



## STATE DEPARTMENT OF HEALTH

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Promoting health practices that reduce society's cost of treating illnesses and epidemics has, since statehood, been the focus of county health departments. The State Department of Health (SDH) is the statewide coordinating body for those local efforts.

### **ORGANIZATION OF THE PUBLIC HEALTH SYSTEM**

The public health effort has expanded greatly over the state's history as new health problems – and new ideas for combating them – have emerged. Services that fall within SDH's mandate include:

- Providing free immunizations for children to prevent contagious illnesses;
- Providing prenatal care, including food vouchers and home visitations, to improve birth outcomes of low-income women;
- Providing family planning services to prevent unplanned and mistimed pregnancies;
- Establishing Eldercare programs to help older citizens live independently.
- Providing food establishment inspections to prevent food-borne diseases.

A typical client at a local health department clinic does not have a low enough income to qualify for Medicaid and does not have a high enough income to purchase private health insurance. While clients are usually charged a fee based on their ability to pay, SDH's operational theory is that recouping costs is not as important as preventing diseases and conditions that can seriously disrupt individual and public health. Primary care – treating diseases and medical conditions after their onset – is not the agency's primary mission. Instead, health department clinics provide preventative services and education to avert the onset of illness and disease – for example, by providing vaccines to children, or running educational anti-smoking or teen pregnancy prevention campaigns.

There are certain exceptions to the emphasis on prevention over treatment. For example, persons with certain communicable diseases can get treatment at a health department as a way to protect public health (e.g., tuberculosis and venereal disease).

SDH serves as the statewide coordinator of public health services, most of which are provided through local (county) health departments. The central office provides administrative and laboratory services to the local agencies and also maintains the state's vital records. Seventy counties are served by county-supported health departments. The other seven counties – Alfalfa, Cimmaron, Dewey, Ellis, Harper, Nowata and Roger Mills – do not contribute local funding. These seven counties receive only state-mandated services (i.e., environmental inspections, outbreak investigation and immunization). Optional services, such as prenatal clinics, are available only in counties that contribute local funds to the public health effort. Oklahoma City and Tulsa are served by city-county health departments that are administratively autonomous (guided by their own boards) but must comply with policies of the State Board of Health. Counties are encouraged to assess property taxes of up to 2.5 mills to fund operations of local health departments. Sixty-seven counties do so, most of them at the highest millage allowed by the Oklahoma Constitution. Three counties provide local support via sales taxes. Total local health monies collected statewide pay for less than one-third of all county health department operations.

**FUNDING TRENDS**

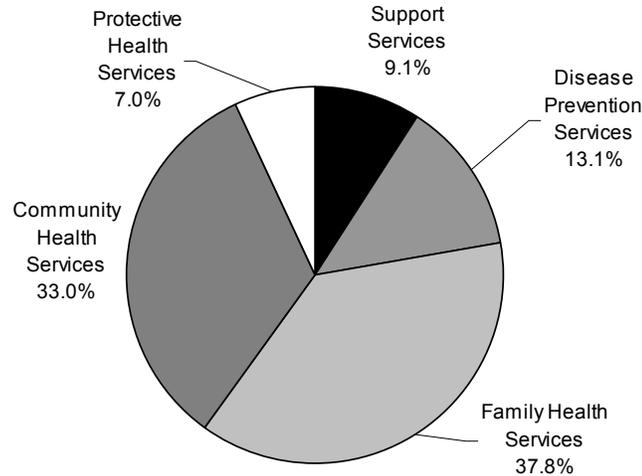
Over half (55.7%) of the FY'02 SDH budget of \$251.1 million came from federal sources (WIC, Medicaid, Maternal and Child Health Block Grant, various grants from U.S. Department of Health and Human Services and Centers for Disease Control). Appropriations accounted for \$68.7 million or 27.4% of spending. Fees charged to clients (for such services as copies of birth and death certificates, occupational and restaurant licensing, trauma fund, organ donation and breast cancer) made up 16.9% of spending. County millage assessment generated \$14.6 million or 5.8% of spending.

**SDH FY'02 Expenditures by Activity**

	<u>General Revenue</u>	<u>Fees</u>	<u>Federal Funds</u>	<u>Millage</u>	<u>Total</u>
Support Services	5,493,455	9,751,056	7,546,290		22,790,801
Disease Prevention Services	7,898,349	2,432,665	22,476,601		32,807,615
Family Health Services	11,404,168	2,182,753	30,104,399		43,691,320
Community Health Services	41,798,704	5,336,316	21,105,772	14,642,697	82,883,489
Protective Health Services	2,118,110	8,155,061	7,224,980		17,498,151
WIC			51,382,361		51,382,361
Total	<u>68,712,786</u>	<u>27,857,851</u>	<u>139,840,403</u>	<u>14,642,697</u>	<u>251,053,737</u>

The sources of funding vary widely for different health department activities. Some activities are funded solely with appropriations; others function with no appropriated dollars. In some cases, each \$1 of appropriations for a particular program is used to access from \$1 to \$9 in federal funds.

### SDH FY'02 Expenditures as a Percent of Total



## SERVICES PROVIDED BY SDH

The State Department of Health provides a wide array of services associated with the goal of preventative health. Major programs fall into the following categories: Family Health, Disease and Prevention, Community Health and Protective Health.

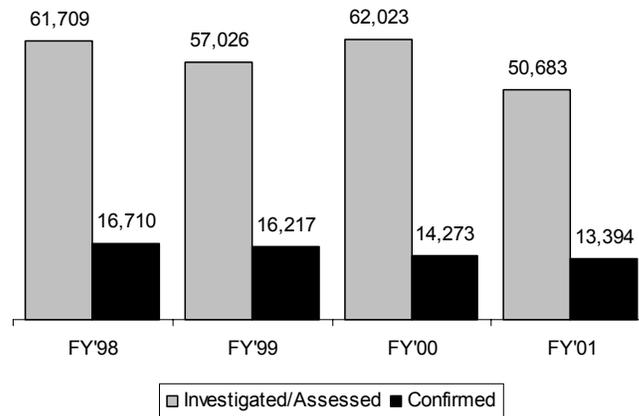
### Family Health Services

This division, the agency's largest, had a budget in FY'02 of \$95.2 million, or 37.8% of the total agency budget. Programs focus primarily on preserving and improving the health of women, children and teenagers:

- **Family Planning Services:** County health departments and non-profit clinics provide family planning services to low-income women at risk for unwanted and mistimed pregnancies. Services include physical exams, contraceptive supplies, education and counseling, and voluntary sterilization. Contracts specifically prohibit use of state funds for abortions.

- **Child Abuse Prevention Programs:** Resources focus on home visitation programs for low-resource mothers to improve health indicators and parenting skills in an effort to avert child abuse, unwanted repeat pregnancies and other adverse outcomes.

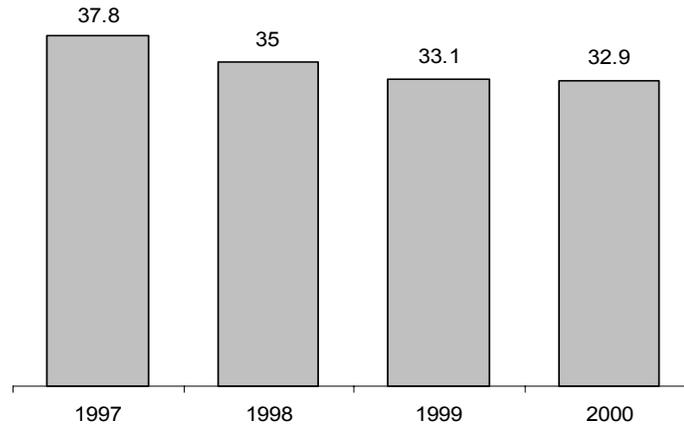
### Confirmed Cases of Child Abuse and Neglect FY'98 Through FY'01



Source: DHS Children & Family Services Division

- **Child Guidance Services:** County health clinics offer diagnostic and short-term treatment services for developmental, psychological, speech, language and hearing problems among children. The agency also staffs the Early Intervention (SoonerStart) program, funded through the State Department of Education, for infants and toddlers.
- **Women, Infants and Children (WIC):** This federally-funded program provides nutritional education and coupons for selected foods to 90,000 pregnant women, infants, and children less than five years of age per month.
- **Dental Health:** Oral health screening and small-scale treatment is provided for children and nursing home residents in some areas through contracts with providers. There is also a school-based dental education program and a fluoridation program to improve the state's drinking water supply.
- **Teen Pregnancy Prevention:** The agency provides community-based programs aimed at lowering the state's teen birthrate via contracts with non-profit providers.

Oklahoma: Birth Rates for Females Age 15-17  
Rates per 1,000  
1997 Through 2000



- **Newborn Metabolic Screening:** The agency coordinates screening of all Oklahoma newborns for various metabolic disorders.

### Disease Prevention Services

This division had a budget in FY'02 of \$32.8 million or 13.1% of the total agency budget. This division includes: Public Health Laboratory; Acute Disease; Chronic Disease Services; HIV/STD Services; Immunization Services; Injury Prevention Services; and Tobacco Use Prevention Services.

**Chronic Diseases:** The agency provides screening, tracking, education and referrals for persons at risk of a number of chronic diseases such as cancer, diabetes, heart disease and high blood pressure.

**Communicable Diseases:** This division is involved in monitoring and combating the spread of communicable diseases. The following services are provided:

- Immunizations –SDH inoculates uninsured children for all state-mandated vaccines and coordinates the distribution of vaccines to private health facilities. In 1998 approximately 79% of Oklahoma's two-year olds were immunized compared with 81% nationally.
- Tuberculosis (TB) Treatment and Prevention –SDH provides screening, diagnosis, and rigorous follow-up programs for persons with TB, many of whom are indigent and difficult to track.

- HIV/STD –SDH coordinates and funds a statewide program for the surveillance and prevention of Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome and other sexually-transmitted diseases. The agency also helps eligible participants pay for prescriptions under the AIDS Drug Assistance Program.

## **Community Health Services**

The Community Health Services Division, the agency's second largest division, accounted for 33.0% or \$82.9 million of the agency's budget in FY'02. The division covers an array of services at the county health department level, including technical oversight for public health nurses and community health workers throughout the state, local finance and budgeting, and record keeping.

## **Protective Health Services**

SDH has responsibility for a wide range of regulatory services in areas that affect the health of citizens. Regulatory responsibilities include enforcing laws and regulations, performing routine inspections, investigating complaints, and issuing, renewing and revoking licenses.

Most of the \$17.5 million budget for this division comes from licensure fees. Federal Medicaid funds help support health and medical facility inspections, which are conducted by SDH employees.

- **Long-Term Care Services:** SDH is responsible for licensing and inspecting nursing facilities, assisted living centers, group homes, intermediate care facilities for the mentally retarded, and residential care centers.
- **Medical Facilities and Entities:** The agency licenses hospitals, ambulatory surgical centers, community health centers, home health agencies, hospices, health maintenance organizations, etc.
- **Occupational Licensing:** SDH licenses plumbers, electricians, barbers, hearing-aid fitters, the alarm industry, and licensed professional counselors.
- **Restaurant and Motel Inspection:** Restaurant and motel inspections are fee-funded and conducted by local sanitarians working out of county health departments.
- **County and City Jail Inspections:** SDH employees inspect local jails to ensure compliance with minimum safety and inmate welfare standards. In response to jail crowding, this division has expanded enforcement efforts in this area.



## **MEDICAID**

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Medicaid, also known as Title XIX of the federal Social Security Act, is the primary mechanism for financing health care for low-income Americans. Unlike Medicare, which targets the elderly and is 100% federally funded, Medicaid is administered by state governments within certain guidelines set by the federal government.

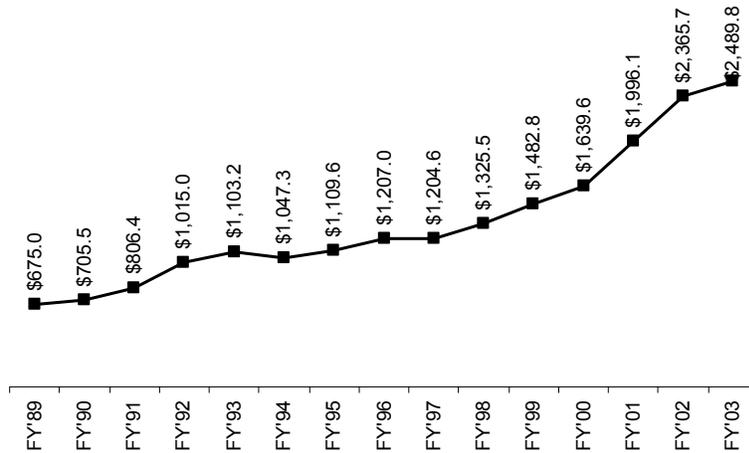
Federal law requires every state to designate a single agency to administer its Medicaid program. Since 1993, the Oklahoma Health Care Authority (OHCA) has been the designated agency in Oklahoma. Prior to that time, the Medicaid program was administered by the Department of Human Services (DHS). DHS continues to play an important role in the Medicaid program because it certifies eligibility of recipients and operates Medicaid programs serving elderly and disabled populations.

## **FINANCING**

Medicaid is funded through a federal-state partnership. The federal share of the program, also known as the federal medical assistance percentage (FMAP), varies by state in inverse relation to a state's per capita income. Oklahoma's per capita income decreased this year, which will cause the federal FY'03 FMAP to increase from 70.43% to 70.56%. Currently, \$1.00 in state spending on Medicaid health services will draw down an additional \$2.38 in federal funds for most Medicaid services. (The federal match for administrative expenses ranges from 50% to 90%, while some program expenditures are also eligible for matching rates of 80% to 100%.)

In FY'02, the state share of the Medicaid program was just under \$599 million. Total program dollar expenditures were in excess of \$2.365 billion, or approximately 17% of total state spending for that year.

Total Medicaid Expenditures  
FY'89 Through FY'03



In FY'03, the Medicaid budget is projected to increase to more than \$2.5 billion, with state appropriations accounting for \$615 million.

While OHCA is the main beneficiary of state appropriations for Medicaid, other state agencies (such as the Department of Human Services, the State Department of Health, Department of Education and Department of Mental Health and Substance Abuse Services, the Office of Juvenile Affairs and the University Hospitals Authority) pay the state match for various services and programs that are covered by Medicaid. Medicaid is also partly funded by taxes on HMOs and long-term care facilities and by rebates from drug manufacturers. The Authority also began receiving inter-governmental transfers from public hospitals in July 2002.

**MEDICAID ELIGIBILITY**

Medicaid eligibility is established by DHS based on standards set by the state and federal government. Individuals are determined to be Medicaid eligible for six-month periods. Recent efforts to simplify and accelerate the eligibility process have included shortening the application form and eliminating the traditional asset test.

**Covering the Uninsured**

In general, Medicaid covers low-income mothers and children, the elderly, and people with disabilities. Most healthy working-age adults are ineligible for Medicaid, even if their income falls considerably below the federal poverty level. Medicaid served 617,218 Oklahomans throughout FY'02, or about 17.8% of the total population. In the mid-1990s, 28% of Oklahoma's low-income population

(defined as 200% of federal poverty level and below) received Medicaid benefits, compared to the national average penetration of 32%.

Children make up two-thirds of Oklahoma's Medicaid population while the aged, blind and disabled account for about one-quarter of the population. Enrollment patterns in the Medicaid program, however, do not correspond with expenditure breakdowns. Nationally, only 20% of Medicaid program dollars are spent on children, compared to 70% that is spent to provide services for the aged, blind and disabled populations. This discrepancy reflects the fact that the aged, blind and disabled are more likely to suffer from chronic health problems which may require ongoing medical assistance, episodes of acute care, and eventually long term care.

### Medicaid Recipients and Expenditures *Federal Fiscal Year 1996*

<u>Percentage of Recipients</u>		<u>Percentage of Expenditures</u>	
Children	63.8	Children	28.0
Adults with Dependent Children/Pregnant Women	15.1	Adults	7.4
Disabled	12.1	Disabled	37.3
Aged	8.9	Aged	27.1
Blind	0.01	Blind	0.02

### **Recipients of AFDC/TANF**

Prior to federal adoption of Welfare Reform in 1996, persons eligible for the Aid to Families with Dependent Children (AFDC) program were automatically entitled to health care coverage under Medicaid. Congress severed this automatic link by repealing the AFDC program and creating the Temporary Assistance for Needy Families (TANF) program. Now, eligibility for Medicaid is no longer tied to receipt of cash assistance. However, anyone who meets the AFDC eligibility criteria that were in effect on July 16, 1996, is still able to receive Medicaid. In Oklahoma, the AFDC eligibility threshold is 25% of the federal poverty level, or \$3,684 per year for a family of three in the year 2002. Transitional Medicaid coverage is also guaranteed for families moving off welfare for a period of up to 12 months.

### **Low-Income Pregnant Women and Children**

While most healthy adults are ineligible for Medicaid, the past decade has seen a concerted effort by Congress and the states to improve the health of children and pregnant women. In 1994, 14.2% of children nationally and 20.6% of Oklahoma children lacked health insurance. Among low-income children, the percentage without insurance was even higher. During the early 1990s, Congress mandated

a phased-in expansion of Medicaid coverage for low-income children and pregnant women. This effort was superseded in Oklahoma by the passage of SB 639 (1997) and the state's Children's Health Insurance Plan.

SB 639 in 1997 increased Medicaid eligibility for pregnant women and children through 14 years of age to cover families whose income was up to 185% of the federal poverty level. A year later, the expanded eligibility level was expanded to cover families with children from 15 to 17 years of age. Under the program, an additional 120,000 children were added to the Medicaid program in the first 30 months following implementation. Of these new enrollees, one-third were newly eligible because of the new expanded criteria, and two-thirds were Medicaid eligible prior to SB 639 but had not been enrolled. Aggressive outreach by state agencies and community groups has played a large role in attracting eligible families to sign up for the program. Federal law required OHCA to begin covering children or persons 18 years of age on 9-1-01.

Concurrent with Oklahoma's initiative, President Clinton and Congress announced a \$24 billion new program known as CHIP (Children's Health Initiative Plan) to encourage and assist states in insuring low-income children. The program provided enhanced federal matching funds to insure uninsured children up to 200% of the federal poverty level either through a Medicaid expansion (Oklahoma's option) or through a stand-alone CHIP program. Oklahoma is currently receiving an enhanced federal match of 80% for the Medicaid costs of children made eligible by SB 639.

### **Recipients of Supplemental Security Income (SSI)**

SSI is a federal cash assistance program for persons who are 65 years of age, blind or disabled and poor, known as ABD. Receipt of SSI assistance automatically qualifies an individual for Medicaid. As of July 2002, there were 101,811 adult and 10,582 children ABD recipients.

### **Medicaid Payments for Medicare Premiums**

Under 1988 federal legislation, states are required to pay Medicare premiums, deductibles and coinsurance for needy elderly and disabled persons who are dually eligible for Medicare and Medicaid. This group is known as Qualified Medicare Beneficiaries (QMBs). The payments are cost-effective from the state's standpoint because it is less expensive to pay such out-of-pocket expenses for Medicare eligibles than it is to have them lose their Medicare benefits and fall into Medicaid eligibility. In FY'02, Medicaid paid for Medicare Part A premiums for 10,863 individuals and Part B premiums for 201,339 individuals.

### **Medically Needy Persons**

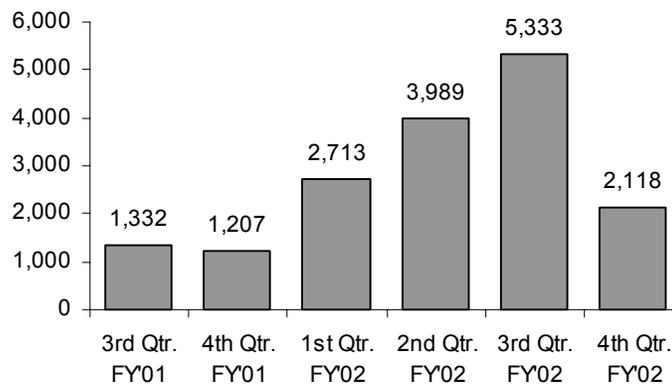
As an option under the Medicaid program, Oklahoma provides short-term medical coverage for individuals who do not meet other income or need criteria but who have such high medical bills that their incomes, in effect, are reduced to an established eligibility level.

Before becoming eligible for assistance, a person must actually incur medical bills and "spend down" his or her resources to an established minimum level (\$2,000 in cash resources or on equivalent and less than \$259 a month in income). In July 2002, some 2,000 Oklahomans qualified for Medicaid as "medically needy."

### Growth in Enrollment

The Medicaid program is designed to be counter cyclical with the economy. For every one percentage point increase in unemployment that occurs, Medicaid enrollment can be expected to increase by 2.7%. Enrollment in the Medicaid program began to increase dramatically after the events of September 11, 2001, and the national recession that followed.

Average Quarterly Growth in Enrollment  
FY'01 Through FY'02



## MEDICAID AND MANAGED CARE

In response to dramatic growth rates in the Medicaid program during the late 1980s and early 1990s, the Legislature created the Task Force on Medicaid and Welfare Reform. The task force's report recommended the transition of Oklahoma's Medicaid program from a fee-for-service type system to one based on managed care principles. As a result, in 1993 the Legislature enacted the Oklahoma Medicaid Healthcare Options Act, which directed the newly-created OHCA to develop and implement a statewide, comprehensive system of managed health care delivery for Medicaid recipients. The objectives of this system are:

- to improve both the quality of Medicaid patient care and access to care through a greater emphasis on preventive services delivered by primary care providers; and

- to control Medicaid health care costs by reducing inappropriate utilization of services (such as non-emergency visits to hospital emergency rooms) while instilling greater budget predictability by shifting cost risk to managed care organizations.

### **Urban vs. Rural Medicaid Options**

In the Medicaid system, §1115(a) waivers allow states to implement many program components that would otherwise not be permissible under federal statutes or regulations. Within certain parameters, this permits states to create programs with features that are unique or innovative. For example, Oklahoma was granted a statewide waiver under which different programs could be established in the rural and urban areas of the state, unlike most other states in which only one managed care model was permitted. Oklahoma was given permission to establish creative integrated rural systems to test various approaches to building a rural managed care infrastructure. In addition, Oklahoma was allowed to waive the usual federal requirement that limited the composition of health plans to no more than 75% Medicaid enrollees. This enabled the state to accept certain Medicaid-only health plans, such as Heartland Health Plan, based out of the University of Oklahoma Health Sciences Center."

**Urban Model:** In urban areas of the state (defined as 16 counties in and around Oklahoma City, Tulsa, and Lawton), the OHCA contracts with managed care organizations (MCOs) to deliver a comprehensive package of benefits to Medicaid recipients in return for a "capitated," per-client monthly payment. Under this program, known as SoonerCare Plus, each recipient is guaranteed the right to choose from multiple health plans (MCOs) and to select a primary care physician who is affiliated with the plan. This primary care physician provides a "medical home" for the recipient and serves as his or her first point of contact for services. With few exceptions, all services must be accessed within the MCO network of providers. There were some 171,822 recipients in the SoonerCare Plus program as of September 2002.

**Rural Model:** In rural areas (61 counties projected as of September 2002), OHCA contracts directly with primary care physicians who serve as case managers coordinating referrals for hospitalization and specialty care. Under this program, known as SoonerCare Choice, each Medicaid recipient has the right to choose a primary care physician, who receives a monthly capitation payment for each recipient under his or her care. This payment covers the cost of providing primary care – including certain lab, X-ray and emergency services, and such preventive services as immunizations and well-child screens – along with case management services, such as specialty referral and general care coordination. In rural areas, all other services – e.g., inpatient hospital care, pharmaceuticals or dental services – are paid to providers on a fee-for-service basis. There are no MCOs involved in SoonerCare Choice. There were 139,009 recipients in the SoonerCare Choice program as of September 2002.

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## **Savings Attributed to Managed Care**

During the first six complete calendar years under managed care for the AFDC population (1996-2001), the Health Care Authority determined that the Medicaid program saved \$770 million over the anticipated cost without managed care. Of these savings, \$547 million accrued to the federal government and \$223 million to the state. In FY'02, capitation payments totaled \$358 million to health plans for recipients in the fully capitated urban managed care program and \$28.6 million to primary care providers in the partially-capitated rural program. In total, capitation payments accounted for roughly 16.3% of the total Medicaid budget.

## **Oklahoma 2001 Healthcare Initiative**

The 2000 Legislature voted to spend \$36 million of national tobacco settlement revenue for the Oklahoma 2001 Healthcare Initiative. The Medicaid program received an appropriation of \$32.8 million of this sum. This allocation of tobacco settlement funds, with its promise of nearly \$2.38 in matching federal funds for every state dollar, aimed to bring Medicaid reimbursement levels closer to rates paid by Medicare and private insurance, and to bolster the state's health care infrastructure.

The bulk of spending went toward provider rate increases in the fee-for-service program and increased capitation rates for managed care. In addition to rate increases of 18% for physicians and other medical practitioners and 12% for hospitals, beneficiaries included dentists (60%), ambulance services (40%), behavioral health counselors (10%), and providers of home health services to the elderly and disabled (hourly wage increases of 13% to 15%). Funding was also provided to extend coverage of inpatient hospital stays from 12 to 24 days and broaden eligibility for the state's home- and community-based waiver for developmentally disabled individuals without cognitive impairment.

## **SERVICES PROVIDED BY MEDICAID**

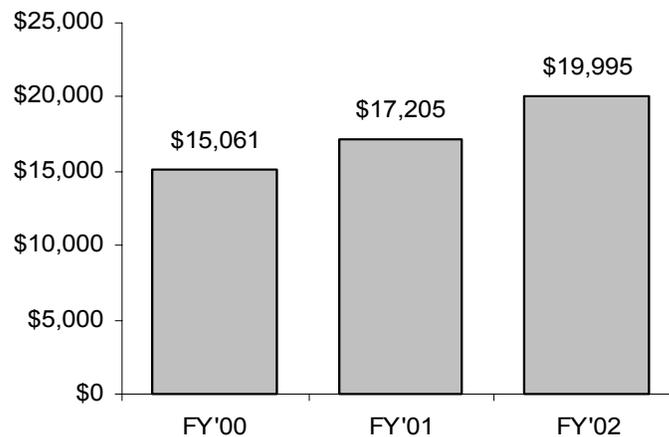
Unlike Medicare, which charges its recipients monthly premiums and includes co-pays and deductibles, Medicaid is a system of essentially free health insurance coverage for eligible beneficiaries. However, Medicaid involves some cost to clients: providers can charge co-payments for certain services (e.g., \$1-\$3 for doctors' visits or prescription drugs), and nursing home residents must "spend down" their own resources to a certain level before Medicaid begins paying their bills.

## What Services are Covered?

Federally Mandated Services	Optional Covered Services	
Early/Periodic Screening Diagnosis & Treatment (EPSDT) Under Age 21	Case Management	Optometrist
Family Planning Services & Supplies	Chiropractor	Personal Care
Inpatient Hospital	Clinic	Physical Therapy
Laboratory & X-ray	Dental	Podiatrist
Non-emergency Transportation	Dentures	Prescribed Drugs
Nurse Midwife	Diagnostic Services	Preventive Services
Nurse Practitioner	Emergency Hospital	Private Duty Nursing
Nursing Facility/Home Health for Age 21+	Eyeglasses	Prosthetic Devices
Outpatient Hospital	Inpatient Hospital for Age 65+ in Institutions for Mental Diseases	Psychologist
Physician	Inpatient Psychiatric under age 21	Rehabilitative
Rural Health Clinic and Federally Qualified Health Center	ICF/MR	Respiratory Care
	Nurse Anesthetist	Screening Services
	Nursing Facility under age 21	Speech/Hearing/Language Disorders
	Occupational Therapy	TB Related

Prescription drug costs for the fee-for-service population often exceeds the agency's budget. In FY'02 the agency budgeted for an 18% increase in the cost of prescription drugs. The prescription drug budget actually increased by 24% for the fiscal year. The cost overruns were attributable to three factors. The number of drugs used per month per recipient increased, the average cost per drug increased, and the number of recipients requiring medication increased.

Average Monthly Expenditures on Prescription Drugs  
FY'00 Through FY'02 (In Millions)



## Caps on Medicaid Services

In order to control spiraling costs in the early 1990s, Medicaid benefits were capped for certain services. Coverage was limited to three prescription drugs and one doctor's visit per month (a limit of twelve hospital inpatient days was lifted as part of the Oklahoma 2001 Healthcare Initiative). These restrictions do not apply

to participants in health maintenance organizations in the urban managed care program, to children, to residents of nursing facilities and other institutions, or to participants in the ADvantage and Home and Community-Based Waiver programs.

## **Long-Term Care**

Medicaid is the nation's primary insurer of long-term health care services for individuals with chronic, non-acute needs. In fact, about 70% of all residents in Oklahoma nursing homes are Medicaid clients. Long-term care services range from personal care, rehabilitative therapies, chore services, and home-delivered meals to durable medical equipment and environmental modification. With the graying of the baby-boom generation and advances in medical technology contributing to a rapidly expanding senior population, providing adequate and affordable long-term care will be one of the great challenges confronting state and federal policy makers in the new century.

Medicaid payments for long-term care falls into two general categories:

**Institutional Care:** This includes such facilities as nursing homes, Intermediate Care Facilities for the Mentally Retarded (ICFs/MR), or state hospitals for the mentally retarded. The state pays private institutional providers a per diem to cover the full range of patients' needs, including room and board. Part of the revenue for nursing homes and ICFs/MR payments is raised by daily per-bed fees imposed on all licensed facilities, which are matched with federal funds.

**Home- and Community-Based Programs:** Through several Medicaid waivers administered by DHS, the state contracts with private agencies to provide needed services set out in an individual care plan. The largest waiver programs are the Home-and-Community Waiver for the developmentally disabled and the ADvantage Waiver for the aged and disabled. All 50 states have developed waivers as a way to allow those who do not need 24-hour nursing care to live fuller, more independent lives outside of institutions.

Eligibility for Medicaid long-term care services is based on a combination of medical and financial criteria. Medically, individuals must be certified as needing a "nursing home level of care" to be eligible either for institutional placement or participation in one of the long-term care waivers. Financially, Medicaid recipients' incomes must be below 300% of the SSI eligibility threshold, which translates to monthly income of roughly \$2,952 per person and \$2,000 in non-exempted assets.

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<u>County</u>	<u>Proj. Pop. 2001 Census</u>	<u>Clients</u>	<u>Total Annual Expenditure</u>
ADAIR	21,118	4,967	\$19,122,990
ALFALFA	6,005	438	\$2,023,843
ATOKA	14,011	2,718	\$9,622,521
BEAVER	5,640	409	\$1,283,466
BECKHAM	19,846	3,265	\$16,236,415
BLAINE	11,920	1,892	\$7,406,853
BRYAN	36,477	6,427	\$28,928,822
CADDO	29,966	6,121	\$20,751,475
CANADIAN	89,978	6,885	\$32,585,120
CARTER	45,909	8,348	\$36,433,388
CHEROKEE	42,697	8,166	\$38,817,033
CHOCTAW	15,169	4,360	\$16,914,966
CIMARRON	3,023	337	\$792,936
CLEVELAND	211,908	16,829	\$75,377,435
COAL	6,074	1,400	\$6,619,541
COMANCHE	112,466	14,160	\$51,373,900
COTTON	6,528	965	\$4,251,028
CRAIG	14,757	2,604	\$21,270,949
CREEK	68,488	8,452	\$44,797,526
CUSTER	25,358	3,696	\$15,097,452
DELAWARE	37,699	6,278	\$26,034,340
DEWEY	4,672	460	\$2,737,799
ELLIS	3,952	399	\$2,018,929
GARFIELD	57,114	7,648	\$74,310,282
GARVIN	27,105	4,674	\$52,807,212
GRADY	46,139	5,957	\$23,376,802
GRANT	5,091	470	\$3,363,770
GREER	5,883	934	\$4,589,991
HARMON	3,155	731	\$3,588,273
HARPER	3,464	358	\$2,039,504
HASKELL	11,763	2,726	\$10,701,217
HUGHES	13,927	2,986	\$17,744,803
JACKSON	27,661	4,267	\$17,092,381
JEFFERSON	6,623	1,383	\$7,131,500
JOHNSTON	10,569	1,996	\$9,241,843
KAY	47,541	7,395	\$24,746,618
KINGFISHER	13,854	1,259	\$6,023,719
KIOWA	9,945	1,751	\$10,740,965
LATIMER	10,634	2,249	\$8,188,614
LE FLORE	48,041	10,338	\$41,663,831

County	Proj. Pop. 2001 Census	Clients	Total Annual Expenditure
LINCOLN	32,154	4,089	\$16,173,613
LOGAN	34,209	3,811	\$17,460,923
LOVE	8,863	1,423	\$4,839,283
MCCLAIN	27,825	2,757	\$11,154,769
MCCURTAIN	34,194	8,965	\$32,342,528
MCINTOSH	19,522	3,504	\$16,292,391
MAJOR	7,528	724	\$3,680,155
MARSHALL	13,433	2,139	\$9,173,699
MAYES	38,697	6,196	\$26,309,047
MURRAY	12,721	2,143	\$10,245,131
MUSKOGEE	69,887	13,221	\$66,581,671
NOBLE	11,388	1,393	\$9,470,058
NOWATA	10,634	1,630	\$7,957,334
OKFUSKEE	11,781	2,392	\$15,244,481
OKLAHOMA	662,153	90,947	\$419,871,232
OKMULGEE	39,715	7,897	\$36,831,045
OSAGE	45,034	4,627	\$20,034,250
OTTAWA	33,046	6,469	\$28,190,366
PAWNEE	16,845	2,255	\$10,999,576
PAYNE	67,830	7,025	\$30,725,231
PITTSBURG	43,779	7,800	\$33,683,550
PONTOTOC	34,611	5,819	\$33,105,838
POTTAWATOMIE	66,269	10,737	\$43,590,729
PUSHMATAHA	11,706	2,959	\$13,188,091
ROGER MILLS	3,331	261	\$1,285,180
ROGERS	74,066	6,527	\$31,057,149
SEMINOLE	24,652	6,235	\$29,477,759
SEQUOYAH	39,262	8,357	\$33,899,694
STEPHENS	42,970	5,986	\$24,677,353
TEXAS	19,754	1,878	\$4,948,196
TILLMAN	9,146	1,662	\$7,329,222
TULSA	564,079	63,102	\$333,470,905
WAGONER	59,059	5,322	\$20,143,356
WASHINGTON	49,087	5,284	\$33,976,082
WASHITA	11,473	1,831	\$7,530,186
WOODS	8,832	969	\$4,591,164
WOODWARD	18,392	2,354	\$8,805,785
	3,460,097	477,388	\$2,256,187,074

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## **MENTAL HEALTH AND SUBSTANCE ABUSE**

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Perhaps no state government function has experienced such a profound change in its mission over the past 40 years than the mental health system. As late as the 1960s, long-term institutionalization was the main service available to mentally ill Oklahomans. Civil commitment laws of the day did not guarantee patients due process. From its crude beginnings, the state mental health system has shifted paradigms. Hospitalization is now considered a temporary solution for all but a few clients. Most mental health services are now provided in the community.

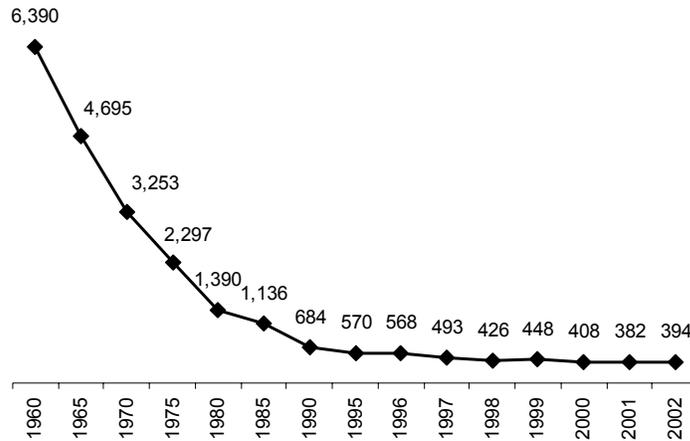
Also, the state mental health agency has broadened its scope beyond those with clinical mental illnesses. The Department of Mental Health and Substance Abuse Services (DMHSAS) now also focuses on addiction services, as well as domestic violence and sexual assault.

### **BACKGROUND ON MENTAL HEALTH CHANGES**

While the federal government takes the national lead in providing physical health care to poor Americans, services for the mentally ill have historically been a state responsibility.

Until the mid-1960s, most mentally ill adults who could not function in society were committed to custodial care in large state hospitals, many of which housed 3,000 or more patients. But in the mid-1970s, the concept of "deinstitutionalization" led states to begin freeing mentally ill clients from the confines of institutions and treating them on an outpatient basis at Community Mental Health Centers (CMHCs). On an average day in 1960, nearly 6,400 Oklahomans were in the state's mental hospitals; in FY'02, the hospital census averaged 394, a decrease of 94%. An even more dramatic figure is that in 1960 about 3 out of every 1,000 Oklahomans were living in mental hospitals; now that number is less than 0.2 out of 1,000 Oklahomans.

### Average Daily Census State Mental Hospitals (1960 Through 2002)



Three major developments changed the direction of mental health services in the United States:

- discovery of psychotropic medications that alleviate many of the disabling symptoms of psychotic disorders such as schizophrenia, and affective (mood) disorders such as severe depression and bipolar disorder;
- passage of the federal Community Mental Health Centers Construction Act in 1963; and
- landmark court rulings on the rights of people with mental illness to due process in commitment hearings and the right to treatment in the least restrictive setting.

## **DMHSAS OVERVIEW**

DMHSAS is responsible for providing services to people who are affected by mental illness, substance abuse, domestic violence, and/or sexual assault. During FY'02 over 100,000 people received services from the agency.

The state subsidizes services for clients with incomes below 200% of the federal poverty level. DMHSAS receives reimbursement for some services to clients served under the Medicaid program (see Medicaid).

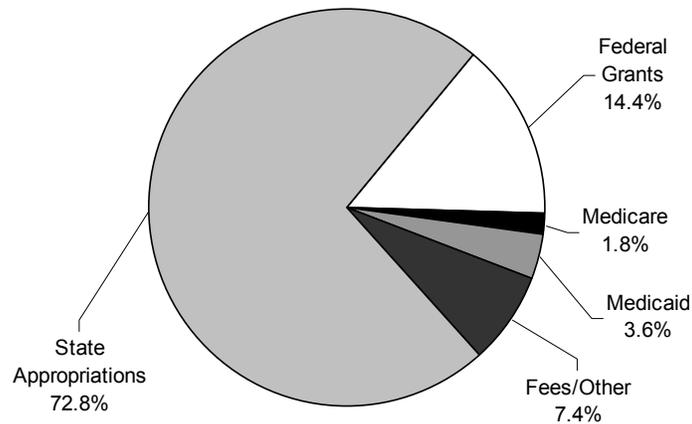
## Funding Sources

Oklahoma's mental health system is centralized and primarily state funded (72.8% in FY'03). Oklahoma differs from many states in that no local funds are required to match state funds for community programs.

Federal funding provides one-quarter of DMHSAS' budget. While federal funding for Medicare and CMHCs has been decreasing over recent years, funding for substance abuse treatment and drug courts has been increasing.

Due to federal Medicare cost-cutting policies, Medicare revenue has decreased by 50% since FY'94. In FY'03 Medicare comprised 1.8% of the agency's total budget. Despite this decrease, increases in funding for substance abuse and increased Medicaid revenue have resulted in a net increase in federal funding as a percentage of the agency's budget.

DMHSAS Budget by Source, FY'03 Estimate  
Total = \$207,273,015



## Services Provided

DMHSAS provides the following inpatient and community-based services in state administered or contracted programs:

- regional adult psychiatric hospital (Griffin Memorial Hospital);
- child psychiatric hospital (Oklahoma Youth Center);
- Community Mental Health Centers or CMHCs (5 state-operated and 13 private non-profit) that provide outpatient counseling and, in some cases, short-term hospitalization;

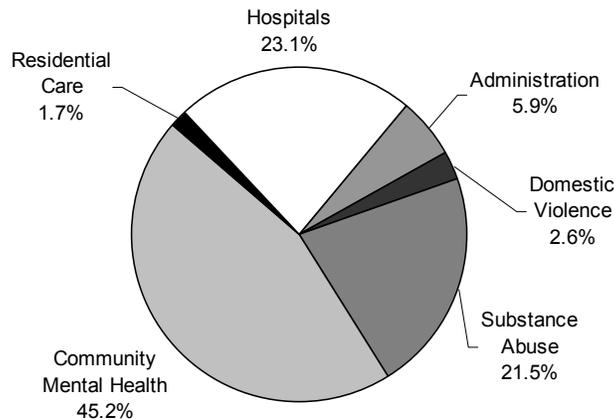
- state-administered alcohol and drug treatment residential centers;
- privately operated alcohol and drug prevention and treatment programs (85 contract providers);
- domestic violence programs (29 contract providers); and
- residential care home programs (33 contracted homes).

### **Program Budgets**

State hospital operations account for 23.1% of the agency's FY'03 budget, down from 43.4% in FY'92. Hospitals serve only 3.4% of the agency's total clients. Behavioral health community-based programs will utilize 45.2% of the budget and serve 55.9% of the clients in FY'03. Substance abuse programs account for 21.5% of the budget and 23.8% of the clients. Domestic Violence utilizes 2.6% of the budget but serves 14.6% of the agency's clients. Central administration accounts for 6.16% of the budget.

### **DMHSAS Budget by Program, FY'03 Estimate**

*Total = \$207,273,015*

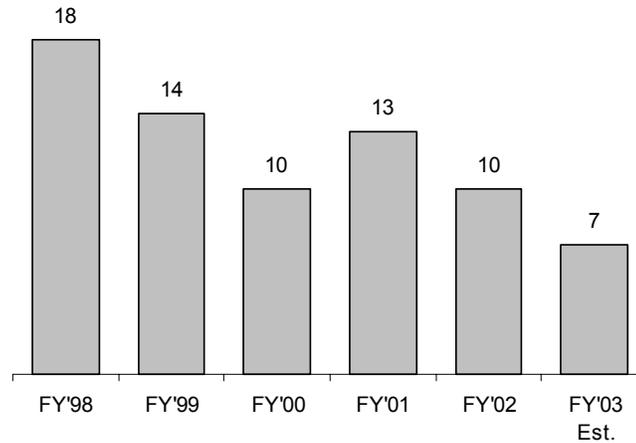


## **Program Overview**

### **Mental Health**

DMHSAS provides a myriad of programs. Several of these services have recent initiatives that have been presented to the Legislature as ways to improve mental health services and control costs. New treatment methodologies and medications have decreased the length of stay for certain disorders.

Average Number of Inpatient Hospital Days Required  
for Mood Disorders  
FY'98 Through FY'03



### Eastern State Hospital Transition

During the 1999 session, the Legislature approved landmark legislation to downsize Eastern State Hospital (ESH) in Vinita and transfer all clinical responsibility for clients to seven Community Mental Health Centers (CMHCs) that serve the northeast region. The CMHCs had previously referred most of their clients who needed long-term treatment to ESH, which then assumed the cost of their care. As of July 1, 2000, however, the CMHCs were required to serve all clients' needs in the community, and the civil unit at ESH was closed. The transition occurred in phases:

- **Phase I:** Beginning January 1, 2000, three of the seven CMHCs began delivering all services, including hospitalization, in their communities. For a six-month period, until July 1, 2000, the three CMHCs could send a client to ESH if they paid a per diem to the hospital.
- **Phase II:** Effective July 1, 2000, the civil unit at ESH was closed. The four remaining CMHCs had to begin accommodating all their clients' clinical needs within the community. Two of the seven CMHCs have inpatient beds available on their sites. The other five must lease beds via contract, usually with community general hospitals.

Griffin Memorial Hospital in Norman, the only remaining state-operated psychiatric hospital, is ultimately the safety valve for the ESH CMHCs if they can't find an available inpatient bed. All seven CMHCs are expected to provide

appropriate levels of outpatient services, including medication management, with the goal of decreasing the need for inpatient services. SB 149 (2000 session) also requires DMHSAS to establish a 44-bed enhanced residential treatment facility at the ESH site. Griffin has been overcrowded since the closure of ESH. At any given time, approximately 30 to 40 Tulsa area residents are receiving inpatient treatment services at Griffin. DMHSAS added nine new beds at the Tulsa Center for Behavioral Health in October 2002 to help address this problem.

### **CMHCs**

One of the major challenges currently facing DMHSAS is that of equitable per capita funding for community mental health centers. There are 18 community mental health centers operating in Oklahoma (five state-operated, 13 private non-profit). State funding for those centers ranges from \$11.23 to \$28.27 per capita (the latter figure excludes Western State Psychiatric Center, formerly Western State Hospital, which operates as a state CMHC; including it would increase the high-end range to \$82.49). A 1997 comparison indicates that the national average per capita funding level of \$27.58 is 16% higher than Oklahoma's FY'03 state average of \$23.81. Without equitable per capita funding, the level and quality of mental health services delivered across the state vary dramatically. For FY'01, DMHSAS adopted a fee-for-service reimbursement system for CMHCs, creating uniform rates for services.

### **Medicaid for Mental Health Providers**

In recent years the Medicaid program has become a significant revenue source for mental health providers. Much of this increase has come about because CMHCs are assuming more responsibility for patients discharged from state hospitals. Many CMHC services are Medicaid reimbursable, while state psychiatric hospitals are considered institutions and are, therefore, ineligible for Medicaid.

### **Managed Care for Behavioral Health**

Under state law, most Medicaid-funded mental health services are delivered under a managed care environment, because of legislative changes enacted in 1999. Medicaid clients receiving mental health services under the Supplemental Security Income (SSI) program began receiving behavioral managed care services beginning July 1, 1999. This transition has raised concerns from consumers, providers and legislators.

### **Medications**

The advent of more effective psychotropic medications for people suffering from schizophrenia, severe depression, and bipolar disorder has enabled many more clients to lead normal, healthy lives in their communities. These "new generation" medications have improved quality of life for many people and have the potential to decrease hospitalization costs for states. Budget constraints hamper the state's ability to provide appropriate medications on a consistent basis for all clients. Thus the "revolving door" syndrome continues in Oklahoma:

mentally ill patients are stabilized in hospitals with medications, discharged, then either cannot or will not continue to take prescribed medications. Their condition deteriorates until law enforcement or loved-ones intervene, then they are re-admitted to a hospital.

### **Forensic Services**

DMHSAS is responsible for providing several forensic services: evaluating all people charged with a crime who are believed to suffer from mental illness, treating defendants waiting for trial, and housing persons adjudicated as Not Guilty by Reason of Insanity (NGRI). The forensic population, housed at Eastern State Hospital, is on the increase. In July 2000, there were 132 forensic patients at ESH. By August 2002, the census was up to 160 patients – above the unit's capacity of 151. DMHSAS has requested \$17 million in capital bond funds to build a new, 225-bed forensic unit. With expanded capacity, the agency proposes it could also treat mentally ill inmates who are crowding state prisons.

### **Substance Abuse Services**

Like many states, Oklahoma has been experiencing an increase in the demand for substance abuse treatment programs. A recent needs assessment by DMHSAS indicates the agency has enough resources to serve only one-fourth of the indigent persons who need substance abuse treatment. Significant waiting lists result.

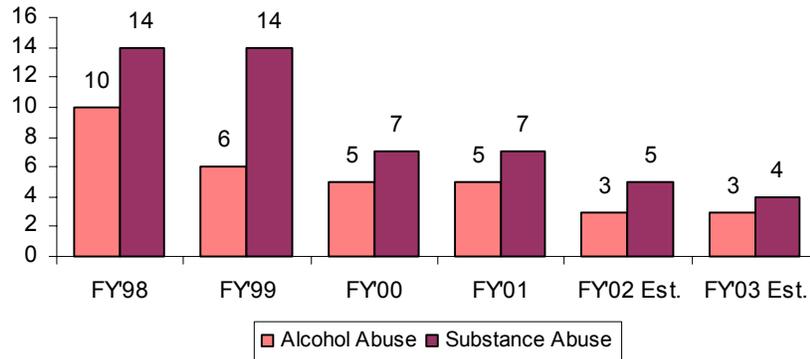
Adolescent residential substance abuse treatment programs are in especially high demand. Currently, only two private, non-profit centers provide such programs for adolescents. There are no residential treatment services in the northwestern or northeastern parts of the state.

Substance abuse in youth and adults is associated with domestic violence, child abuse, and other crimes. National studies conclude:

- 15% to 35% of adults receiving the Temporary Assistance for Needy Families Block Grant have an alcohol/substance abuse problem;
- More than 66% of inmates report some type of alcohol/substance abuse problem; and
- In 70% of child welfare cases investigated by the Department of Human Services, alcohol/substance problems play a role.

New treatment methodologies and medications have decreased the average hospital stay for substance abuse services.

### Length of Inpatient Hospital Stays for Alcohol and Substance Abuse FY'98 Through FY'03



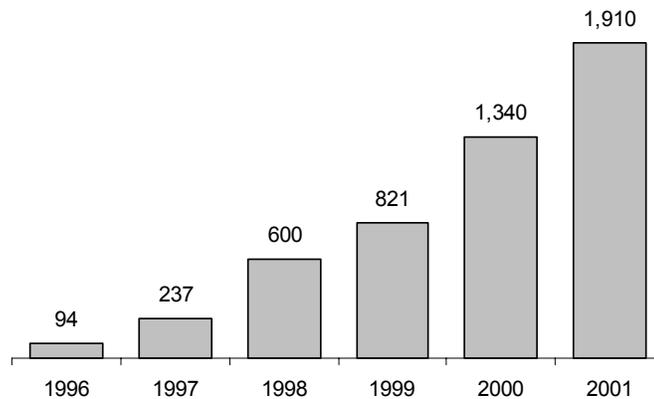
### Drug Courts

Drug Courts are being developed across Oklahoma as a means of controlling alcohol and drug abuse and related criminal activity. Drug Courts, operated by district judges in county courthouses, are designed as a cost-effective means of addressing criminal activity through rehabilitation rather than incarceration. In FY'03 there will be 32 Drug Courts operating in Oklahoma; they serve adults, juveniles and/or families as a whole. Of those, 30 receive funding from DMHSAS to pay for offenders' treatment. The remaining two receive federal criminal justice grants.

Drug Court participants are offenders who plead guilty to a suspended sentence and agree to follow program rules. They can be incarcerated if they do not participate and complete their rehabilitation program. Drug Courts serve low-risk, drug-dependent offenders with several programs, including:

- judicial supervision;
- frequent drug testing;
- drug counseling;
- treatment for substance abuse/addiction;
- educational opportunities;
- employment services; and
- sanctions and incentives.

## Drug Court Participants 1996 Through 2001



The programs are supervised by a team that is headed by the judge. The multidisciplinary teams include drug treatment providers, counselors, law enforcement officers and district attorney staff.

Those Drug Court Teams who are planning a new Drug Court utilize a mentor court system, which has been developed by DMHSAS to assist these courts as part of their planning and training. One of the mentor court sites is the Pontotoc County Adult Drug Court. Some of the FY'02 statistics relevant to the Drug Court in Ada include:

- 115 participants in the Drug Court Program and out of DOC custody.
- Participants average length of time in prison:
  - ✓ 45% - 10 plus years;
  - ✓ 33% - five to nine years; and
  - ✓ 22% - two to four years.
- 11 drug free babies born in the program.
- 21% not only acquire a GED, but go on to higher education.
- Cost effective and fiscally sound:
  - ✓ Incarceration per year per person - \$18,000
  - ✓ Drug Court per year per person - \$3,800
  - ✓ Cost savings per year per person - \$14,200
- Average age of beginning drug use is 13-16 years.
- Gender specific to the drug court:
  - ✓ 67% Male
  - ✓ 31% Female

## **Domestic Violence**

DMHSAS provides services to adults and children who have been affected by domestic violence or sexual assault, as well as perpetrators of the violence when appropriate. Services include:

- crisis intervention;
- safe shelter;
- help in obtaining legal assistance;
- victim/survivor support and advocacy;
- referral services; and
- education and training.

In 1999, a national study indicated that Oklahoma had the eighth highest incidence of death due to domestic violence in the nation. With the aid of the above mentioned services provided through DMHSAS, the state improved its position in the study to number 19 by the year 2000. There is much work left to do. A recent study concluded that 19% of Oklahoma students surveyed reported being intentionally physically hurt by a boyfriend or girlfriend compared with 8.8% of students surveyed nationally. In addition, 9.7% of Oklahoma students surveyed reported being forced to have sexual intercourse against their will, compared with 8.8% of students surveyed nationwide.

In FY'02, domestic violence services were provided to more than 14,000 individuals, 22% of whom were children. DMHSAS expenditures for domestic violence totaled \$5.3 million. For every state dollar spent, domestic violence and sexual assault programs contribute an average of \$3 in other resources.