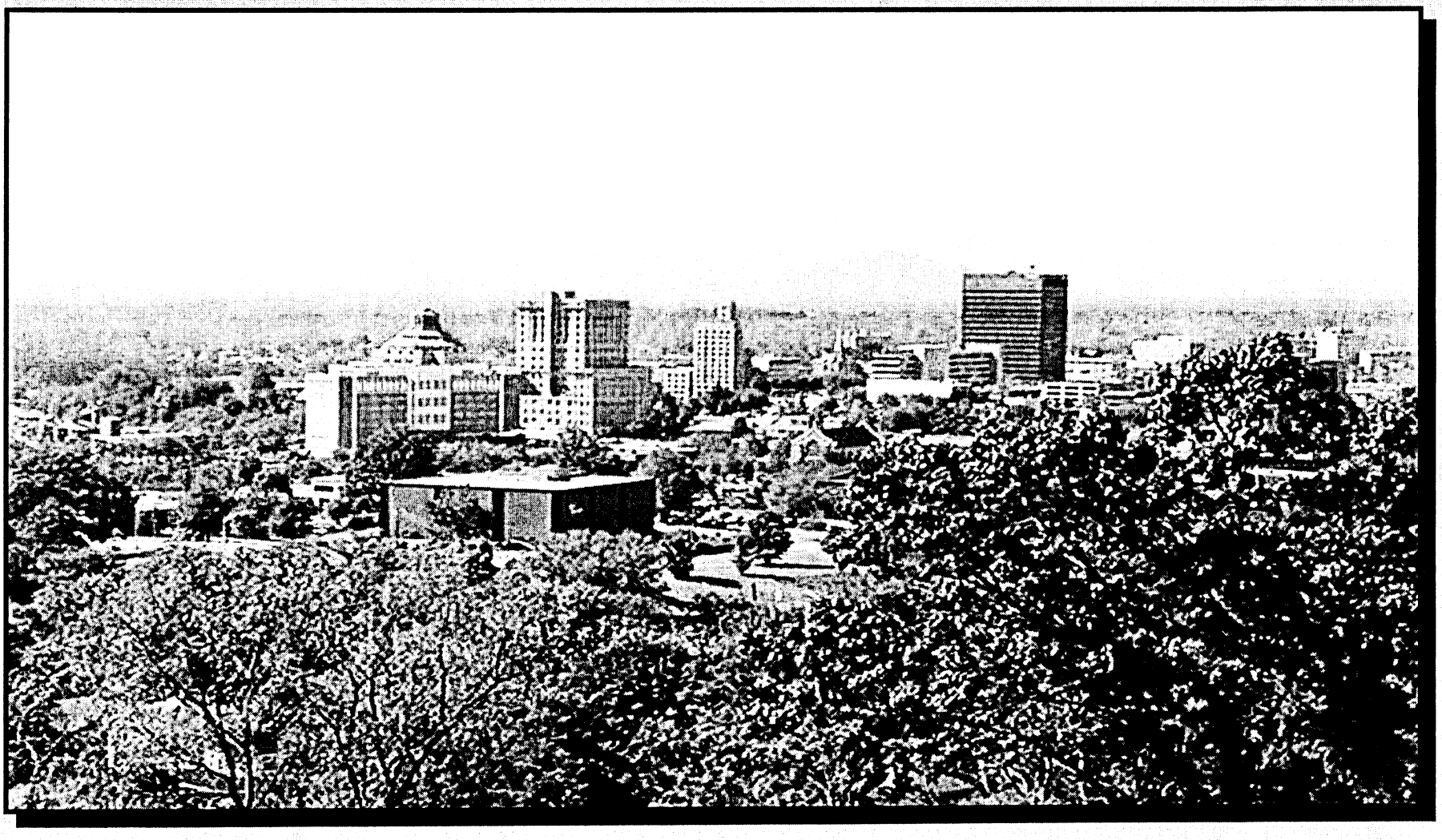
- Provider Toolkit & Guidelines
- Patient Self Management & Education
- Training Materials

http://www.indianacdmprogram.com/

Appendix N

Beyond Asheville

John Miall



Patient Centric Drug Therapy

- Patient is the:
  - Applier
  - Utilizer
  - Determiner

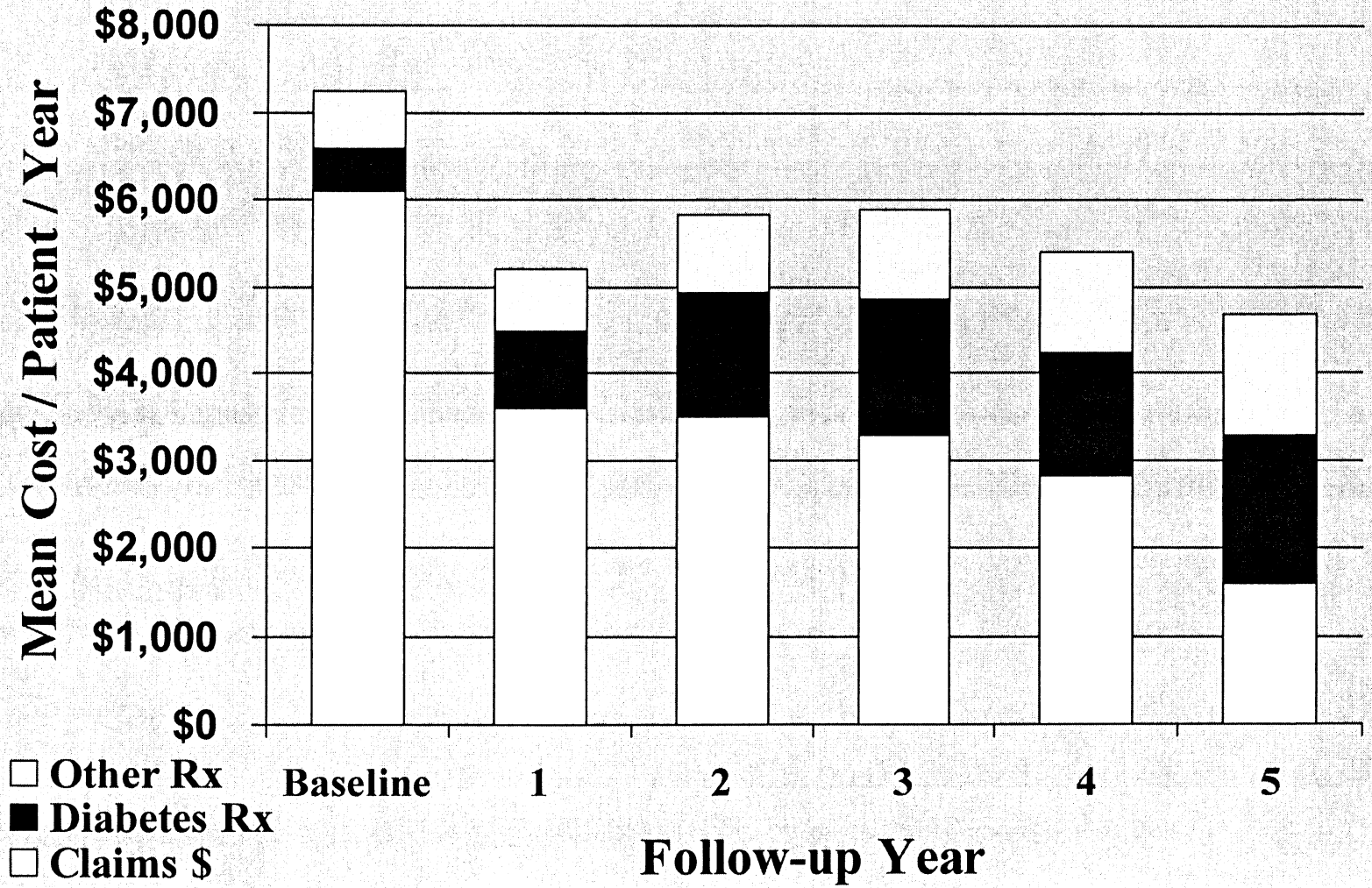
...of the outcomes associated with medication "technology"

Patients on drug therapy ultimately "*manage* their own *care*".

50% of Prescriptions that are written are not filled or taken

Direct Medical Costs Over Time[1]

[1]Cranor CW, Bunting BA, Christensen DB. The Asheville Project: Long-term clinical and economic outcomes of a community pharmacy diabetes care program. *J Am Pharm Assoc.* 2003;43:173-84.



Employer A 2nd Year Participant A1c Results*

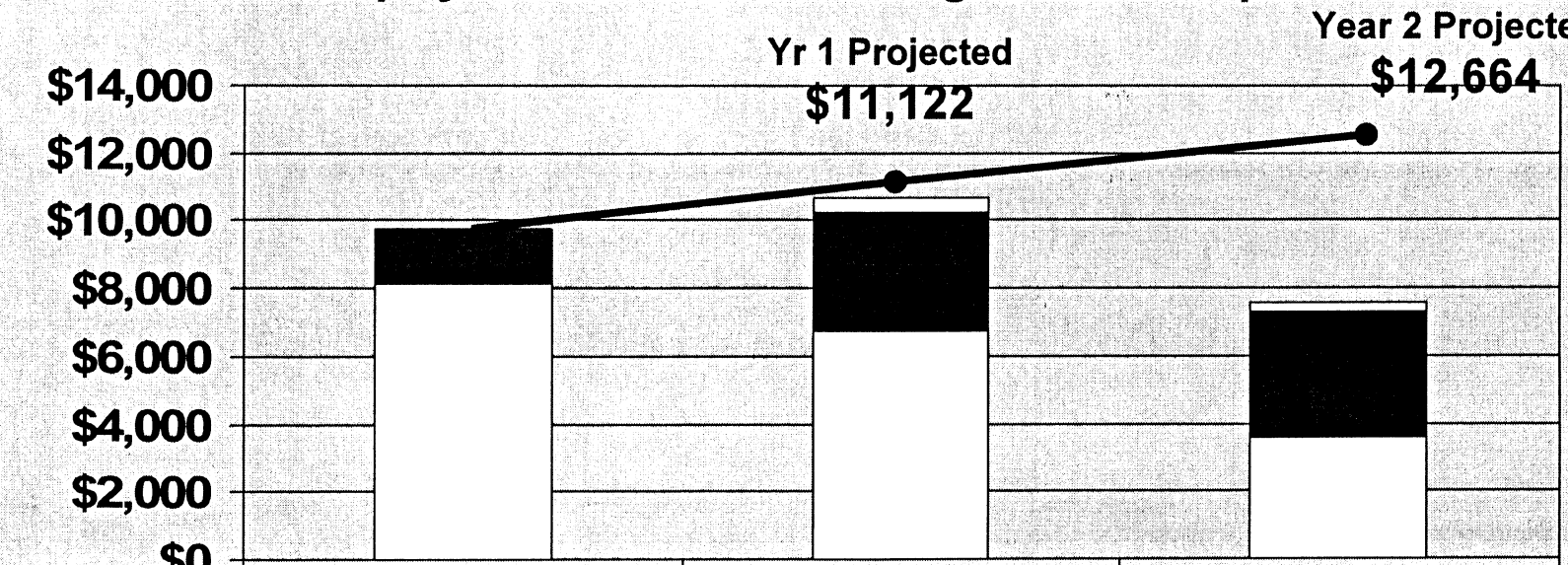
	Baseline Visit	2nd Year
Average A1c	8.3	7.0
% of A1c<9.0 (HEDIS Goal)	64%	92%
% of A1c<7.0 (ADA Goal)	39%	61%
% of A1c<6.5 (AACE Goal)	25%	47%

*for 36 patients with baseline, 1st and 2nd year results

Total Employer A Spend

Baseline, Year 1 & Year 2 compared to Projected Costs (n=36)

Total Employer A Health Benefit average annual cost/patient



	Baseline	Year 1 Actual	Year 2 Actual
☐ MTMS	$0	$404	$264
■ Medication	$1,628	$3,505	$3,715
☐ Medical	$8,143	$6,747	$3,589
Total costs	**$9,771**	**$10,656**	**$7,568**

Yr 2 savings Per Patient from projected Costs **$5,096** from Baseline Costs **$2,203**

*for 36 patients with baseline,1st and 2nd year results

Employer A Participant MD Office Visits

	Baseline	Year 1	Year 2
MD office Visits	184	243	161
Avg MD visits/year	5.1	6.8	4.5
Total MD office Visit $	$7,571	$9,451	$7,271
Avg MD office visit $	$41	$39	$45

*for 36 patients with baseline,1st and 2nd year results

Average Employer A Medical Claim Cost Shift

	Baseline	Year 1	Year 2
# of Hospital Visits	25	21	10
Total Medical Claims	1499	1902	1195
Total Medical Claim $	$293,140	$242,896	$129,191
Average $ per claim	$196	$128	$108

*for 36 patients with baseline, 1st and 2nd year results

Clinical – HEDIS 2003 Indicators

...Averages through 25-Sep-04 (n=256)

- NCQA Commercial Accredited Plans
  - A1c Testing = 85%
  - A1c Control (< 9) = 68%
  - Lipid Profile = 88%
  - Lipid Control (< 130) = 60%
  - Lipid Control (< 100) = 31%
  - Flu Shots = 48%
  - Eye Exams = 49%
- PSMP Pilot Sites – (Aggregate)
  - A1c Testing = 100%
  - A1c Control (< 9) = 94%
  - Lipid Profile = 100%
  - Lipid Control (< 130) = 78%
  - Lipid Control (< 100) = 49%
  - Flu Shots = 77%
  - Eye Exams = 82%

Health Insurance

The pilgrims did not land at Plymouth Rock with a Blue Cross card in their wallets

Appendix O

Oklahoma Dental Association

Oklahoma House of Representatives Task Force on Medicaid Reform

December 7, 2005

Dana A. Davis, MEd, ODA Executive Director

Wavel Wells, DDS, Lawton, Oklahoma

Good morning. I am Dr. Wavel Wells and I am a Pediatric dentist with a private practice in Lawton. I have been practicing dentistry for 30 years and am pleased to have this opportunity to meet with you today regarding Dental Medicaid in Oklahoma since 50 percent of my practice is Medicaid patients. I am here on behalf of the Oklahoma Dental Association. The ODA represents 1550 licensed dentists in the state or 85% of all Oklahoma dentists. The Association has been in existence for 98 years and will celebrate its Centennial year in 2007 along with the great state of Oklahoma. ODA's purposes are to promote public health and health services, advance the art and science of dentistry, represent the interest of its member, and foster an awareness of the obligations and responsibilities of the dental profession to society. It is with these purposes in mind that I am here today to provide comments regarding the Dental Medicaid program in Oklahoma.

First let me make a few comments about oral health care and dental disease.

- The first ever *Oral Health in America: A Report of the U.S. Surgeon General* authored by Surgeon General Dr. David Satcher, provided three policy themes: 1.) oral health means much more than healthy teeth; 2.) oral health is integral to general health---you cannot be healthy without oral health; and 3.) safe and

effective disease prevention measures exist that anyone can adopt to improve oral health and prevent disease.

- Oral health care is cost-effective and saves money in the long run, because dental disease is highly preventable at minimal costs. Lack of access to basic preventive and restorative treatments creates a cycle in which dental problems that could be treated easily and inexpensively instead worsen.
- Dental disease generally progresses slowly but, unlike many diseases, it does not heal without therapeutic intervention. It is chronic, progressive and destructive, becoming more severe and painful over time.
- Oral pain is particularly severe because nerve tissue is connected directly to the brain.
- Untreated oral diseases affect economic productivity by compromising ones ability to function at home, at school, or on the job. Untreated cavities result in absence from school. Over 51 million school hours are lost due to dental-related illnesses---poor children suffer nearly 12 times more restricted activity days than children from higher income families. Untreated decay also results in pain, dysfunction, reduced weight/poor nutrition, and poor appearance problems that can greatly reduce a child's capacity to succeed in life.
- Social stigma among children and even adults has a profound effect on social success which is in direct correlation to personal and professional growth. One of the first things you notice about someone is their smile.
- Children eligible for Medicaid are 3 to 5 times more likely to have untreated tooth decay.

- Nationally dental care accounts for about 20 percent of all children's health care expenditures. Medicaid children's dental care expenditures are estimated to be 2.3 percent of the program's overall children's health care spending. This is similar to Oklahoma Dental Medicaid expenditures.
- Dental caries (tooth decay) is the most common chronic childhood disease according to the Centers for Disease Control and Prevention; it is 5 times more common than asthma and 7 times more common than hay fever. By age 17, 78 percent of young people have had a cavity, and 7 percent have lost at least one tooth.
- Only dentists can provide comprehensive dental care. Efforts to increase access to dental care can only succeed if patients are in a continuum of care supervised by a dentist.

What are the barriers to dental care for the indigent?

- Misdistribution of dentists. Economic conditions discourage dentists from practicing in some inner city and rural areas, creating location specific dentist's shortages.
- Low levels of oral health literacy lead to often severe dental disease that could otherwise be prevented cheaply and easily.
- Medicaid reimbursement rates are often so anemic and administrative burdens so onerous, as to discourage provider participation. Medicaid reimbursement rates in many cases fail to cover the dentists' overhead costs in providing care.

- Even when care is available, programs often fail to provide case management services needed to help people get to a dental appointment and comply with post-treatment instructions and oral hygiene protocols.
- Missed dental appointments add to the financial burden dentists experience when providing services to Medicaid recipients. Greater incidences of missed appointments occur in the Medicaid population.

There were significant changes in the Oklahoma Dental Medicaid Program in 2004 that have helped to address some of these barriers.

- OHCA employed its first full time dentist to administer the dental services program.
- OHCA transitioned from using managed care organizations to a single benefit manager administered by OHCA. By using electronic data services and a fee for service program OHCA has established a record of timely payments to dental providers. These efforts have eliminated many of the administrative burdens previously faced by dentists.
- OHCA has dedicated staff members who provide outreach to dentists by providing assistance in program enrollment and responding quickly to inquiries about billing and policy issues.
- OHCA has improved its eligibility and verifications systems. Dentists have 24 hour access via the web to member eligibility and patient in formation.
- OHCA has improved its claims process reducing paperwork yet maintaining an accuracy rate of over 90%.

- In 2003 only 286 dentists were Medicaid providers. Since the improvements nearly 550 dentists are now in the program and 80% increase.

The members of the ODA have and continue to provide programs and services to addresses the needs of the elderly, indigent, and special needs populations in Oklahoma

- In 2004 ODA members donated $19,500 per member in free dental services which equates to $ 2.2 million dollars.
- Dentistry Cares, an ODA program focused on denture care for the elderly and dental services for the "gap" population, facilitated the treatment of 400 patients per year.
- Dentists who volunteer for the D Dent and EODDS programs treated 2400 patients in a year.
- The Oklahoma Dental Foundation recently purchased 2 mobile dental units and will begin treating patients throughout the state, especially those in underserved areas.
- The OU College of Dentistry dental student annual Kids Day has provided over $ 200,000 in free dental care.
- In 2005 the annual ODA Give Kids a Smile Day treated 500 children in a one day period.
- During National Children's Dental Health Month, ODA members screened and educated 3,000 children.
- The ODA is developing a program to help recruit dental graduates to the highest need areas in the state. This is entitled the Dental Student Loan Repayment Program and you will be hearing more about it in the near future.

The dentists of Oklahoma are committed to continuing our partnership with both the State Legislature and the OHCA to ensure that all Oklahomans have access to quality dental care on an ongoing basis. We are acutely aware of the federal budget cuts in the Medicaid program, the increased demand for Medicaid services, and the soaring health care costs.

We have 3 final comments regarding the Oklahoma Dental Medicaid program:

- First, "it ain't broke so don't fix it." Do not undo the many positive changes that have been made in the past 2 years. Keep dental care carved out.
- Second, do not decrease funding. Dental Medicaid dollars are a very insignificant amount of the overall Medicaid budget.
- Third, when financially feasible expand the dental Medicaid program to provide care to adults.

I thank you for this opportunity to meet with you today and I welcome any questions.

Oklahoma Dental Association

317 NE 13th Street

Oklahoma City, OK 73104

405-848-8873

ddavis@okda.org

Appendix P

ONCOR –Oklahoma Network of Community Options and Resources

413-A East Broadway
Sand Springs, OK 74063
918-245-1884
Comments to the Medicaid Task Force and Advisory Committee
December 7, 2005

We are private Providers who Support Oklahomans with Developmental Disabilities who live and work in your communities.

The members of ONCOR serve the majority of DDSD Consumers through funding from the Home and Community Based Waiver. We provide services to people who live in community ICF/Mr.'s

- Direct Care Staff who provide these services are called HTS-Habilitation Training Specialists.

A Developmentally Disabled Oklahoman who needs services:

- Applies for services with DDSD
- DDSD determines eligibility, type, and level of service needed.
- Person is placed on DDSD waiting list.
- When funding for services is available the person is notified of eligibility.
- A DDSD Case Manager is assigned to the person.

Provider Perspective

- Oklahoma is a choice system.
- DDSD Case Managers provide Consumers and their Parents/Guardians with a list of available providers.
- Consumers interview potential agencies then choose the provider who can best meet their needs.
- The Interdisciplinary team meets and determines level of service to be provided by Residential, Vocational, Therapy and Behavioral Providers.
- The Provider Agency assigns a Program Coordinator, who in turn works closely with the Consumer and Family to hire and train the HTS Staff.

Issues facing ONCOR Providers: Poor Quality Workforce, Low Wages, Low Employee Benefit Participation, High Employee Turnover—64%, High Insurance Costs including liability insurance.
Over 4000 Oklahomans currently receive community services

The average FY05 community plan of care per person for Developmentally Disabled Oklahomans paid through DDSD is $55,600 ($152.32 per day per person). This is the breakdown for the three DDSD Administered Waiver Services: Community Waiver $46,300, Supported Living $109, 000, In Home Supports Waiver $11,500.

Over 400 people live in the two State run ICF/MR's NORCE and SORC. It has been suggested that the people who live in those two institutions are too severely disabled to move in to the community and be served by private providers. This is just not the case people with medical challenges and severe disabilities have been successfully served in the communities since the closing of Hissom Memorial Center.

The members of ONCOR respectfully make the following statement for your consideration:

Down Size NORCE and SORC to eight beds or less community ICF/MR's.

Save $12 million State Dollars:

1. Per person costs for the State instructions are reported to be **$405** per day ($147,825 per person per year), this has been compared to Supported Living costs, but those costs are just under $300 per day. Community ICF/MR programs that are required to provide the same level of staffing and professional services that are federally mandated in the State run Institutions. Community ICF/MR's only receive $132.50 per consumer per day.
2. The State pays **$121.50** per day of State funds for the care of the Consumers in NORCE and SORC and **$39.75** per day of State funds for the same care in the community. State Institutions can be downsized and converted to community ICF/MR placements to save:

$121.50
- $39.75

$81.75

$81.75 x
410 Consumers

$33,517.50

$33,517.50x
365 days per year **$12,233,887.50 savings per year State dollars**

The homes can be built in the communities that currently support NORC and SORC, the people who benefit from employment at these two institutions will find employment through the private ICF/MR. The parents who are opposed to this change will see that their child receives a better quality of care in the community, while still receiving the same services they are used to.

Legislative Priorities for ONCOR this session:
Limit DD Contract Provider liability to $250,000 per occurrence
Annual Rate Study Legislation
Reimbursed Provider Training
State Paid Vocational Training for ICF/MR

Thank you for the opportunity to present this information to you today.
Lisa LaTray

Appendix Q

Medicaid Reform Task Force Presentation

January 4, 2006

10:00 am

OPhA Oklahoma Pharmacists Association

PPOk

Oklahoma Medicaid Drug Costs

SFY 2005

Prescriptions 7,000,000

FMAP 70.18%

	Total Drug Program $		Federal $		State $	
Drug Spend	$467,000,000	100%	$327,740,600	70.2%	$139,259,400	29.8%
OBRA 90 Rebates	$ 96,000,000	20.6%	$ 67,372,800	14.4%	$ 28,627,200	6.1%
***Supplemental Rebates**	$ 1,600,000	.3%	$ 1,122,880	.2%	$ 477,120	.1%
Net Program $	$369,400,000	79.1%	$259,244,920	55.5%	$110,155,080	23.6%

*Projected $11,000,000 SFY 2006

Average AWP Discounts

Brand Name (Single Source)	-13.93%
Brand Name (Multi Source)	-18.70%
Generic Multi Source (non-MAC)	-31.75%
Generic Multi Source (FUL-SMAC)	-62.15%
Average AWP Discounts	**-35.07%**

University of Oklahoma/OHCA Study

December 2004

Cost of Dispensing	$8.30

Net Profit per Rx

$8.78	Gross Profit
$8.30	COD
$ .48	Net Profit per Rx

Cost Considerations

- 87% of Total Costs Represented by Manufacturer Drug Costs
- 13% of Total Costs Represented by Pharmacy Fees

Implemented Cost Containment Strategies

- Generic Mandate
- Step Therapy Protocols
  - NSAIDS
  - PPI – OTC Prilosec
  - ACE Inhibitors
- Prior Authorizations
  - Benzodiazepines
  - H2 Antagonists
- State Maximum Allowable Costs (SMAC)
- Retrospective DUR
- Supplemental Rebates

Oklahoma Medicaid Pharmacy Network Accessibility

- Comprehensive
  - Over 900 Pharmacies
- Diversity
  - Independent Retail Pharmacies
  - Chain Retail Pharmacies
  - Closed Door Nursing Home Pharmacies
  - Outpatient Hospital Pharmacies

Oklahoma Medicaid Pharmacy Network Accessibility

- HR4241 – Deficit Reduction Act of 2005
- "Federal Medicaid Reform"
- Implementation: January 1, 2007

Ideas to Improve Current Medicaid Program

- Enhance claims processing system to deny claim when recipient has other insurance
- Enhance Technology to accept electronic Prior Authorization Requests
- Obtain Federal Waiver to require co-payment
- Implement higher tiered co-payments for non-preferred drugs
- Implementation of a coordinated Medication Therapy Management Program Utilizing Pharmacists

Medication Therapy Management

CMS Medicare Drug Discount Program
Medication Therapy Management Services

10/01/2004 - 07/31/2005

Cost Avoidance/Pharmacy Payment Ratio
$11.95

Overall Concept

- Invest a small amount to optimize therapy
- Prevent more costly complications
  - ER visits
  - Additional physician visits
  - Heart attacks, strokes, foot amputations, etc.
- Decrease overall medical costs

Ideas to Improve Current Medicaid Program

- Implement a Tablet Splitting Program

		AWP
Zoloft 25 mg	#30	$90.51
Zoloft 50 mg	#15	$45.25
Savings		$45.26
Pharmacist Splitting Fee		$6.50
Net Savings		**$38.76**

Ideas to Improve Current Medicaid Program

- Promote e-prescribe implementation to enhance efficiencies and patient safety

Oklahoma Pharmacy Supports Initiatives and Change to Improve the Cost Efficiencies and Outcomes of the Oklahoma Medicaid Population

Appendix R

Resolutions From The 2005 White House Conference on Aging

1 Reauthorize the Older Americans Act Within the First Six Months Following The 2005 White House Conference on Aging

2 Develop a Coordinated, Comprehensive Long-Term Care Strategy by Supporting Public and Private Sector Initiatives that Address Financing, Choice, Quality, Service Delivery, and the Paid and Unpaid Workforce

3 Ensure That Older Americans Have Transportation Options to Retain Their Mobility and Independence

4 Strengthen and Improve the Medicaid Program for Seniors

5 Strengthen and Improve the Medicare Program

6 Support Geriatric Education and Training for All Healthcare Professionals, Paraprofessionals, Health Profession Students, and Direct Care Workers

7 Promote Innovative Models of Non-Institutional Long-Term Care

8 Improve Recognition, Assessment, and Treatment of Mental Illness and Depression among Older Americans

9 Attain Adequate Numbers of Healthcare Personnel in All Professions Who are Skilled, Culturally Competent, and Specialized in Geriatrics

10 Improve State and Local Based Integrated Delivery Systems to Meet 21st Century Needs of Seniors

11 Establish Principles to Strengthen Social Security

12 Promote Incentives for Older Workers to Continue Working and Improve Employment Training and Retraining Programs to Better Serve Older Workers

13 Develop a National Strategy for Supporting Informal Caregivers of Seniors to Enable Adequate Quality and Supply of Services

14 Remove Barriers to the Retention and Hiring of Older Workers, Including Age Discrimination

15 Create a National Strategy for Promoting Elder Justice Through the Prevention and Prosecution of Elder Abuse

16 Enhance the Affordability of Housing for Older Americans

17 Implement a Strategy and Plan for Accountability to Sustain the Momentum, Public Visibility, and Oversight of the Implementation of 2005 WHCOA Resolutions

18 Foster Innovations in Financing Long-Term Care Services to Increase Options Available to Consumers

19 Promote the Integration of Health and Aging Services to Improve Access and Quality of Care for Older Americans

20 Encourage Community Designs to Promote Livable Communities that Enable Aging in Place

21 Improve the Health and Quality of Life of Older Americans through Disease Management and Chronic Care Coordination

22 Promote the Importance of Nutrition in Health Promotion and Disease Prevention and Management

23 Improve Access to Care for Older Adults Living in Rural Areas

24 Provide Financial and Other Economic Incentives and Policy Changes to Encourage and Facilitate Increased Retirement Savings

25 Develop a National Strategy for Promoting New and Meaningful Volunteer Activities and Civic Engagements for Current and Future Seniors

26 Encourage the Development of a Coordinated Federal, State, and Local Emergency Response Plan For Seniors in the Event of Public Health Emergencies or Disasters

27 Enhance the Availability of Housing for Older Americans

28 Reauthorize the National and Community Service Act to Expand Opportunities for Volunteer and Civic Engagement Activities

29 Promote Innovative Evidence-Based and Practice-Based Medical and Aging Research

30 Modernize the Supplemental Security Income (SSI) Program

31 Support Older Adult Caregivers Raising Their Relatives' Children

32 Ensure Appropriate Recognition and Care for Veterans across All Healthcare Settings

33 Encourage Redesign of Senior Centers for Broad Appeal and Community Participation

34 Reduce Healthcare Disparities among Minorities by Developing Strategies to Prevent Disease, Promote Health, and Deliver Appropriate Care and Wellness

35 Educate Americans on End of Life Issues

36 Develop Incentives to Encourage the Expansion of Appropriate Use of Health Information Technology

37 Prevent Disease and Promote Healthier Lifestyles through Educating Providers and Consumers on Consumer Healthcare

38 Promote Economic Development Policies that Respond to the Unique Needs of Rural Seniors

39 Apply Evidence Based Research to the Delivery of Health and Social Services Where Appropriate

40 Improve Health Decision Making through Promotion of Health Education, Health Literacy, and Cultural Competency

41 Strengthen the Social Security Disability Insurance Program

42 Evaluate Payment and Coordination Policies in the Geriatric Healthcare Continuum to Ensure Continuity of Care

43 Encourage Appropriate Sharing of Healthcare Information across Multiple Management Systems

44 Ensure Appropriate Care for Seniors with Disabilities

45 Strengthen Law Enforcement Efforts at the Federal, State, and Local Level to Investigate and Prosecute Cases of Elder Financial Crime

46 Review Alignment of Government Programs That Deliver Services to Older Americans

47 Support Older Drivers to Retain Mobility and Independence through Strategies to Continue Safe Driving

48 Expand Opportunities for Developing Innovative Housing Designs for Seniors' Needs

49 Improve Patient Advocacy to Assist Patients in and across All Care Settings

50 Promote Enrollment of Seniors into the Medicare Prescription Drug Program

Appendix S

Long Term Care

What is it?

Continuum of Care & Payer

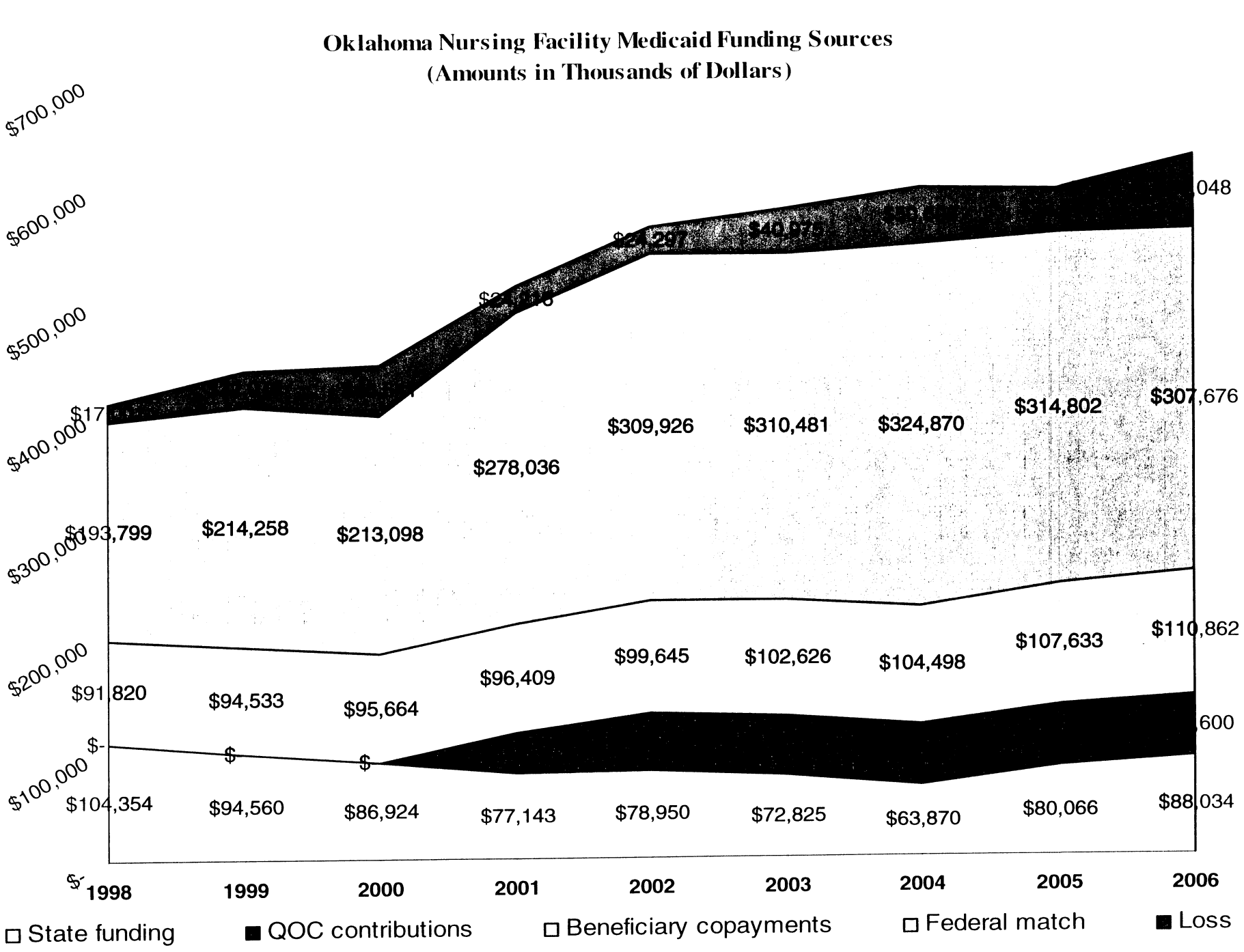
• Adult Day Care	• DHS
• Assisted Living	• Private Pay
• Home & Community Based Services	• Medicaid
• Home Health	• Medicare
• Hospice	• Medicare
• Nursing Home Care	• Private & Medicaid
• Residential Care	• Private Pay
• Skilled Nursing Care	• Medicare

Medicaid Programs

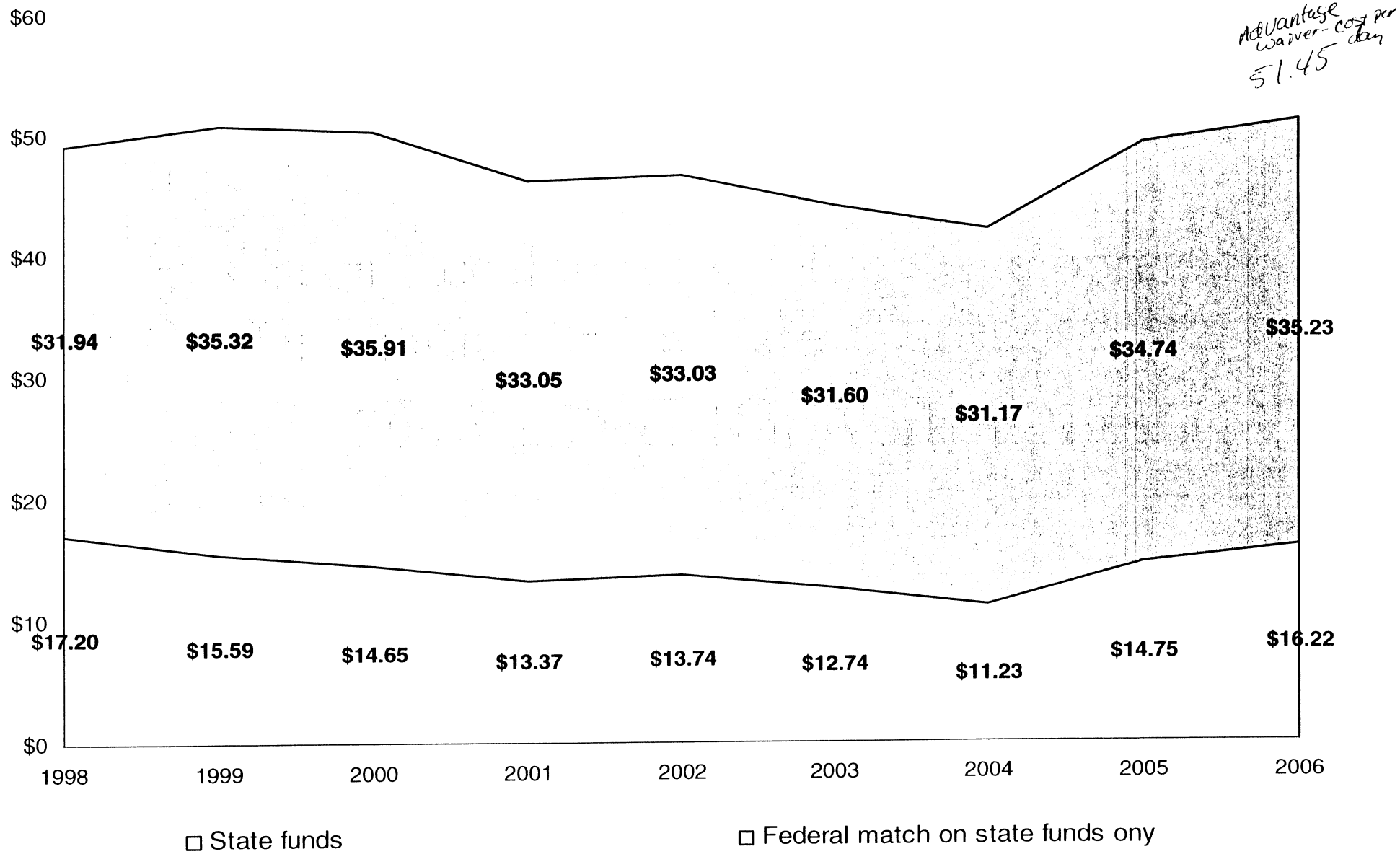
- ADvantage Waiver
- Nursing Home Care

ADvantage Waiver

- Home & Community Based Program
- UCAT Assessment Tool
- No Co-pay
- No Provider Fee
- Medicare Supported
- Delays Nursing Home Placement
- Less Expensive Than Nursing Home Care?


Oklahoma Nursing Facility Medicaid Funding Sources
(Amounts in Thousands of Dollars)
$700,000
$600,000
$500,000
$400,000
$300,000
$200,000
$100,000
$-
$193,799
$214,258
$213,098
$278,036
$309,926
$310,481
$324,870
$314,802
$307,676
$91,820
$94,533
$95,664
$96,409
$99,645
$102,626
$104,498
$107,633
$110,862
$104,354
$94,560
$86,924
$77,143
$78,950
$72,825
$63,870
$80,066
$88,034
1998
1999
2000
2001
2002
2003
2004
2005
2006
State funding
QOC contributions
Beneficiary copayments
Federal match
Loss

State + Federal Match Funds Only
Dollars per Resident Day



Advantage waiver cost per day
$1.45

Nursing Home Care

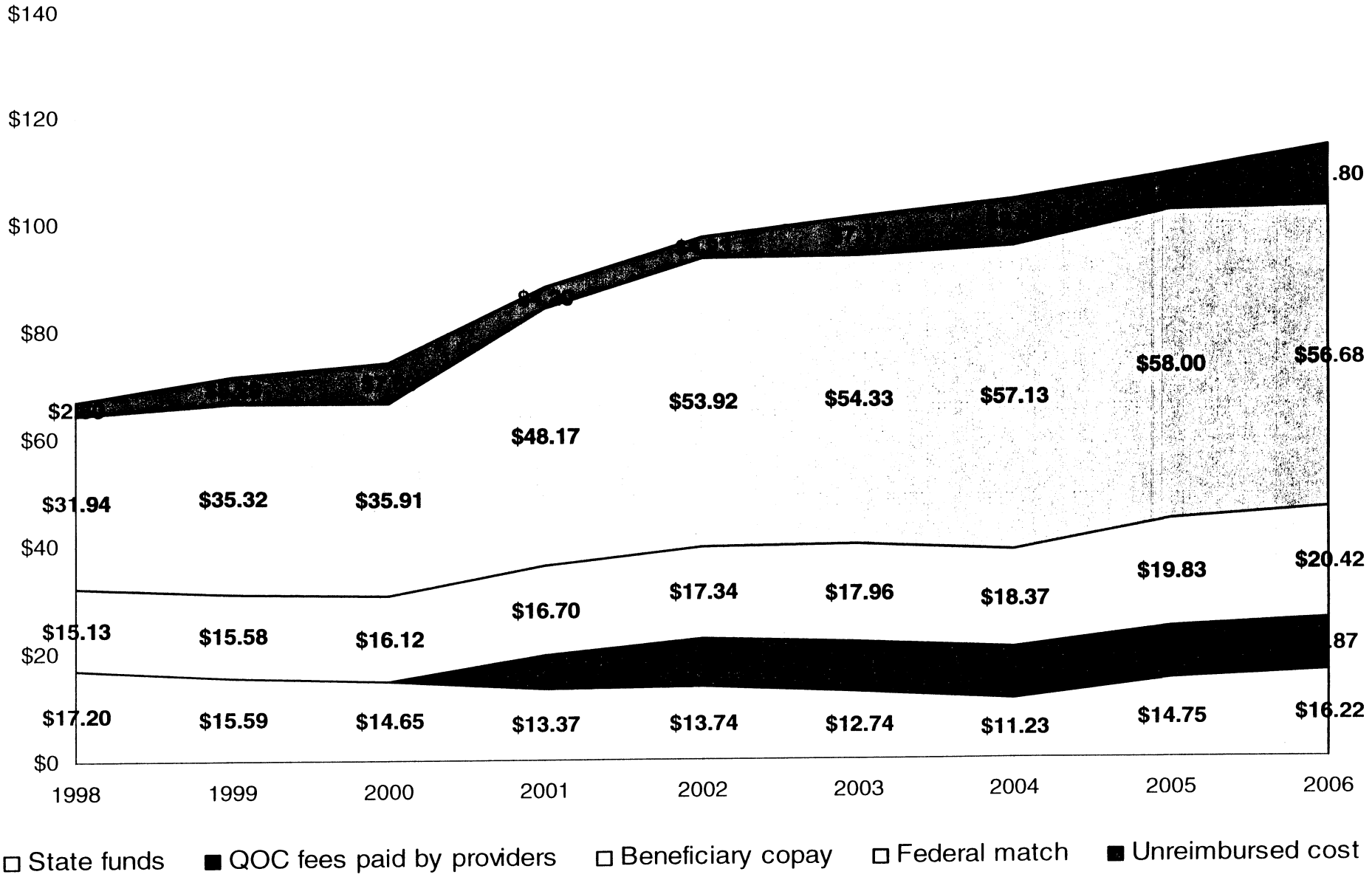
- 2nd Most Regulated Industry In U.S.
- MDS Assessment Tool
- Resident Co-pay
- Provider Fee
- Medicare Benefit Less
- Continuum Delivers Sicker Residents
- Cost Shifting No Longer An Option

1995		2004	
• Occupancy	80%	• Occupancy	67%
• Medicaid	67%	• Medicaid	71%
• Private Pay	30%	• Private Pay	23%
• SNF	3%	• SNF	6%

Current Crisis

- Reimbursement Shortfall
- Nursing Shortage
- Regulation
- Changes To Medicare

Sources of Medicaid Funds
Dollars per Resident Day



Regional Nursing Home Rates

- Arkansas $118.36
- Colorado $148.00
- Kansas $111.93
- Louisiana $102.00
- Missouri $108.00
- New Mexico $136.00
- Oklahoma $103.20
- Texas $112.61

Nursing Shortage

- It Is Real
- Has Been Accelerated By The Development Of The Continuum Of Care
- Agency Staffing Does Not Work In Nursing Homes

Regulation

- Oklahoma State Department Of Health Paid By Medicare And Medicaid To Inspect Nursing Homes
- Oklahoma State Department Of Health Is Dependant On State Appropriations To Inspect Residential Care And Assisted Living Facilities
- Policy And Rule Changes Increase Cost

Changes To Medicare

- Medicare Is Looking To Eliminate Inefficiencies
- The Continuum Of Care Is Supported By Medicare Services
- A Single Change Can Either Expand Or Shrink The Continuum
- Just Ask OHCA And Pharmacist About Medicare Part D

Recommendations

- Increase All Providers To Their Respective Regional Averages
- Do Not Add Levels Of Service Until All Current Providers Are Adequately Reimbursed
- Pass Legislation That Will Encourage and Attract People To Jobs In The Healthcare Industry
- No More Mandates Without Funding By Legislation Or Changes In Policy Or Rule

Appendix T

oklahoma health care authority

Financing needs and options

Mike Fogarty, Chief Executive Officer
Oklahoma Health Care Authority
January 17, 2006

Strategic Plan Goal

To purchase the best value health care for Oklahomans by paying appropriate rates.

Cost to achieve goal in SFY07

Provider Rate Increase	Performance Measure	State $
Physicians	100% Medicare	$3,455,490
Hospitals/RTC's	Cost	$26,342,458
Dental	CPI increase	$5,719,429
Behavioral health	CPI increase	$820,001
Other practitioners	CPI increase	$169,578
Nursing Home & ICF/MR facilities	Cost	$20,440,893
Total		$56,947,849

*Note: Rate assumes current rate as base rate regardless of revenue source.

How can it be funded?

- Qualified state match, for example
  - General fund
  - Cash fund
  - Tax revenue
    - -earmarked to program
    - -through General revenue
  - Tax refund check box.

How have other states raised revenue?

- ➔ Alcoholic beverages
- ➔ Health care providers
- ➔ Soft drinks
- ➔ Tobacco

Appendix U

MIKE FOGARTY
CHIEF EXECUTIVE OFFICER

Brad Henry
Governor

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

January 31, 2006

The Honorable Kris Steele
Chairman, Medicaid Task Force
House of Representatives
436 State Capitol Building
Oklahoma City, OK 73105

Dear Chairman Steele:

As requested on behalf of the Medicaid Reform Task Force, please find attached a brief cost or savings analysis by the Oklahoma Health Care Authority of the general recommendations. In the limited time available we were unable to provide information on every recommendation. Also, similar recommendations were combined and reported as one analysis.

Specifically, we were requested to report the program's payment accuracy rate or error rate in response to the Sagem Morpho, Inc. report distributed on Jan. 25. Since accountability measures were one of the recommendations, we have included our primary response to the referenced report in item 9. The agency leads the effort to protect taxpayer dollars and the availability of services by working to identify, recover and prevent inappropriate provider billings and payments. In fact, in state fiscal year 2005 alone, the agency recovered nearly $16 million in improper payments and prevented more than $500 million in inappropriate payments. The effort is there but we agree more work needs to be focused on educating providers and recipients on how to comply with rules and regulations.

In regards to the recommendations, the potential costs and/or savings of any of the programs may be adjusted as details of any work plans are developed. We stand ready to assist with questions or provide more information as requested.

Sincerely,

Nico Gomez, Director
Communications Services

Member, Advisory Committee

Attachment

Medicaid Task Force Recommendations

Cost/Savings Analysis by the Oklahoma Health Care Authority - Feb. 1, 2006

1. **Patient Empowerment** – There is insufficient detail to determine potential savings or cost of recommendation.

2. **Health Savings Account** - There is insufficient detail to determine potential savings or cost of recommendation.

3. **E-Prescribing** – The agency has requested $1 million ($500,000 state) to purchase hardware, software and related support to begin a pilot program with 1000 providers.

4. **Electronic Medical Records** – There has been insufficient information and time to be able to project a cost and/or savings. However, the research activities concerning this subject are reflected in the agency's current strategic plan.

5. **Disease Management** – The agency has requested $1.75 million ($875,000 state) to develop a comprehensive disease management program. The agency is currently reviewing utilization data, specifically in vascular diseases, to determine the best approach. This initiative would have potential long-term savings.

6. **Tiered Reimbursement for Nursing Facilities** – This recommendation would redistribute the pool of reimbursement based upon a determined set of quality measurements.

7. **Emergency Room Utilization** – The agency expects to spend $60 million in State Fiscal Year 2007 for emergency room services. If a program were developed to encourage proper utilization and resulted in appropriately diverting 1 in 5 people, it would be reasonable to save up to $12 million ($3.8 million state) a year.

8. **Long-term Care Medicaid Look Back Period** – The agency estimates approximately $6 million ($1.9 million state) in annual expenditures could be saved by extending the look back period from 3 years to 5 years.

9. **Accountability Measures** – Based on recent payment accuracy measurement reviews by the agency, it appears providers overall are appropriately billing and being reimbursed correctly. However, improper payments do occur. Improper payments can result from simple billing errors to those made for treatments or services that are not covered by program rules, that were not medically necessary, that were billed but never actually provided, or have missing or insufficient documentation to show whether the claim was appropriate. Improper Medicaid payments can result from inadvertent errors, as well as intended fraud and abuse. Improper payments can also occur when a client has Medicaid eligibility and is provided a medical service, when in fact, they should not have been eligible.

   As requested, Oklahoma's current accuracy rate for SFY2005 was 90.42 percent with errors in processing validation of 0.06 percent, medical review of 7.10 percent and

beneficiary eligibility of 2.42 percent. With a total error rate of 9.58 percent, it is below the national average for Medicaid program payment errors of 10 to 20 percent alleged by a recent consultant presentation.

A solution to reduce this potential error rate and protect valuable resources by preventing improper payments is to identify where problems exist and target improvement efforts to address these areas through provider and client education activities. Preventing improper payments can be a cost-effective way to protect program dollars. Prevention can help avoid what is known as "pay and chase" in which efforts must be made to detect and attempt to recover inappropriate payments after they have been made.

The agency suggests the creation of a payment accuracy team to develop a comprehensive strategy to measure and reduce improper payments which would include focused efforts on provider and client education and partnering with the Oklahoma Department of Human Services to strengthen controls in eligibility determination. The goal of the agency is to reduce the error rate at least three percentage points within three years.

Any such plan would require legislative support as the state prepares for federal contractors who will be mandated to audit each state Medicaid program once every three years to determine an official payment error rate for comparison to other states.

Reducing the error rate three percentage points would result in an annualized savings of more than $93 million ($29.4 million state) by year three.

10. **Planning for Future Long-Term Care Needs** (including tax incentives for long-term care insurance) - There is insufficient detail to determine potential savings or cost of recommendation.

11. **Funding** - There is insufficient detail to determine potential cost of recommendation. The current blended federal match rate for state Medicaid dollars is $2.17 for every $1 in qualified state dollars.

12. **Preventive Wellness Programs** (i.e. a children's "diabesity" program) - There is insufficient time to determine potential savings or cost of recommendation.

13. **Continue/Improve Physician Reimbursement Rates** – The agency has requested $10.7 million ($3.5 million state) to maintain physician reimbursement rates at 100 percent of the current Medicare fee schedule.

14. **Phase out of Medicaid Benefits** - There is insufficient time to determine potential savings of recommendation.

15. **Form cooperative purchasing pools** - There is insufficient time and detail to determine potential savings or cost of recommendation.