

SECTION 2: DESCRIPTION OF OKLAHOMA MEDICAID PROGRAM

This Section presents a description of the Medicaid program in the State of Oklahoma and the role of the Medicaid Management Information System (MMIS) Contractor. Oklahoma also administers a variety of other State and locally funded programs that provide health care assistance to its citizens. An overview of those other related programs is also included in this Section. The program is operated by the Oklahoma Health Care Authority (OHCA).

The first subsection provides a description of the OHCA organizational structure. This is followed by a description of the data systems currently in use and a discussion of the programs and services administered by the Medical Assistance Unit. In addition, the current processing environment and program initiatives currently being considered are presented.

2.1 ORGANIZATIONAL STRUCTURE

In Oklahoma, the Oklahoma Health Care Authority has the responsibility of administering the state's Medicaid program. Created in 1993 by legislative authorization, the Designated Single State Medicaid Agency was transferred from the Department of Human Services to OHCA, effective January 1, 1995. The agency's mission "...is to purchase all State-funded health care in the most efficient and comprehensive manner possible, and to study and recommend strategies for containing costs and optimizing the delivery of health care in State programs."

The agency must balance this fiscal responsibility with two, equally important goals:

- o assuring that State-purchased health care meets acceptable standards of care, and
- o ensuring that citizens of Oklahoma who rely on State-purchased health care are served in a progressive and positive system.

2.1.1 STATE OFFICE ADMINISTRATIVE STAFF

The Oklahoma Health Care Authority is governed by the Health Care Authority Board. Mr. Michael Fogarty is the current Chief Executive Officer of the Authority. The OHCA contains five (5) operational areas and an administrative support group. The six major areas of the Authority are:

- o Program Operations, comprised of the following offices:
 - Medical Director,
 - ~~SoonerCare~~ Operations,
 - Medical, Professional and Health Policy Services, and
 - Customer Relations;
- o Information Services, comprised of the following offices:

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- Associate Director,
- Contractor Systems,
- Network and Telecommunication Services,
- Mainframe Development and Maintenance,
- Microsystems Development and Maintenance, and
- Data Processing Administration;

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o Financial Services, comprised of the following offices:

- Associate Director,
- Financial Management,
- General Accounting,
- Claims Resolution and Monitoring, and
- Medicaid Financial Operations:
 - Adjustments,
 - Third Party Liability, and
 - Drug Rebate;

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o Audit, Evaluation and Information, comprised of the following offices:

- Associate Director,
- Audit and Special Projects,
- Program Design and Evaluation,
- Public Information, and
- Agency Support Services;

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o Legal Services; comprised of the following offices:

- Associate Director,
- Legal Services,
- Professional Service Contracts, and
- Provider Enrollment; and

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o Administrative Support.

Organizational charts for OHCA and specific units within the Authority are included in Appendix E.

Although the primary responsibility for management of the Oklahoma Medicaid program and the operation of the MMIS lies within OHCA, several divisions within other State agencies interface with the operation of the MMIS. *Exhibit 2-1: Entities Interfacing with MMIS*, lists these entities and indicates whether the nature of the interface is to input data to the MMIS or receive output (reports or tapes), or if the entity is involved in actual processing of MMIS data:

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**Exhibit 2-1
ENTITIES INTERFACING WITH MMIS**

Entities	MMIS Interface		
	Input	Output	Processing
Data Services Division (DHS)	X	X	X
Family Support Services (DHS)	X	X	
Audit and Review (OIG)		X	
Aging Services Division (DHS)	X	X	
State Treasurers Office	X	X	
Office of Management Services (Research, Evaluation, and Statistics Unit)		X	
Department of Rehabilitation Services	X	X	
Development Disability Services Division (DHS)	X	X	
Children and Youth Services (DHS)		X	
Oklahoma Juvenile Justice		X	
Department of Mental Health	X	X	
Department of Health	X	X	
University of Oklahoma College of Pharmacy	X	X	X
Oklahoma Foundation for Medical Quality	X	X	

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2.1.2 FIELD OPERATIONS STAFF

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2.2 DATA SYSTEMS

The major systems utilized by the OHCA staff are described in the following section. The primary system is the MMIS. The original MMIS consisted of the standard MMIS sub-systems of:

- o Recipient,
- o Provider,
- o Reference,
- o Claims,
- o EPSDT,
- o SURS, and
- o MARS

These sub-systems have been significantly enhanced to accommodate many program and policy changes over the years including managed care enrollment, capitation and encounter claims processing. In addition, the following sub-systems have been implemented as enhancements and interfaced/integrated with the current MMIS:

- o Recipient Eligibility Verification System (REVS);
- o Point of Sale/Recipient Eligibility Verification System/Automated Voice Response System (POS/REVS/AVRS) Communications Network;
- o Rx-Point of Sale, including a soon to be implemented Prospective Drug Utilization Review System (Rx-POS/DUR);
- o Drug Rebate System;
- o PC/SURS;
- o Data Warehouse/Decision Support/Executive Information System; and
- o Managed Care Bulletin Board via dedicated dial-up (the bulletin board via the internet is part of an on-going Interoperability Pilot project and is scheduled for implementation by the end of January 2000).

OHCA is currently implementing the HBOC Claim Check System through an amendment to the UNISYS contract. UNISYS has subcontracted with HBOC to integrate Claim Check with the MMIS Claims processing sub-system. The product is an extended claims audit sub-system designed to enhance an existing claims processing systems auditing capabilities. Following a long design process, the system is currently being tested and implementation is expected in February of 2000.

UNISYS is operating this MMIS environment under its current contract with OHCA. The MMIS is written primarily in COBOL and utilizes VSAM file structure. The IBM compatible mainframe is located at a UNISYS data center in California where many other states MMIS are also operated. The local claims process operation is connected to the mainframe over the UNISYS HealthNet Wide Area Network (WAN). MMIS claims imaging and data entry takes place at the local UNISYS facility.

The external interfaces maintained by the MMIS Contractor in Oklahoma are the following:

- o Recipient Sub-system:
 - PS/2 Transaction File – Provides eligibility file updates from the Oklahoma Department of Human Services (DHS) Eligibility System for recipients of Medicaid and State sponsored medical programs, and
 - BENDEX – Beneficiary Data Exchange from SSA.

- o Reference Sub-system:
 - Blue Book – weekly update of drug codes,
 - ICD-9-CM - the annual ICD-9-CM Commission on Professional and Hospital Activities (CPHA) update tape, and
 - DDS (DHS) Prior Authorizations, daily batch updates.
- o Claims Sub-system:
 - Electronic Media Claims (EMC) – EMC claims submitted by authorized providers, and
 - Medicare Crossover Claims – received from the Medicare carrier.
- o Financial Sub-system:
 - Disbursement File – file sent to the State Treasurer’s Office (STO) providing a list of all claims that OHCA has approved for payment,
 - Register File – Warrant register of all checks written by STO,
 - Redemption File – File from STO reporting all warrants that have been cashed,
 - EFT Participant File – File from STO of providers who will be paid by electronic funds transfer and who will be paid by paper warrant.

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Eligibility determination is performed by staff from the Oklahoma Department of Human Services (DHS). The Oklahoma DHS captures and determines eligibility for most Medicaid recipients through its statewide automated eligibility system, PS/2. PS/2 maintains eligibility data on the Categorically Needy and Medically Needy populations related to TANF, TANF-related populations, SSI-related populations, and institutional and community-based waiver populations.

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Thirty-six (36) months of Medical assistance eligibility data is maintained by the MMIS Contractor in an electronic file in the MMIS. Updates to this file are received daily through electronic transactions from the PS/2 system.

In addition to the MMIS operations and the DHS PS/2 Eligibility System, the Information Services Division (ISD) within OHCA, provides automated support in the following areas:

- o Mainframe development and maintenance,
- o Microsystems development and maintenance,
- o PC installation and support,
- o Office automation,
- o Local Area Network (LAN),
- o Internet/Intranet development and maintenance, and

- o MMIS Contractor contract monitoring.

Mainframe development and maintenance is limited to special processing and reporting requirements that are not currently satisfied by the MMIS. These special functions, which are processed on the DHS mainframe, are being phased out. They are being replaced with enhanced Data Warehouse capabilities or are being eliminated entirely.

ISD provides all support for the OHCA LAN environment. The MMIS Contractor supports and maintains the WAN environment to the router. ISD is responsible for troubleshooting and support from the router to the desktop.

ISD is implementing and supporting the Great Plains-Dynamics Financial System for OHCA internal financial management and reporting. ISD also supports end-user developed applications that utilize MS-Office 97 (Access, Excel), and other tools. ISD is currently developing the OHCA Web Site that will eventually include:

- o OHCA Quarterly Statistical Data Bulletin,
- o SoonerCare Information and Brochures,
- o SoonerCare Enrollment Statistics,
- o HID Information,
- o State Medicaid Plan,
- o Waivers (115, 1915, CHIPS, and so forth),
- o OHCA Policy and Rules,
- o Consumer Oriented Medicaid Terms and Definitions,
- o EIS Information,
- o Frequently Asked Questions (FAQ's),
- o Provider Newsletter,
- o Global Messages to All Provider Types,
- o Provider Letters,
- o Sanctioned Provider List,
- o Provider Billing Instructions,
- o Provider Billing Manuals,
- o Provider FAQ's,

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- o HMO/PCP/CM Telephone Numbers, and
- o Secure Provider Pages Login.

Links will also be provided to other sites such as the State of Oklahoma Home Page and HCFA.

2.3 MEDICAID ELIGIBILITY

The Oklahoma Medicaid program provides access to quality health care for approximately three hundred and eighty (380,000) eligible recipients. These recipients receive care either by fee-~~for~~-service or managed care service delivery. The total Medicaid program expenditures in state fiscal year 1999 totaled \$1.5 billion.

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The Oklahoma Medicaid program provides medical assistance to the categorically needy population (those individuals eligible for or receiving federally aided financial assistance or who are eligible without the need to spend their own income for medical care) and to the medically needy population (those individuals whose income or resources are too high to qualify for a categorical program but are insufficient to meet the cost of medical care). The medically needy eligibles must utilize their excess income to meet an established amount of medical costs, whether past or current, before payment for covered medical services will be made from Title XIX funds. Appendix G: Listing of Oklahoma Eligibility Populations, identifies the eligible categories used in Oklahoma

2.3.1 ALIENS

In Oklahoma, Title XIX medical services are provider to qualified aliens. Non-qualified aliens are ineligible for Medicaid for five years from the date of entry. The only exception is that non-qualified aliens are eligible for emergency services only when the individual has acute symptoms that may result in placing his/her health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of body organ or part without immediate medical attention.

Illegal aliens are eligible for emergency services only when the individual has a medical condition with acute symptoms that may result in placing his/her health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of body organ or part without immediate medical attention.

Ineligible aliens who are not otherwise eligible and who have been admitted for temporary or specified periods of time are eligible for emergency medical services as quoted for non-qualified and illegal aliens.

2.3.2 MEDICALLY NEEDED PROGRAM

The State of Oklahoma maintains a Medically Needy program. Medically Needy clients are those individuals whose income exceed the amount allowed for the categorically needy but the income amount is insufficient to meet the cost of medical and remedial care services.

Categorically related groups whose income exceeds the categorically needy standards may be determined medically needy. The maintenance standard, which is 133% of the AFDC payment standard in effect on July 16, 1996, and medical expenses are used to calculate a spend down. For a family of three \$417 per month is the Medically Needy standard. There are resource tests for all categories except for those who are categorically related to AFDC.

2.4 MEDICAID COVERED SERVICES

The following describes the Medicaid cover services for Oklahoma.

2.4.1 MANAGED CARE

The following describes the managed care program and services covered in Oklahoma.

2.4.1.1 Managed Care Background

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

An immediate attempt to curb the growth in 1992 resulted in reductions in rates and specific services available to Oklahoma’s Medicaid population. Physicians and other practitioners saw a 5% reduction in their rates and adult recipients saw limits placed on office visits and hospitalization. The state also eliminated dental services for adults in total.

In an effort to avoid additional, dramatic cuts in services and reductions in eligible populations, the Governor and Legislature placed health care reform near the top of their legislative agendas. From 1992-93, Oklahoma’s leadership formed two broad-based citizen's committees, the Task Force on Medicaid and Welfare Reform and the Commission on Oklahoma Health Care. These groups were directed to study access and cost-containment problems within the existing system and to propose meaningful reforms. As a result of their recommendations, the Oklahoma Health Care Authority was established by the legislature in 1993. In addition, their recommendations were the catalyst for Oklahoma to begin the transition of its traditional fee-for-service Medicaid program to a coordinated system of managed care – focusing on primary care, prevention and increased access.

The decision for Oklahoma to move its Medicaid program from a fee-for-service to a managed care delivery system is not unique. To date, 48 states have implemented some form of managed care delivery systems in their Medicaid programs. The Health Care Financing Administration (HCFA), for example, has documented a burgeoning enrollment in Medicaid managed care nationwide from 1991 to 1998 - 9.53% to 53.64% respectively.

The Authority became the designated agency for the administration of Oklahoma's Medicaid program on January 1st, 1995. Prior to this date, however, a significant amount of work had to be accomplished. Before Oklahoma could transition its Medicaid program to one of managed care, it had to submit a waiver to HCFA for approval. The Federal government currently grants two kinds of Medicaid managed care waivers: Section 1915(b) "Freedom of Choice" waivers and Section 1115(a) "Research and Demonstration" waivers.

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

Section 1115(a) demonstrations allow states to test new approaches to benefits, services, eligibility, program payments, and service delivery, often on a statewide basis. These approaches are frequently aimed at saving money to allow states to extend Medicaid coverage to additional low-income and uninsured people. Research and demonstration waiver authority can normally be granted for up to 5 years at a time. Such authority permits States to try out a far greater range of policies than would otherwise be permissible in ordinary freedom of choice waiver programs.

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

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2.4.1.2 Managed Care Delivery

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

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The benefits under SoonerCare Plus include, but are not limited to: office visits, hospital care, emergency room services, specialty care, prescription drugs and immunizations. "Plus" refers to the enhanced benefit package created through the removal of limitations of hospital days, prescriptions and office visits for adults, all of which are present under the traditional fee-for-service program.

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The SoonerCare Plus program's operational details are outlined in the waiver

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application submitted to HCFA and in the Request for Proposals (RFP). In addition, the RFP specifies all the medical benefits as well as appropriate methods of administration. All the Health Plans participating in SoonerCare Plus must offer a standard level of benefits outlined in the RFP but may offer more. Entering its fifth year of operations, there are four Health Plans participating in the SoonerCare Plus program - BlueLincs, CommunityCare, Heartland Health Plan, and Prime Advantage. Any Health Plan has the option to bid on one or all of the service areas covered under SoonerCare Plus.

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Eligible recipients who reside in the service areas covered by SoonerCare Plus have the opportunity to choose a Health Plan and primary care provider (PCP). If they are eligible for the program, they are provided a SoonerCare Plus enrollment packet at the time they apply for Medicaid. The enrollment packet contains an enrollment brochure as well as a provider directory of each participating Health Plan in that specific area. From the point that the client receives their enrollment packet, they have two weeks to make a choice of Health Plan and PCP. If they fail to do so, SoonerCare Plus will align them with a Health Plan and it will, in turn, select a PCP for them.

The recipients can enroll through one of three different methods. They can enroll at the time of their application at the Department of Human Services office, they can mail the postage-paid enrollment card enclosed in their enrollment packet or they can call the toll-free SoonerCare Helpline and enroll by phone. Regardless of the method used, SoonerCare Plus must receive their selection within the two-week period. Prior to their effective date in the managed care program, each case will receive a medical ID card indicating the Health Plan in which they are enrolled. In addition, within 15 days of their membership in a Health Plan, each person on the case will be issued an ID card from their plan which clearly indicates the name of their PCP and other relevant information such as customer service numbers.

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The SoonerCare Plus program requires that all members on a TANF case enroll in the same Health Plan. Each person may, however, select a different PCP. Or, if desired, all family members may choose one PCP to provide their care. SoonerCare Plus members who are Aged, Blind or Disabled (ABD) can choose a different Health Plan from other members of their family as well as PCP. The PCP will be responsible for coordinating most of the recipient's health care, including a majority of specialty care and referrals. The PCP becomes a "Medical Home" for the recipients who have traditionally navigated a fragmented health care delivery system through the use of yellow pages and numerous phone calls to determine if providers took Medicaid as payment for services.

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Once the recipient selects a Health Plan and PCP, they will have the first thirty (30) days of their enrollment in the program to change without cause. After their first thirty days are up, they will be "locked-in" to their Health Plan until open enrollment (mid-May to mid-June), unless they move to an area where their particular Health Plan is not offered. The lock-in provision is one of the key elements of the 1115(a) waiver that Oklahoma transitioned to on July 1, 1996. Other notable changes from the 1915(b) to the 1115(a) waivers are the institution of 6 months of guaranteed eligibility for the recipients and statewide expansion of the SoonerCare program.

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Total SoonerCare Plus enrollment in October of 1999 was 129,366.

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It was through the Health Care Financing Administration's approval of Oklahoma's 1115(a) waiver that the Oklahoma Health Care Authority was able to implement SoonerCare Choice - the initial statewide non-urban or rural model - on October 1, 1996. SoonerCare Choice is a Primary Care Case Management (PCCM) program where the State contracts directly with primary care providers throughout the state to provide basic health care services. The program is partially capitated in that providers are paid a capitated rate for a fixed set of services with remaining non-capitated services compensated under the traditional, fee-for-service program.

The pre-paid benefit package and responsibilities of the Primary Care Provider/Case Manager (PCP/CM) include: Unlimited office visits for primary and preventive care; Early Periodic Screening, Diagnosis and Treatment (EPSDT) visits; injections and immunizations; basic lab and x-ray; basic family planning; case management; urgent care; and 24 hour, 7 day a week access to care. It is important to emphasize that the PCP/CM is not at risk for specialty referrals, hospitalizations or prescriptions; these remaining services are compensated under the fee-for-service schedule, with associated limitations still being in place for adults.

Enrollment for the recipients in this delivery system is very similar to those participating in the SoonerCare Plus program. However, instead of choosing a Health Plan from an enrollment packet provided at the DHS office, they choose a PCP/CM from a comprehensive, statewide list to provide their basic health care needs. As of July 1, 1999, SoonerCare Choice has contracted with over 500 providers offering primary health care services at over 600 sites.

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For SoonerCare Choice recipients, the two-week timeframe still applies for their selection. If a recipient fails to make a choice of provider, SoonerCare Choice will align them with the closest, appropriate provider. Also, at the request of Oklahoma pediatricians, families may be split between different types of providers during this process to allow children to be dispersed between providers who see children in their practice. Should a guardian wish to coordinate their children's care through a single provider, one phone call to the SoonerCare helpline will achieve this. The change will normally take affect within 15 to 45 days with effective dates always occurring on the first of the month.

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The word "Choice" in the program name refers to the recipient's ability to change providers on a monthly basis. In other words, recipients enrolled in SoonerCare Choice are not locked-in with the PCP/CM like their counterparts in the SoonerCare Plus delivery system. This is an important facet to the program that allows providers to be added in rural areas of Oklahoma on a continuous basis - especially in areas of the state that may be historically under-served or be limited on the types of available providers. Allowing the recipients to change, consequently, gives them greater choice in terms of choosing a medical home for themselves and their family.

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Another element to the SoonerCare Choice program is the development of a Nurse Advice Line that is available to a Choice recipient 24 hours a day, seven days a week. This service was initiated concurrently with the statewide implementation of the SoonerCare Choice

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program on October 1, 1996. It is hoped that the availability of such a service will reduce unnecessary emergency room utilization and provide the recipients with additional means of having medical questions answered in a timely manner.

Total ~~SoonerCare Choice~~ enrollment in October of 1999 was 114,176. Total managed care enrollment (including ~~SoonerCare Plus~~) for the same month was 243,542.

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2.4.2 FEE-FOR-SERVICE (NON-MANAGED CARE) SERVICES

Oklahoma's Medicaid program provides all federally mandated services for the categorically needy and other, more limited services (identified by an asterisk) for the medically needy. Covered services and the claim type used for billing and MMIS processing include:

- o UB-92:
 - Inpatient hospital services*,
 - Inpatient psychiatric services*,
 - Home health services,
 - Outpatient hospital services*,
 - Skilled nursing facility services,
 - Renal dialysis services*,
 - Intermediate care facility services,
 - Intermediate care facility services for the mentally retarded, and
 - Skilled nursing facility services,
- o HCFA-1500:
 - Rural health clinic services*,
 - Laboratory and X-ray services*,
 - Family planning services*,
 - Physician services*,
 - Nurse-midwife services*,
 - Durable medical equipment*,
 - Prosthetic devices*,
 - Podiatrist services*,
 - Psychologist services*,
 - Outpatient mental health clinic services*,
 - Speech and hearing services,
 - Room and board services,
 - Home- and community-based waiver programs:
 - Habilitation aid services,
 - Respite foster care services,
 - Specialized foster care services,
 - Case management services, and
 - Nutritionist,
 - Freestanding outpatient surgical centers*,

- Child health centers*,
 - Clinic services*:
 - Maternity,
 - EPSDT, and
 - Mental health,
 - Audiologist services*,
 - Rehabilitation services*,
 - Case management*,
 - Optometric services*,
 - Prescription eyeglasses and contact lenses*, and
 - Non-Technical Medical Care (NTMC) services*,
- o ADM-36-K:
 - Early and Periodic Screening and Diagnosis (EPSDT) services*,
 - o ADM-84:
 - Transportation services*,
 - o ADM-53:
 - Prescribed drugs (paper)*,
 - o NCPDP:
 - Prescribed drugs (point-of-service)*,
 - o ADM-36-D:
 - Dental services*.

2.4.3 OKLAHOMA'S TITLE XXI PROGRAM

OHCA operates a Title XXI program for children and pregnant women as an extension of their existing Medicaid program. All of the eligible clients participate in the SoonerCare managed care program. The program covers eligible clients up to 185% of the poverty level. As of October of 1999 there were over 29,000 clients enrolled in the program. Clients with third party coverage are not eligible for this program. The projected uninsured in the State of Oklahoma number 41,000. Applications for eligibility are processed at the DHS County offices, as are all other Medicaid eligibility applications.

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2.5 WAIVER AND OTHER MEDICAL ASSISTANCE PROGRAMS

Oklahoma has implemented certain Home and Community Based Services (HCBS) waiver programs. These HCBS waivers are designed to provide needed services to recipients in a community setting. These HCBS waiver categories include:

- o Home/Community Based Waiver,
- o Alternative Disposition Plan Waiver, and
- o Advantage Long Term Care Waiver.

A listing of all medical assistance programs and the expenditures is included in Appendix K.

2.6 PROVIDER TYPES

There are approximately twenty two thousand (22,000) enrolled active medical professionals providing medical services to Oklahoma Medicaid recipients. Oklahoma Medicaid provider types include:

- o hospital,
- o physician,
- o certified nurse,
- o dentist,
- o podiatrist,
- o long term care facility,
- o home health,
- o independent laboratories,
- o ambulatory surgical centers,
- o private duty nursing,
- o hospice,
- o optometrist
- o optician,
- o transportation,
- o rehabilitation services,
- o EPSDT,
- o HMO,
- o free standing ambulatory health center,
- o inpatient psychology service center,
- o occupational therapist,
- o psychologist,
- o guidance center,
- o room and board,

- o respite care,
- o nutritionist
- o habilitate aid,
- o special foster care,
- o adult day care,
- o free standing dialysis facility,
- o pharmacy,
- o case manager,
- o employment specialist,
- o homemaker service,
- o DDS,
- o early intervention,
- o federal qualified health center,
- o skilled nursing center,
- o certified nurse practitioner,
- o group practice,
- o occupation therapy assistant,
- o physical therapy assistant,
- o licensed professional counselor,
- o adaptive equipment,
- o family counsel,
- o transportation/HCBW,
- o school EPSDT,
- o residential behavior,
- o non-federal medical DDS,
- o physician assistant,
- o advanced skill home,
- o advanced unskilled home,
- o advanced health care,
- o advanced nursing facility respite,
- o advanced home delivery meals,
- o advanced case manager,

- o birthing center,
- o agency personal care,
- o special home nurse,
- o other mental,
- o MSDG dealer,
- o speech pathologist,
- o physical therapist,
- o chiropractor,
- o audiologist,
- o portable x-ray/radiologist,
- o outpatient mental health center,
- o family planning clinic,
- o speech and hearing clinic,
- o rural health clinic, and
- o clinics.

2.7 REIMBURSEMENT

In order to be considered for reimbursement for medical services rendered to an eligible Medicaid recipient, a medical professional must be an enrolled provider in the Oklahoma Medicaid program. Hospital providers must be Medicare certified as well. Claims must be submitted within one year of the date the service was rendered. The only exception to the one year limitation is with crossover claims, the one year limitation is from the date of issuance of the Medicare remittance advice, not the date of service.

Oklahoma Medicaid reimburses providers in a variety of methods:

- o capitated payments, established via contractual arrangements with an organization of providers for a package of services under managed care; and
- o fee for service claims through:
 - level of care payments for inpatient hospital facility services,
 - procedure codes for outpatient hospital services,
 - state wide set fees,
 - Medicare rate for free-standing dialysis,
 - average wholesale price less ten and one half percent (10 1/2%) for pharmacy,
 - negotiated rates, and
 - level of care specific rates for long term care.

2.8 CURRENT PROCESSING ENVIRONMENT

The MMIS Contractor, currently UNISYS, plays a significant role in the Oklahoma Medicaid program. Responsibilities of the MMIS Contractor under the operational phase of the current MMIS contract are:

- o Operates and maintains the MMIS;
- o Receives and processes claims received from the provider community in a variety of media including:
 - paper: HCFA-1500, UB-92, ADM-36-K, ADM-84, ADM-36-D, ADM-53 and turnaround documents (TADS) for nursing home claims;
 - electronic: received via modem and diskette using MMIS Contractor software and specifications for all claim types and claim forms; and
 - Point-of Sale: for pharmacy claims;
- o Completes the following processes in the claim receipt and adjudication process:
 - assigns an Individual Claim Number and date stamps paper claims;
 - performs a high-level screen on paper claims for completeness (provider number, recipient number, and provider signature);
 - batches and microfilms claims; and
 - data enters claims into the MMIS. Includes on-site storage of claims in the MMIS Contractor office and archived in accordance with the OHCA requirements;
 - working of suspended claims as specified by the state;
- o Operates a mailroom that performs the following activities:
 - tracks the amount of postage usage and assigns to the correct account code; and
 - provides a bonded courier to pick up provider checks and notices of EFT deposit from the State Treasurer's Office and delivers to the MMIS Contractor for mailing.
- o Processes the claims through the MMIS through the adjudication and payment cycles on a weekly basis. This activity includes:
 - pays, denies, or suspends claims based on state-defined logic;
 - issues Remittance Advices;
 - works suspended claims when a step-by-step process or decision tree has been established (state personnel resolve suspended claims that require interpretation of policy or procedures);
 - performs all research and provides necessary documentation for resolution of the claims; and
 - maintains the Edit and Audit Manual;

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Deleted: <#>pulls claims and claim facsimiles from history for many Medicaid operational functions such as TPL, working of suspended claims and so forth;¶

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- o Performs the following activities relating to financial processing, reconciliation, and reporting:
 - identifies and reports the amount of funds required to pay for the claims adjudicated for payment during the previous weekly cycle;
 - issues payments via paper checks or electronic funds transfer;
 - identifies the allocation of funds to the individual programs as well as other specially funded programs and payments;
 - receives and posts to the appropriate funding source refunds from providers;
 - balances the refund and MMIS accounts;
 - tracks and processes stale-dated checks;
 - performs a financial reconciliation process (checks and balances); and
 - submits the financial reconciliation to the state;
- o Provider enrollment:
 - receive requests for enrollment, and mail all enrollment packets to providers and process and track all provider enrollment applications (from receipt to final disposition), including tracking and reporting on application status, provider agreements, certifications, and re-certifications; and
 - assign provider numbers to newly enrolled providers;
- o Perform certification and re-certification activities to ensure that all Oklahoma Medicaid providers maintain required certifications for participation in the Medicaid program;
- o Generate and distribute permanent recipient identification cards in State-approved format to the location specified in the recipient eligibility master file for each recipient at the person level;
- o Issue replacement permanent recipient identification cards, when directed by the State;
- o Generate and mail out TPL Verification letters;
- o Generate and mail out weekly TPL Retro bills;
- o Generate and mail out monthly TPL Pay and Chase bills;
- o Maintain a claims/encounters resolution unit to resolve claims suspended for edits and audits designated by OHCA as a MMIS Contractor resolution responsibility;
- o Process "special" claims, including late billing, recipient retroactive eligibility, out-of-state emergency, payment under court order, result of an appeal/fair hearing, class

action suit, and any other State-defined situation, in accordance with State instructions;

- o ~~Generate drug rebate invoices and cover letters on a quarterly basis. Invoices are produced on paper or via electronic media;~~
- o Generate follow-up letters to manufacturers who have not responded to the invoice;
- o Generate and maintain a tickler file to track non-responding manufacturers and to generate follow-up letters;
- o Generate and maintain a tickler file to track each manufacturer's status in the dispute resolution process;
- o Provide drug product utilization reports to assist in resolution of disputed rebate invoicing;
- o Create quarterly drug rebate invoices, cover letters, rebate reports, mailing labels, and accounts receivable statements;
- o Mail out quarterly invoices, cover letters, follow-up letters, collection letters, and accounts receivable statements;
- o ~~Maintains and operates the Voice Response System that provides client eligibility information to providers;~~
- o Maintains, acquires, or produces all forms, claim forms, medical identification cards, and so forth necessary to operate the Medicaid Program;
- o ~~The state identifies, ranks, and authorizes Customer Service Requests to modify or enhance the MMIS. Unisys is responsible for identifying the potential cost or impact, participating in the discussion and decision process, and programming the required changes;~~
- o Produces and distributes all required MMIS reports;
- o Maintains and processes all required interfaces with other systems; and
- o Maintains online access to the MMIS for Oklahoma state staff.

Deleted: <#>Maintain sufficient staff to manually price certain claims according to State-specified criteria;¶

Deleted: <#>Update and maintain SURS control file to generate valid exceptions;¶
<#>Update and maintain the SURS case review/correspondence tracking system;¶

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Statistics on claim volume are available in Appendix J.

2.9 PROGRAM INITIATIVES

The most current information on initiatives will be described in the final ITB that is released.