Oklahoma Health Care Authority

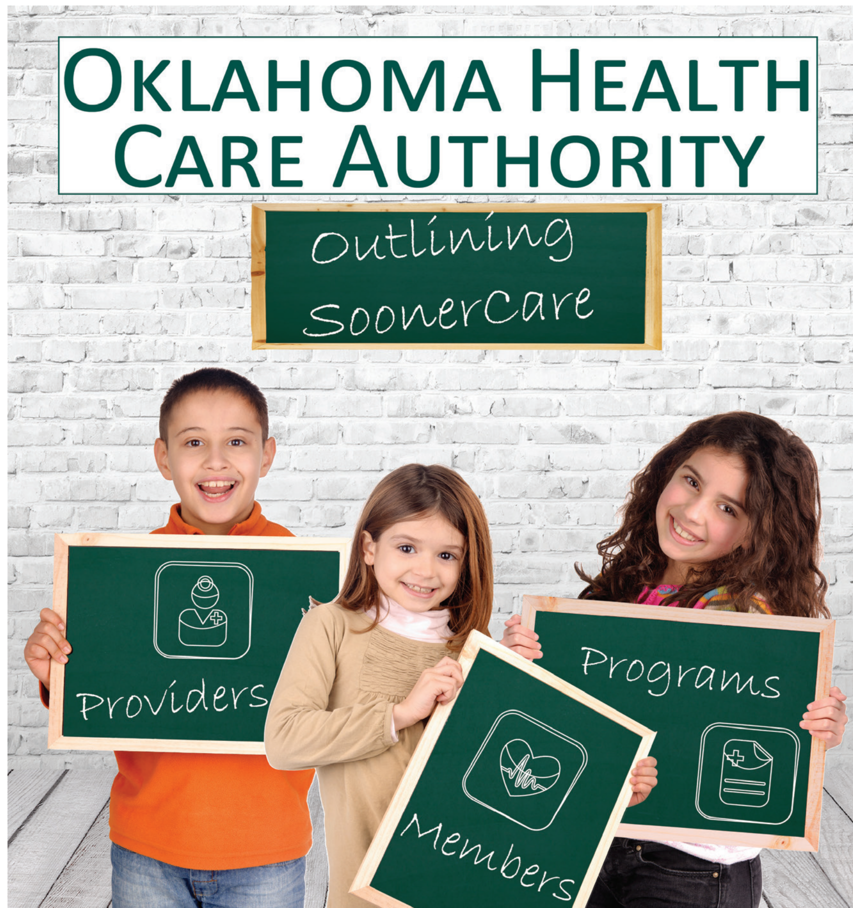
Outlining SoonerCare

Providers

Members

Programs

2013 Annual Report



On the cover: We make it possible every day for thousands of Oklahomans to access services to protect their health and sometimes their lives. Oklahoma Health Care Authority provided access to health care to more than 1 million Oklahomans during the state fiscal year 2013. While it is concerning the economy and other circumstances have put individuals in the income range to qualify for SoonerCare, it is good to know basic health care coverage was available to them in times of need.

Oklahoma Health Care Authority offices are temporarily located at:

2401 N.W. 23rd St., Suite 1A,
Oklahoma City, OK 73107
405-522-7300

Visit our websites at:
www.okhca.org
www.insureoklahoma.org
www.okltcpartnership.org

You can also follow us on Twitter and Facebook!

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The report is coordinated through the OHCA Reporting and Statistics Unit. If you have questions or suggestions, please call Connie Steffee at 405-522-7238.

oklahoma
health care
authority

Our Vision

Our vision is for Oklahomans to enjoy optimal health status through having access to quality health care regardless of their ability to pay.

Our Mission Statement

Our mission is to responsibly purchase state and federally funded health care in the most efficient and comprehensive manner possible; and to analyze and recommend strategies for optimizing the accessibility and quality of health care; and to cultivate relationships to improve the health outcomes of Oklahomans.

Our Values and Behaviors

OHCA staff will operate as members of the same team, with a common mission and each with a unique contribution to make toward our success.

OHCA will be open to new ways of working together.

OHCA will use qualitative and quantitative data to guide and evaluate our actions and improve our performance in a purposeful way over time.

Mary Fallin

Governor
State of Oklahoma

EXECUTIVE BRANCH

Todd Lamb
Lieutenant Governor

Dr. Terry Cline
Secretary of Health & Human Services

LEGISLATIVE BRANCH

1st Session of the 54th Legislature

Brian Bingman
President Pro Tempore, State Senate

T. W. Shannon
Speaker, House of Representatives

OHCA Board Members

as of June 2013

Vice-Chairman
Anthony (Tony) Armstrong

Ann Bryant

Chairman
Charles (Ed) McFall

Melvin McVay

George Miller

Mark Nuttle

Carol Robison

Message from the Chief Executive Officer

Since our inception, the Oklahoma Health Care Authority (OHCA) has taken great pride in providing Oklahomans a transparent view of the agency. We hold ourselves accountable to the taxpayers that fund the programs; the state leaders that approve the policies; the SoonerCare and Insure Oklahoma members that access quality health care across the state; and, the health care professionals that provide high quality service.

OHCA is a nationally recognized leader in designing innovative Medicaid managed care programs. In future annual reports, you will see positive results of our most recent innovations such as Patient-Centered Medical Homes, Health Access Networks and the Comprehensive Primary Care Initiative. I firmly believe these initiatives, along with targeted interventions such as efforts to reduce Oklahoma's infant mortality rate, will help improve the health of SoonerCare members. Given that SoonerCare serves one in four Oklahomans each year, we have the opportunity to make a significant contribution to our state's broader efforts to improve our overall health rankings.

Very caring people make this agency work well. In this annual report, you will see a glimpse of the great people who come to work every day to fulfill the agency's mission. I am humbled and grateful for their service. There is one person who deserves special thanks for his leadership and legacy. Mike Fogarty announced his retirement this fiscal year, serving the state for 31 years, 18 of those years at OHCA and 14 of those as CEO. This agency and its programs are better because of Mike. You will see his fingerprints outlined throughout the pages of this book, and we pause to thank him for his positive impact on our state.

As we look forward, you can help us outline the future of our programs. We count on many people outside of OHCA to improve our performance, including other state agencies and private partners. We serve best when we serve together. I welcome your review and input as we can only develop more responsive and responsible programs with people who care enough to make informed recommendations and decisions. I look forward to another successful year as we work side-by-side to make a difference in the lives of Oklahomans.

Joel Nico Gomez

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OHCA Report Renovations

Annual Report

The *Oklahoma Health Care Authority Annual Report* has been renovated. This year's annual report has been streamlined to include updates, projects, accomplishments, awards and highlights which occurred during the state fiscal year.

During the renovation, new content has been added. Healthcare Effectiveness Data and Information (HEDIS) measures are used for quality evaluation purposes. The HEDIS measures focus on member utilization and target key health issues. The former Performance and Quality report, *Minding Our P's and Q's*, which highlighted quality improvement and quality assurance projects, has now been joined into the annual report.

In previous years, the report included valuable history of programs and definitions of common SoonerCare (Oklahoma Medicaid) terms. The historical information and definitions have been moved to a new document called the *Primer*. The *Primer* will decrease repetitive information that takes up space and paper. The *Primer* puts all common terms in one place for those who are new to the SoonerCare programs and definitions.

Primer

The *Primer* will serve as an introduction to the SoonerCare program. Medicaid terms and terms specific to the SoonerCare program will be defined and discussed. The robust *Primer* report covers the history of Oklahoma's SoonerCare program and specific program details in one location.

Service Efforts and Accomplishments

The *Service Efforts and Accomplishments (SEA)* highlight OHCA's efforts with key performance indicators, administration efficiency and member satisfaction. A multitude of measures are described with detailed reports and scores. The SEAs are made available to the public to allow the ability to assess progress and become involved in achieving OHCA's mission.

Strategic Planning

A sound, deliberate strategy for the future is not just a good idea; it is a requirement for organizations in today's fast-paced environment. OHCA's *Strategic Plan* begins by providing a brief overview of the mission, vision, and goals of the agency; followed by specific action plans the agency has developed to meet the strategic goals. The report concludes with a summary defining the key external factors and assumptions related to our strategic goals and objectives.

All of the above reports can be found at www.okhca.org/reports.

Fast Facts

SoonerCare Fast Fact reports are created monthly, quarterly and yearly. They provide an overview of enrollment, program demographics, provider network monitoring and other subject-specific details. The Fast Facts can be found online at www.okhca.org/fast-facts.

SFY2013 Highlights

Members

- There were 1,040,332 unduplicated members enrolled in either SoonerCare or Insure Oklahoma during SFY2013 (July 2012 through June 2013).
- A total of 1,015,939 SoonerCare members received services.
- Overall SoonerCare enrollment increased by 3.3 percent; the number served increased 7.7 percent.
- Enrollment in the Insure Oklahoma program has decreased 1.7 percent since June 2012. As of June 2013, 29,860 enrollees and 4,697 businesses were participating.
- OHCA provided coverage to 92,049 SoonerPlan enrollees and 1,882 women needing further diagnosis or treatment for breast and/or cervical cancer through the Oklahoma Cares program.
- SoonerCare covers approximately 63 percent of the births in Oklahoma. Calendar year 2012 SoonerCare deliveries were 32,517 of the 51,859 overall state births (OSDH final figures accessed 9/26/2013).

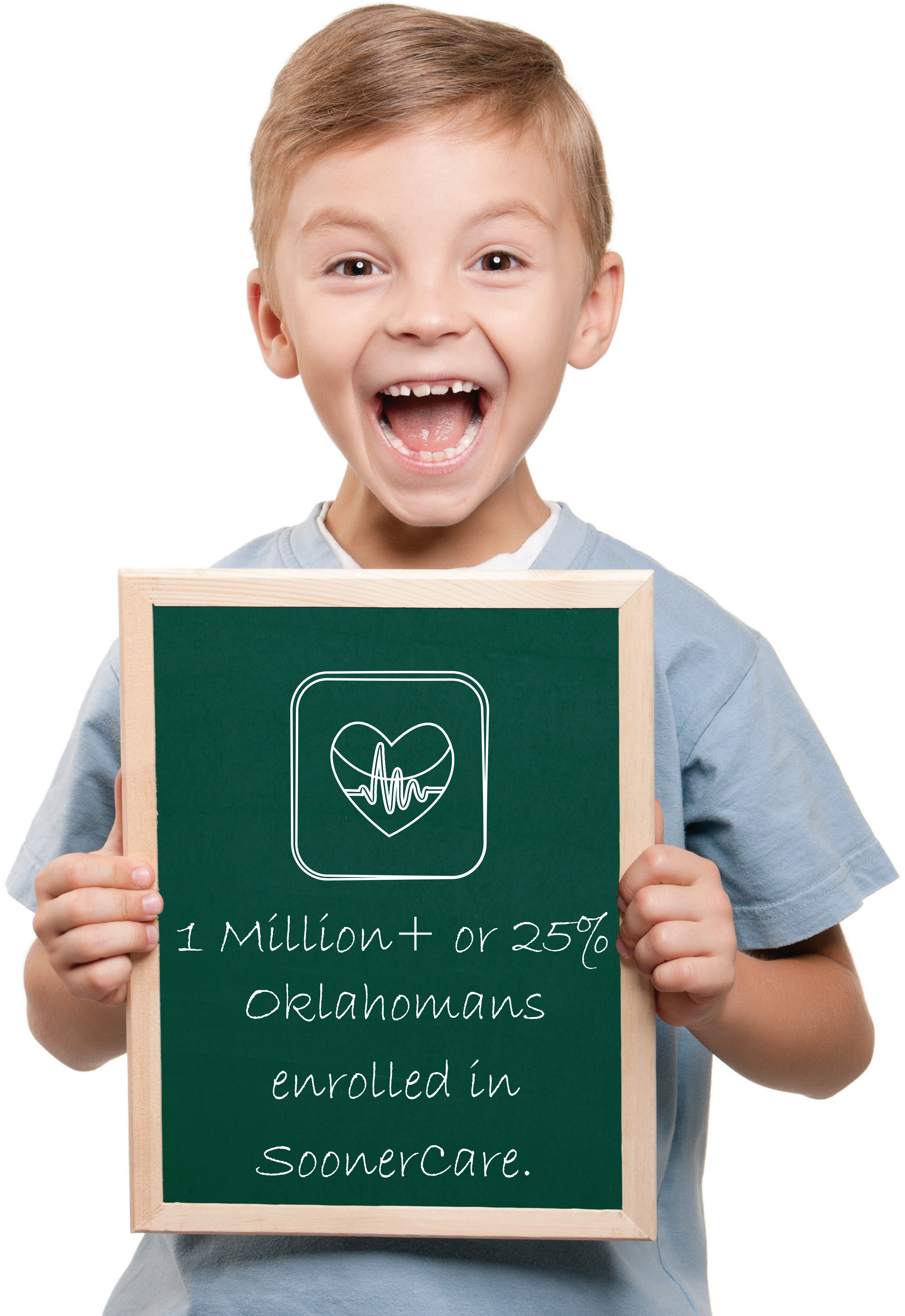
Expenditures

- An average of 16.1 percent of SoonerCare members were aged, blind and disabled enrollees. These enrollees accounted for 46.5 percent of the SoonerCare expenditures.
- SoonerCare funded 67.3 percent of Oklahoma's total long-term care occupied bed days.
- OHCA expended $16.7 million on behalf of the breast and cervical cancer enrollees and $10.1 million on SoonerPlan enrollees.
- 49,470,567 claims were processed. Electronic claims comprised 94 percent of the filed claims.
- Nursing facility Quality of Care revenues totaled $64,679,143.
- Dollars recovered by OHCA through post-payment reviews totaled $41,823,236.
- Federal and state drug rebate collections, including interest, totaled $195,033,662.
- By limiting the amount paid for generic drugs, OHCA saved more than $138.0 million through the State Maximum Allowable Cost (SMAC) program.

Administration

- OHCA processed seven emergency rules, six permanent rules, and 15 State Plan amendments.
- There were 28 group provider training sessions attended by more than 5,000 providers. OHCA and Hewlett-Packard enterprise services held 10,712 individual on-site provider training sessions.
- OHCA received and investigated 283 SoonerCare member complaints. This represents less than .03 percent of the 1,040,332 SoonerCare enrollees.
- There were 52 provider and 506 member formal appeals filed.
- OHCA administrative costs comprised 5.89 percent of the total SoonerCare expenditures. OHCA operating costs represented 37 percent of OHCA administrative costs, and the other 63 percent were contract costs.

SoonerCare Members



SoonerCare Members

Health Management Program continues to be a Success

The SoonerCare Health Management Program (HMP) addresses the health needs of chronically ill SoonerCare members while reducing unnecessary medical expenditures at a time of significant fiscal constraints. Each year the HMP has been evaluated by Pacific Health Care Group and APS Healthcare. To measure the program's impact on quality of care, APS Healthcare evaluated the preventive and diagnostic services provided to SoonerCare HMP participants. Six prime targeted chronic conditions were measured: asthma, congestive heart failure, chronic obstructive pulmonary disease, coronary artery disease, diabetes and hypertension. The evaluation was performed using administrative (paid claims) data. APS also calculated the SFY2012 compliance rates for a "comparison group" consisting of SoonerCare members found eligible for, but not enrolled in the SoonerCare HMP.

14 out of 21

Participant compliance rate exceeded the comparison group rate for 14 of the 21diagnosis-specific measures. The difference suggests that the Health Care Management Program is having a positive effect on quality of care.

As in previous years, findings from the fourth annual analysis were promising. According to the report, the participant compliance rate exceeded the comparison group rate for 14 of the 21 diagnosis-specific measures. The difference was statistically significant for nine of the 14, suggesting that the program is having a positive effect on quality of care. The most impressive results, relative to the comparison group, were observed for participants with congestive heart failure, coronary artery disease and hypertension.

Another approved modification to the Health Management Program was to rename nurse case managers as health coaches. These health coaches will be embedded within primary care practices. To view the full Health Management Program Evaluation report including satisfaction rates and cost-effectiveness of the HMP, go to www.okhca.org/studies.

OHCA Receives Grant for Health Efforts for Expectant Mothers and Infants

The Oklahoma Health Care Authority was chosen as one of 27 recipients of the "Strong Start for Mothers and Newborns" Initiative awarded by the Centers for Medicare & Medicaid Innovation Center.

The Strong Start for Mothers and Newborns initiative, an effort by the United States Department of Health and Human Services, aims to reduce preterm births and improve outcomes for newborns and pregnant women.

"OHCA is committed to improve the health of women and infants in Oklahoma," said OHCA Chief Medical Officer Dr. Sylvia Lopez. "It is an honor to be recognized for our efforts and to receive an award with the name 'strong start for mothers and newborns' which is exactly what we want to accomplish-giving them a healthy and happy start in life as new mothers or babies."

The Strong Start effort promotes new approaches to prenatal care delivered in a group setting and evaluates enhanced prenatal care interventions for women enrolled in SoonerCare who are at risk for having a preterm birth. The goals of the initiative are to reduce the rate of preterm births, improve the health outcomes of pregnant women and newborns, and decrease the anticipated total cost of medical care during pregnancy, delivery and the course of the first year of life for children born to mothers in SoonerCare.

OHCA has partnered with three clinic sites who serve SoonerCare members in Oklahoma to implement the strategy of enhanced prenatal care through a group visit model. OHCA's three clinic partners in this endeavor are the Oklahoma City Indian Health Clinic, the Choctaw Nation Tribal Clinic in Talihina and the Oklahoma State University Department of Obstetrics in Tulsa. Other non-clinical partners who are critical to the success of this initiative are the Oklahoma State Department of Health, Vital Statistics Department, and the March of Dimes.

Lopez added that OHCA, through a very competitive process open to all states including Puerto Rico and the District of Columbia, was one of 15 applicants to be selected to receive this grant for "enhanced prenatal care through the group visit" model. This model features peer-to-peer interaction in a supervised setting. Desired outcomes include a health assessment, education and psychological and social support.

OB (Pregnancy) Outreach Program

Each month OHCA mails a letter to every newly pregnant member asking her to call the SoonerCare Helpline to receive important information concerning SoonerCare benefits. If the member responds to the letter, the call is routed to a member service representative. During the discussion, the member is asked a series of trigger questions: Do you have diabetes? Have you had problems with a previous pregnancy? Are you having problems with this pregnancy? If the member responds yes to any of these questions, a referral is sent to care management for further clinical assessment. The care management department received and worked 637 new OB outreach cases.

Every Week Counts: A Statewide Quality Improvement Initiative to Eliminate Non-Medically Indicated Births Less than 39 Weeks

Elective deliveries are associated with increased risk of maternal and neonatal morbidity as well as longer hospital stays for both mothers and newborns. For more than 30 years, the American College of Obstetricians and Gynecologists has promoted a clinical guideline discouraging elective deliveries prior to 39 weeks gestation without medical or obstetrical need. Between 1991 and 2007, the number of births at 37 and 38 weeks gestation in Oklahoma was increasing, while births after 39 weeks were decreasing. During the same time period, there was also a rise in the scheduling of non-medically indicated births via induction and scheduled cesarean sections. The Oklahoma State Department of Health, Oklahoma Hospital Association, Oklahoma March of Dimes, OUHSC Office of Perinatal Quality Improvement, and Oklahoma Health Care Authority worked with Oklahoma birthing hospitals and developed a quality improvement collaborative to eliminate these early, elective deliveries. Fifty-five of 59 birthing hospitals participated in the "Every Week Counts" initiative, affecting over 95 percent of Oklahoma births. Data indicate a 77 percent decrease in early elective deliveries among participating hospitals since the commencement of this initiative in 2011.

77%

A 77% decrease in early elective deliveries occurred since 2011.

Population Care Management Encourages Child's Healthy Start

Beginning in August 2012, OHCA retooled care management to include coordinating care for infants with special needs after their first birthday. Population Care Management (PCM) had 2,041 mothers and 2,100 infants identified and placed in active care management.

PCM also provides case management for each baby born in counties with high infant mortality rates. Case management continues through the at-risk infant's first birthday. Specialized program care nurses ensure the newborn is enrolled in SoonerCare; the mother has chosen a primary care provider for her new baby and is taking her newborn for well-child visits. PCM supplies education on safe sleep, newborn/infant home safety and cautions against tobacco usage in the home. Postpartum depression screening is conducted on all mothers of these at-risk infants.

OHCA's Tribal Relations Unit receives National Recognition

86%

286,358 children received dental services and accounted for 86 percent of the dental expenditures in SFY2013.

The National Indian Health Board (NIHB) recognized OHCA's Tribal Relations for their commitment to providing dental care to students at the Riverside Indian Boarding School in Anadarko. OHCA's SoonerCare program was the first Medicaid program in the nation to formally provide coverage to American Indian boarding school students.

"Your services, including SoonerCare, as well as your toothbrush, toothpaste, and floss donations are ensuring that kids are receiving the proper education and services needed to sustain healthy teeth and overall good hygiene and health. Your devotion can help expand dental outreach efforts to other boarding schools in Oklahoma, and serve as an inspiration to other schools across the nation," said Cathy Abramson, NIHB board chairperson.

OHCA staff joined nurses and dental hygienists at the fifth annual Riverside Indian School back-to-school event to evaluate the health care needs and provide oral health education for almost 500 students returning to the school.

"Forty-eight students were Priority 1 cases, meaning they needed urgent dental care. Volunteer staff made sure these cases had follow-up appointments scheduled," said Dana Miller, OHCA Tribal Realtions director.

"Some of the kids have never seen a dentist before and were in desperate need of care," said Miller. "It truly is so amazing being able to help these children and provide these necessary services."

Program improvements for Insure Oklahoma

The OHCA worked with the Centers for Medicare & Medicaid Services (CMS) to make several program improvements to Insure Oklahoma. First, approval for the SoonerCare Section 1115(a) to receive a Medicaid demonstration extension was achieved. SoonerCare 1115(a) defines the federal authority to operate the SoonerCare demonstration waiver program which includes SoonerCare Choice and Insure Oklahoma.

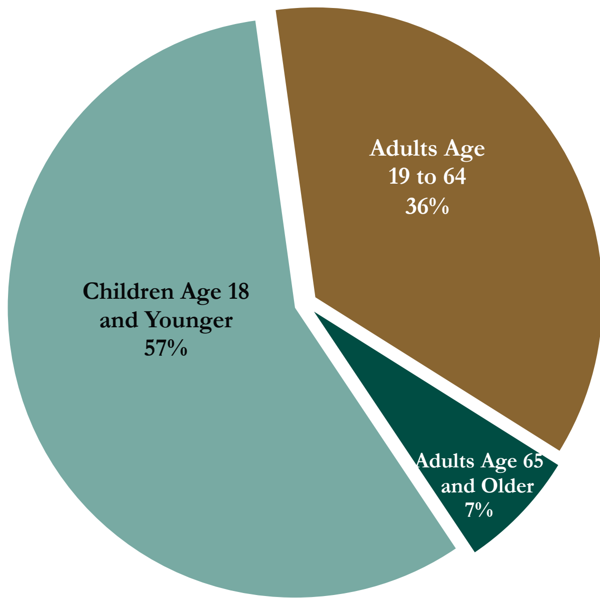
Improvements include an outpatient 48 visit limit which was established on the behavioral health services for adults in the Insure Oklahoma Individual Plan.

Figure 1 SoonerCare Children Under 21

Total unduplicated children under 21	625,680
Children qualified under TANF	554,363
Children qualified under Blind and Disabled	22,512
Children qualified under TEFRA	511
Children qualified under Insure Oklahoma	1,841
Children qualified under CHIP	149,625

Children above may be counted in multiple qualifying groups. The list above is not all inclusive; there are other groups that children are qualified through.

Figure 2 Age of SoonerCare Enrollees



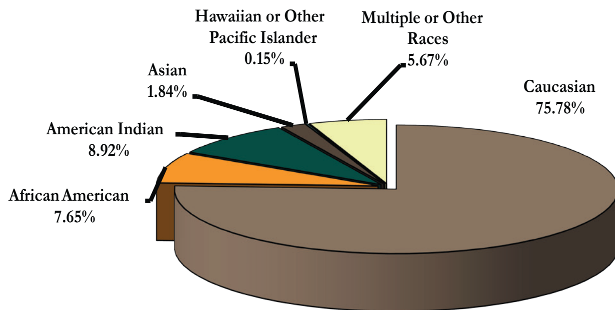
1 in 4 Oklahomans Enrolled in SoonerCare

There were 1,040,332 unduplicated members enrolled in the SoonerCare or Insure Oklahoma programs during SFY2013. On average, 809,904 members were enrolled each month of the state fiscal year. Females comprised 58 percent of the unduplicated enrollees.

Figure 3 SoonerCare Population by Race

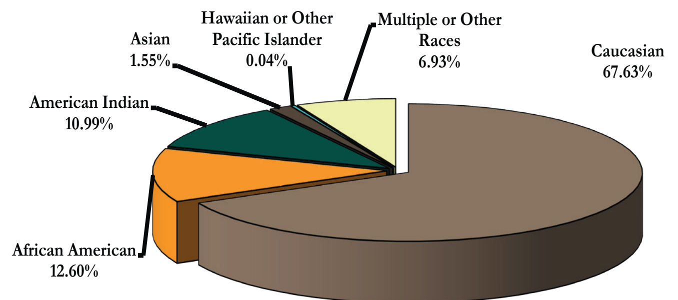
Oklahomans can declare any combination of five races. The pie charts below represent the counts of races reported alone. The bar chart below is the total SoonerCare count of each race for every reported occurrence either alone or in combination with another race.

State of Oklahoma Population 2011

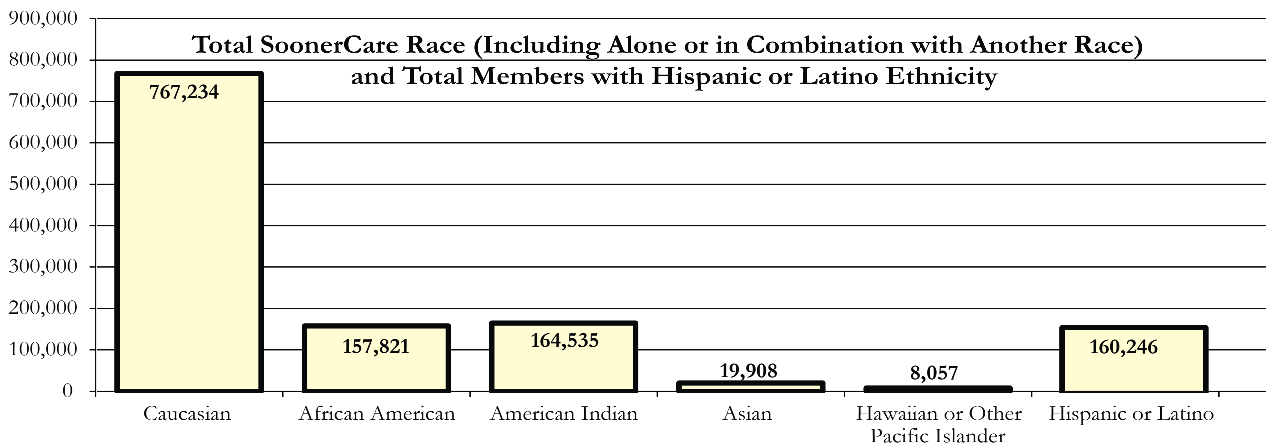


Total Estimated Population 2011 - 3,791,508 (Hispanic or Latino Ethnicity = 347,620)
Oklahoma totals based on U.S. Census Bureau, Oklahoma State Data Center 2011 Population - single race reported alone counts. Census collects Other Race, not listed in the other five major categories.

SoonerCare Population SFY2013



Total Enrolled in SoonerCare and/or Insure Oklahoma - 1,040,332 (Hispanic or Latino Ethnicity = 160,246).
The multiple race group has two or more races reported. Race is self-reported by members at the time of enrollment.



Oklahoma state totals based on U.S. Census Bureau, Oklahoma State Data Center 2011 Population - single race reported alone counts.
Oklahoma SoonerCare unduplicated single race reported alone counts based upon data extracted from member files on July 15, 2012.
The multiple race group has two or more races reported. Race is self-reported by members at the time of enrollment.

Note: Hispanic or Latino is considered an ethnicity, not a race. Ethnicity may be of any race.

Consumer Assessment of Healthcare Providers and Systems

CAHPS®

Child Member Satisfaction Survey

OHCA conducts the version of CAHPS® designed for children on an annual basis. The 2013 version of the survey ushered in several changes. Beginning this year, the survey will only sample SoonerCare members enrolled via the Children's Health Insurance Program (CHIP). SoonerCare rates were at or exceeded the national 50th percentile in five of the eight key measures. Comprehensive CAHPS® survey results can be found at www.okhca.org/CAHPS.

CAHPS® Child Survey

Key Measure	CHIP	Child Medicaid Quality Compass®
Getting Care Quickly	92.7%	88.4%
Shared Decision Making	52.5%	NA
How Well Doctors Communicate	93.3%	92.1%
Getting Needed Care	88.7%	79.6%
Customer Service	83.8%	82.7%
Rating of Health Care	82.0%	83.4%
Rating of Personal Doctor	85.2%	86.7%
Rating of Specialist	89.3%	82.3%
Rating of Health Plan	84.0%	84.4%

One change that is new for 2013 with OHCA's CAHPS® reporting is with the identification of Children with Chronic Conditions (CCC). Members with CCC are now reported separately. SoonerCare rates were at or exceeded the national 50th percentile in nine of the 13 key measures.

CAHPS® Child Survey (CCC)

Key Measure	CHIP	Child Medicaid Quality Compass®
Getting Care Quickly	93.9%	90.8%
Shared Decision Making	56.5%	NA
How Well Doctors Communicate	94.0%	93.2%
Getting Needed Care	87.0%	81.9%
Customer Service	88.2%	82.2%
Rating of Health Care	83.2%	82.5%
Rating of Personal Doctor	85.4%	87.3%
Rating of Specialist	85.0%	84.6%
Rating of Health Plan	83.1%	82.6%
Access to Prescription Medicines	94.3%	90.6%
Access to Specialized Services	76.0%	78.2%
Family-Centered Care: Personal Doctor Who Knows Child	89.1%	89.8%
Family-Centered Care: Getting Needed Information	93.1%	90.4%
Coordination of Care for Children with Chronic Conditions	76.8%	78.9%

Adult Member Satisfaction Survey

Adult member satisfaction rates with medical home dropped slightly during 2013 compared to 2012, when several rates showed improvement. Despite the small drop, comparing 2013 rates to the pre-medical home rates of 2008, members appeared to be happier with SoonerCare Choice than before. Comprehensive CAHPS® survey results can be found at www.okhca.org/CAHPS.

CAHPS® Adult Survey

Key Measure	2008 Rate	2012 Rate	2013 Rate
Getting Needed Care	72.8%	80.6%	80.0%
Getting Care Quickly	77.1%	82.5%	79.4%
How Well Doctors Communicate	80.4%	84.9%	87.1%
Customer Service	78.1%	80.6%	90.3%
Shared Decision Making	52.7%	58.0%	47.8%
Rating of Health Care	60.6%	66.1%	64.0%
Rating of Personal Doctor	65.1%	75.8%	70.7%
Rating of Specialist	68.8%	79.1%	74.5%
Rating of Health Plan	62.1%	68.4%	61.3%

STUDIES

Emergency Department Utilization Study

Telligen, OHCA's external quality review organization, performed a study on Emergency Department (ED) utilization for claims that occurred during calendar year 2011. The study focused on member utilization over several demographics, as well as a review of the appropriateness of care. Some of the notable findings of SoonerCare members that utilized ED services:

- Members not aligned with a primary care provider (PCP) had higher utilization rates than those aligned with a PCP.
- Members in rural areas had lower ED utilization rates.
- Although about two thirds of the SoonerCare population is children, children only accounted for just over half of the ED visits during 2011.

The complete Emergency Department Utilization study can be found at www.okhca.org/CAHPS.

Diabetes Study

Telligen performed a diabetes study for calendar year 2011 that focused on screening and control for SoonerCare members identified with diabetes. The study was based on HEDIS criteria, but review of medical charts allowed for the collection of information that was not available for OHCA's other HEDIS diabetes measure. The study focuses on four key areas:

- Blood sugar level test and control. Observing blood sugar levels is important in helping people monitor diabetes. SoonerCare member's rates are comparable with national rates on having HbA1c screening performed. In addition, members fared more favorably than national averages on the percentage exhibiting good control of blood sugar (OHCA 53.0 percent, National 48.1 percent).
- Eye Exam. Eye disorders are a common complication of diabetes. Regular checkups are needed to prevent conditions from worsening. Members with an eye exam in 2011 or a chart-reviewed negative eye exam in 2010 (43.3 percent) were less than the national rates (53.4 percent).
- Low-Density Lipoprotein (LDL) screening and control. People with diabetes are more susceptible to higher levels of LDL cholesterol. Screening rates and control readings were both below national averages. Screenings were at 65.1 percent compared to 75 percent nationally. Members with good control levels (100mg/DL) were at 28.7 percent compared to 35.2 percent nationally.
- Medical Attention for Nephropathy. Kidney disease can be a consequence of diabetes. Proper treatment can slow the disease down. In 2011, SoonerCare members received nephropathy screenings (77.9 percent) on par with the national rate (77.8 percent). Collection of laboratory data contributed to this measure.

The complete Diabetes study can be found at www.okhca.org/CAHPS.

Experience of Care and Health Outcomes Survey

ECHO®

Adult ECHO® Adult Member Satisfaction Survey

Select SoonerCare Choice adults who utilized behavioral health services filled out a satisfaction survey based on those services. While there were fewer members reporting that they accessed treatment and information from the plan, there was an increase in the satisfaction of the treatment and in the rating of the health plan since the last time the survey was completed. Comprehensive ECHO® survey results can be found at www.okhca.org/CAHPS.

ECHO® Adult Survey		
Key Measure	**2011 Rate**	**2013 Rate**
Getting Treatment Quickly	69.0%	68.0%
How Well Clinicians Communicate	86.0%	86.0%
Getting Treatment and Information from Plan	72.0%	64.0%
Perceived Improvement	53.0%	55.0%
Information About Treatment Options	73.0%	73.0%
Rating of Treatment	66.0%	71.0%
Rating of Health Plan	67.0%	70.0%

Adult Medicaid Quality Grant

Oklahoma was one of 26 states that the Centers for Medicare & Medicaid Services selected for a two-year grant to support state agencies on the development, testing and evaluation of the Initial Core Set of Health Care Quality Measures. OHCA's goals for the grant are to create and promote health screenings for patients in providers' offices, thereby minimize medical care disparities. Two quality improvement projects will concentrate on preventive screenings and diabetes. OHCA will collaborate with state universities, tribal nations, and the Oklahoma State Department of Health. Plans include increasing current agency screening rates for cervical cancer and blood sugar testing. The University of Oklahoma's Department of Family and Preventative Medicine will provide an external quality process and outcome evaluation of the two quality improvement projects. More information about the Adult Medicaid Quality Grants can be found online at www.medicaid.gov.

Healthcare Effectiveness Data and Information

HEDIS®

The National Committee for Quality Assurance has designed several program measures to score preventive health care tasks, rate access to condition-specific care and evaluate quality enhancement efforts. The measures allow states to access their overall performance with other states and report progress on major health issues of interest. The Oklahoma HEDIS measures are reported annually and are generally expressed as a proportion of the SoonerCare members that are eligible for the particular measure.

The measures are based on the previous year's available data. Therefore, HEDIS 2012 is using information claimed during the 2011 calendar year. In general, each measure includes members' age as of December 31, 2011, who were eligible for Medicaid and who were not enrolled in any Home & Community-Based waiver. Members must have had 320 days of enrollment (this equates to allowing for any 45-day gap).

Not all calendar year increase and decreases are statistically significant.

Annual Dental Visit

The Annual Dental Visit measure included members 2 through 21 years of age who had at least one dental visit. The final results are grouped by ages 2-3 years, 4-6 years, 7-10 years, 11-14 years, 15-18 years and 19-21.

Annual Dental Visit	2010	2011	2012
Aged 2-3 years	37.8%	39.3%	41.0%
Aged 4-6 years	63.5%	64.6%	67.2%
Aged 7-10 years	69.0%	70.5%	72.6%
Aged 11-14 years	66.1%	68.3%	70.3%
Aged 15-18 years	58.8%	61.2%	62.9%
Aged 19-21 years	42.6%	43.2%	40.2%
Total	60.2%	62.0%	64.0%

Access to a Primary Care Provider

This measure determines the percentage of members who had a visit with a primary care provider (PCP). Members who have an available PCP reduce preventable illnesses and medical incidents by utilizing their services.

Children & Adolescents' Access to PCP	2010	2011	2012
Aged 12-24 months	97.8%	97.2%	96.6%
Aged 25 months-6 years	89.1%	88.4%	90.1%
Aged 7-11 years	89.9%	90.9%	91.7%
Aged 12-19 years	88.8%	89.9%	91.6%

Access to Preventive/ Ambulatory Health Services	2010	2011	2012
Aged 20-44 years	83.6%	84.2%	83.1%
Aged 45-64 years	90.9%	91.1%	91.0%
Aged 65+ years	92.6%	92.1%	92.2%
Total	88.7%	88.8%	88.5%

Well-Child Visits in the First 15 Months of Life

The well-child visits measure is a percentage of SoonerCare members, ages 21 and younger, which went to their primary care provider for a well-child visit. During a well-child visit, providers check the child's hearing, sight, growth and any health concerns. The well-child checkup offers an opportunity for a provider to address health concerns early and provide therapy or beneficial treatment to meet that child's needs.

Well-Child Visits	2010	2011	2012
Aged <15 months 1+ visits	95.4%	98.3%	98.3%
Aged <15 months 6+ visits	48.8%	59.0%	58.6%
Aged 3-6 years 1+ visits	61.9%	59.8%	57.4%
Aged 12-21 years 1+ visits	37.1%	33.5%	34.5%

HEDIS®

Appropriate Medications for the Treatment of Asthma

The appropriate medications for the treatment of asthma measure, includes members ages 5 through 64, who were identified as having persistent asthma and were appropriately prescribed medication. Using the prescribed asthma medicines can reduce the number of asthma attacks and improve the quality of the members' life through proper management.

Medications for the Treatment of Asthma	2012
Aged 5-11 years	90.3%
Aged 12-18 years	85.2%
Aged 19-50 years	60.4%
Aged 51-64 years	56.9%
Total	85.0%

Lead Screening in Children

This measure is the percentage of children two years of age who had one or more blood tests for lead poisoning by their second birthday.

Lead Screening in Children	2010	2011	2012
Aged < 24 months	43.5%	44.5%	44.7 %

Comprehensive Diabetes Care

The diabetes care measure includes members 18 through 75 years of age who are diagnosed with diabetes (type 1 and type 2). The diabetic population was assessed for Hemoglobin A1c (HbA1c) testing, LDL-C screening, eye exam (retinal) and medical attention for nephropathy.

Comprehensive Diabetes Care (Aged 18-75 years)	2010	2011	2012
Hemoglobin A1C Testing	71.0%	71.1%	70.5%
Eye Exam (Retinal)	32.8%	31.8%	31.8%
LDL-C Screening	63.6%	62.9%	62.0%
Medical Attention for Nephropathy	54.4%	55.9%	56.8%

Breast Cancer Screening

This measure records the percentage of women between 40 and 69 years of age who had a mammogram to screen for breast cancer. Early detection and treatment of breast cancer is important to help prevent the spread of cancer.

Breast Cancer Screening	2010	2011	2012
Aged 40-69 years	41.1%	41.3%	36.9%

Cervical Cancer Screening

The percentage of women ages 21 through 64 years who received one or more Pap tests to screen for cervical cancer. Women who have already had a hysterectomy are excluded. Early detection of cervical cancer is proven to have a positive impact on cancer treatment outcomes.

Cervical Cancer Screening	2010	2011	2012
Aged 21-64 years	44.2%	47.2%	42.5%

HEDIS®

Cholesterol Management for Patients with Cardiovascular Conditions

The percentage of members 18 through 75 years of age who were discharged with related heart conditions who had LDL-C screenings.

Cholesterol Management	2010	2011	2012
Aged 17-75 years	69.5%	69.9%	68.6%

Appropriate Treatment for Children with Upper Respiratory Infections

This measure identifies members who were prescribed antibiotics for upper respiratory infections (URI). This assures providers test first for infections prior to prescribing antibiotics.

Appropriate Treatment for Children with URI	2010	2011	2012
Aged 3 months-18 years	67.7%	69.5%	66.8%

Appropriate Testing for Children with Pharyngitis

This measure identifies members who were prescribed antibiotics for strep infections who received a throat culture. This assures providers test first for infections prior to prescribing antibiotics.

Appropriate Treatment for Children with Pharyngitis	2010	2011	2012
Aged 2-18 years	38.8%	44.8%	49.1%

Race/Ethnicity Diversity of Membership

An unduplicated count and percentage of members enrolled any time during the measurement year, by race and ethnicity.

Members can only be of one race and one ethnic code at any particular time.

Race Diversity of Membership	2010	2011	2012
American Indian/Alaskan Native	12.0%	11.7%	11.6%
Asian	1.2%	1.3%	1.3%
Black/African American	14.2%	13.9%	13.5%
Native Hawaiian/Pacific Islander	0.2%	0.2%	0.3%
White	67.9%	68.8%	67.4%
Multiple Races	4.5%	4.0%	5.9%

Ethnicity	2010	2011	2012
Hispanic (percentage of total)	13.1%	13.2%	14.3%

SoonerCare Providers

SoonerCare Providers

Oklahoma Electronic Health Record Incentive Program

The Electronic Health Record (EHR) incentive program provides financial incentive to assist eligible providers to adopt (acquire and install), implement (train staff, deploy tools, exchange data), upgrade (expand functionality or interoperability) or meaningfully use certified EHR technology. Since program implementation, OHCA has issued more than $118 million in EHR Incentive payments to 1,737 Eligible Professionals (EPs) and 90 Eligible Hospitals (EHs). In SFY2013, 780 EPs and 46 EHs received EHR Incentive payments of which 45 percent of the EPs and 74 percent of the EHs achieved meaningful use.

Focus on Excellence

Focus on Excellence is the OHCA program designed to measure and ensure the integrity, quality and overall wellness of consumers and Long-Term Care (LTC) facilities. All Oklahoma LTC facilities are eligible to participate in the program. Evaluation of LTC facilities is important as approximately 13,000 nursing home residents receive SoonerCare support on any day, with some 21,000 served over the course of a year.

The annual report for Focus on Excellence can be found at www.okhca.org/FOE.

Provider Profiles

Well-child visits, women's cancer screening and cesarean section (C-Section) provider profiles continued to be sent out to our SoonerCare Choice providers. These profiles offer feedback to providers which can help them evaluate how they have performed to expectations, as well as how they have performed compared to their peers.

The well-child visit profile report shows providers how many children were on their panel for any part of a one-year review period. The profile also shows how many well-child visits were performed. The expected number of checkups is calculated and reported, taking into account how long the children were on the provider's panel. There were 693 well-child visit profiles generated, with 54 additional letters being sent to providers who had insufficient data for valid statistical profiling.

For women's health screenings, providers receive a profile on cervical cancer screenings (Pap smears) and breast cancer screenings (mammograms) based on the members in the provider's panel. For mammography screenings, 401 profiles and 590 "insufficient-data" letters were mailed; and for cervical cancer screenings, 621 profiles and 447 "insufficient-data." Providers were more likely to have sufficient data for the cervical cancer screenings because we serve greater numbers of younger women, who would not be candidates for mammograms.

C-Section profiles are sent on a quarterly basis to providers and facilities. The profiles indicate to the recipients the percentage of their deliveries for SoonerCare members that were performed through a C-section. Profiles also notify the recipients the percentage of their members that experienced a primary C-section. There were 297 letters sent to facilities and 1,925 letters sent to providers.

Patient-Centered Medical Home Components

The Patient-Centered Medical Home model of care, implemented in January 2010, is designed to provide SoonerCare Choice members with a comprehensive, coordinated approach to primary care. Primary Care Providers (PCPs) will receive additional reimbursement for each panel member enrolled for providing enhanced services and a supportive infrastructure.

The new primary care payment structure for SoonerCare Choice includes three components:

- A care coordination component.
- A visit-based fee-for-service component.
- Payments for excellence (SoonerExcel).

The care coordination payment is determined by the capabilities of the practice and the member populations served. Practices submit a voluntary self-assessment process to determine the level of care coordination payment. There are three medical home tiers: (1) entry level, (2) advanced and (3) optimal. There are three peer groupings within the three tiers: providers who see children only, providers who see all ages and providers who see adults only.

Tier 1 providers may receive an additional 50 cents per member per month (PMPM) if voice-to-voice service is provided 24/7 and an additional 5 cents PMPM if providers elect to receive communications from OHCA electronically.

The visit-based component is paid on a fee-for-service basis. Rendered services are reimbursed according to the SoonerCare fee schedule. The fee schedule is available on the Web at www.okhca.org/feeschedules.

Figure 4 Care Coordination Fee by Tier

Type of Panel	Tier 1	Tier 2	Tier 3
Children Only	$3.46	$4.50	$5.99
All Ages	$4.19	$5.46	$7.26
Adults Only	$4.85	$6.32	$8.41

Figure 5 Budgeted SoonerExcel Incentive Payment Components

SoonerExcel Incentive Program	SFY2013 Payments[1]
Emergency Department Utilization	$482,346
-based on emergency department utilization of panel members	
Breast and Cervical Cancer Screenings	$340,046
-based on breast and cervical cancer screenings of panel members	
Generic Drug Prescription Rate	$966,875
-based on generic/multi-source prescribing profile	
Inpatient Admissions/Visits	$850,000
-based on inpatient admissions/visits to SoonerCare Choice members	
EPSDT & 4th DTaP - Well-Child Checks	$984,388
-based on meeting the EPSDT screening compliance rate and 4th DTaP administration	
Total	**$3,623,655**

Source: OHCA Financial Services Division, October 2013.
1. SFY2013 payments are an estimate, at time of reporting SFY2013 4th quarter payments had not been calculated.

Patient-Centered Medical Home – Record Review

Registered nurses at OHCA conduct on-site reviews of contracted SoonerCare Choice providers. Using standardized audit tools, the analysts review for contract and Patient-Centered Medical Home (PCMH) compliance. The nurses review a random sample of medical records for PCMH compliance as well as for of quality care. Assistance in the form of education is offered to each provider to facilitate successful compliance. Best practices are also identified and shared with providers. The OHCA conducted 298 reviews of providers enrolled in PCMH.

Each new PCMH submits a self-assessment form which is reviewed by OHCA staff. Based on this review, the PCMH is contacted for education. Formal PCMH education (telephonic or on-site) is also scheduled for new PCMH providers. Medical record review results this year have reflected a marked improvement in compliance. Ninety percent of the medical record reviews met compliance compared to 54 percent during the first year of PCMH reviews in 2010.

44,300

SoonerCare had a provider network of 44,300 during SFY2013.

Figure 6 SoonerCare Capitation Payments

Aged, Blind and Disabled (ABD)	Member Months	Capitation Payments
IHS Adults	13,569	$40,707
IHS Children	6,782	$20,346
Children/Parents (TANF)*	**Member Months**	**Capitation Payments**
IHS Adults	17,073	$34,146
IHS Children	169,309	$361,359
SoonerCare Choice Medical Home	**Member Months**	**Care Coordination Payments**
Medical Home - Open to All Ages	3,228,957	$16,976,477
Medical Home - Open to Children Only	1,560,372	$7,051,611
Medical Home - Open to Adults Only	35,794	$195,783
Miscellaneous Capitation (not SoonerCare Choice)	**Member Months**	**Capitation Payments**
Insure Oklahoma - Individual Plan	154,305	$462,915
Non-Emergency Transportation (ABD)	1,702,517	$24,561,712
Non-Emergency Transportation (TANF)	5,388,937	$2,846,311
Program of All-Inclusive Care for the Elderly (PACE)	1,380	$3,861,481
Health Access Network Payments	**Member Months**	**Capitation Payments**
Oklahoma State University	171,758	$858,790
Oklahoma University Tulsa	569,496	$2,847,480
Canadian County	35,944	$179,720

*Temporary Assistance to Needy Families (TANF) is referred to as Children/Parents in this report. IHS indicates Indian Health Services members. For more information about PACE visit the *Primer*.

SoonerCare Programs

67%

SoonerCare funded 67% of the total nursing facility bed days for SFY2013.

SoonerCare Programs

Living Choice

The Living Choice program is Oklahoma's brand name for the Money Follows the Person (MFP) grant. The MFP grant was created as a means to rebalance the state's long-term care system by transitioning individuals from nursing facilities back into the community. Each individual who transitions to a home in the community receives a range of necessary medical and home and community-based services for a year after moving from the institution. At the end of their 365 days in the community, those with physical disabilities and older persons graduate to one of the two waivers born out of the Living Choice program: My Life, My Choice for members ages 19 through 64 and Sooner Seniors members ages 65 and older. The program has transitioned 240 members this state fiscal year. The cost comparison was $14,598 for services provided in Living Choice compared to $26,886 for services being provided in a nursing facility and $64,118 in an intermediate care facility for the intellectually disabled.

The Living Choice program continued to work with the Department of Mental Health and Substance Abuse Services to add the psychiatric residential treatment facility population.

My Life, My Choice

The My Life, My Choice (MLMC) waiver program offers SoonerCare qualified persons with physical disabilities, who meet nursing facility level of care criteria, the same services received through the Living Choice demonstration in a residential setting of their choosing. Not only does the program promote improved quality of life, it is very cost effective. The average cost per member for services in the MLMC waiver is $9,227 annually, compared to the $26,886 per member annually in a nursing facility.

The Centers for Medicare & Medicaid Services extended the My Life, My Choice waiver for five years.

An average of 2,275 Part A premiums and more than 91,574 Part B premiums were paid by Medicaid each month.

Figure 7 Long-Term Care Facility Utilization and Costs

Facility	Unduplicated members	Bed Days	Reimbursement	Yearly Average Per Person	Average Per Day
Nursing Facilities *	19,618	4,758,800	$527,443,066	$26,886	$111
ICF/ID (ALL)	1,737	582,616	$111,373,096	$64,118	$191
ICF/ID (Private)	1,440	481,833	$58,150,088	$40,382	$121
ICF/ID (Public)**	297	100,783	$53,223,008	$179,202	$528

ICFs/ID = Intermediate Care Facilities for the Intellectually Disabled. *Average Per Person figures do not include the patient liability that the member pays to the nursing facility (average nursing facility $26.07/day; private $16.26 and for Public ICF/ID's $18.88).
**This does not include Crossover claims paid to nursing facilities of $8,720,981. This would add 857 additional unduplicated members and 131,418 days.

72%

Statewide, Oklahoma nursing facilities had a 71.7 percent occupancy rate.

Occupancy rate is unadjusted for semiprivate rooms rented privately, and for hospital and therapeutic leave days.

Sooner Seniors

The Sooner Seniors waiver program is designed to assist SoonerCare individuals who have chronic long-term illnesses and meet nursing facility level of care to remain in the community after completing the 365-day Living Choice demonstration.

By building upon the delivery of services already established through the Living Choice demonstration benefit package, the waiver is able to provide continuity of care and ensure that Medicaid dollars spent for members participating in the waiver were considerably less, $7,616 cost per waiver member, than the Medicaid dollars spent for those members receiving care in a nursing facility ($26,886 per member annually).

Medically Fragile

The Medically Fragile waiver program assists members with medical challenges that require more extensive care to remain at home or residential setting of their choice. The program is specifically designed for members who require a hospital/skilled nursing facility level of care; without these services such members would be forced to receive their care in a much more restrictive or institutional setting.

Centers for Medicare & Medicaid Services acknowledged the benefits of this program by renewing the waiver program for an additional five-year period, effective July 2013. The Medically Fragile waiver program continues to provide opportunities to serve members in the community who are elderly or have extreme disabilities.

Other Long-Term Care Waiver Operations Initiatives

Waiver members can now participate in Self-Direction. Self-Direction allows the members to comfortably choose and determine their supports and services they need to successfully live in the community.

Beginning in SFY2013, the Long-Term waiver introduced a Pre-Assessment Team designed to address the holistic approach to member health, safety, access and safeguards in transitioning back into the community.

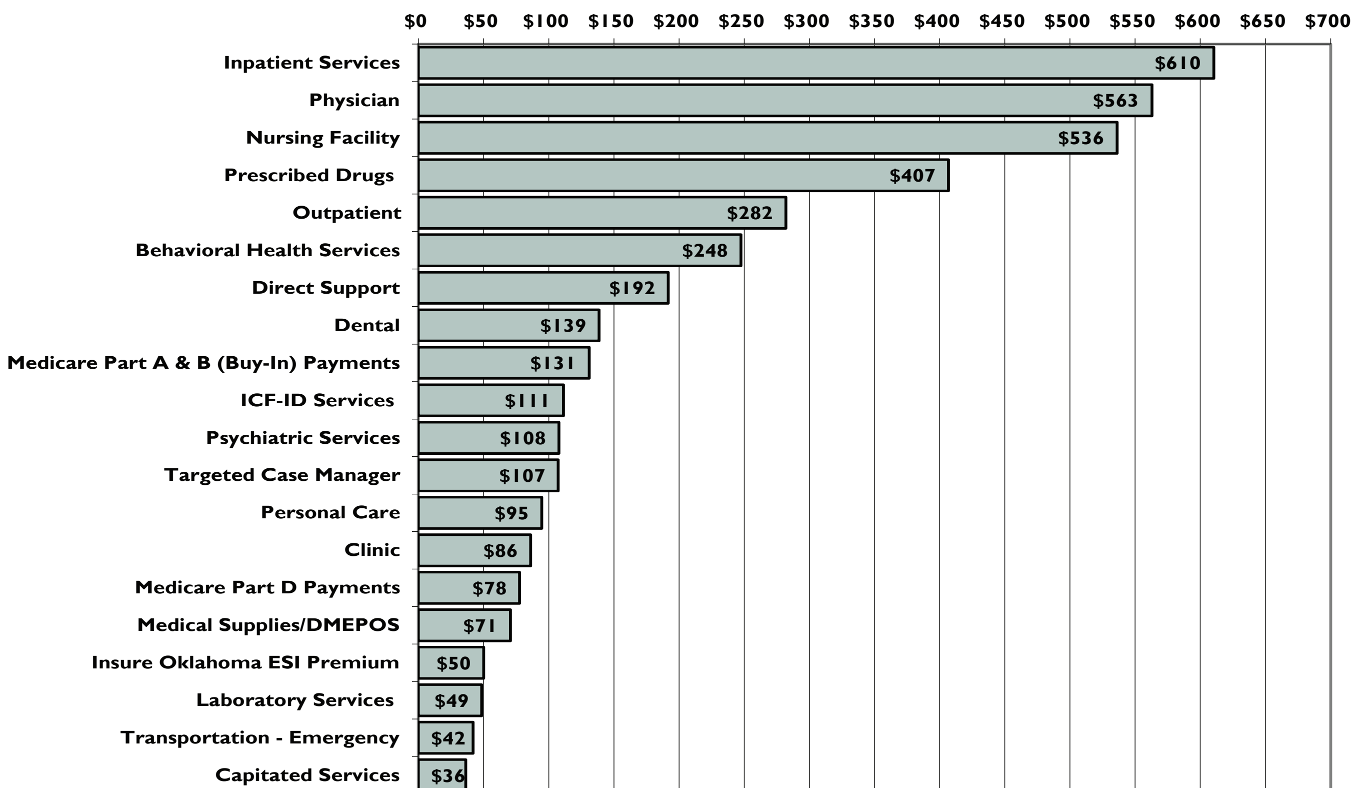
Software programs are created to efficiently track and measure aggregate data to help support quality measures. Aggregate data will improve the agency responsiveness, quality and integrity of our waiver programs.

Program of All-Inclusive Care for the Elderly

The goal of the Program of All-Inclusive Care for the Elderly (PACE) is to manage care through collaborative efforts of the member, member's family, caregivers and PACE team. Members live in the community and attend the PACE center once or twice a week for primary care services. They also meet with their case manager and engage in social activities with other PACE members. PACE enrollees must be at least 55 years old, live in the catchment area of the PACE program, be able to live safely in the community at the time of enrollment and be certified as qualified for nursing home level of care.

PACE programs receive Medicare and/or Medicaid capitation payments for individuals enrolled. People not financially qualified for Medicaid or Medicare pay the capitation amount out of pocket. PACE assumes full financial risk for a member's care without limits on dollars or duration and is responsible for a full range of needed services. The PACE benefit package for participants, regardless of the source of payment, includes all SoonerCare covered services specified in the State Plan. For SFY2013 there were 126 program participants

Figure 8 Top 20 SoonerCare Expenditures



Administration

5 out of 10

Nearly five of every ten SoonerCare dollars were paid for services rendered to the Aged, Blind and Disabled (ABD) population. This group includes dual eligibles, people with chronic medical conditions and residents of long-term care facilities.

Administration

Health care services are a substantial economic presence in Oklahoma. Most people do not think of SoonerCare health care services beyond the critical role they play in meeting the needs of vulnerable and low-income Oklahomans. The health care sector affects the economy in much the same way a manufacturing plant does; it brings in money, provides jobs to residents and keeps health care dollars circulating within the state economy. Health care businesses, in turn, have an additional impact through the purchase of utility services and cleaning supplies, as well as the payment of property taxes. Just like the changes in a manufacturing plant or farm operation, changes in the health care sector influence Oklahoma's economy.

$1 state + $1.78 federal
= $2.78 total available*

**For every $1 in state Medicaid dollars spent, Oklahoma receives $1.78 in federal dollars available for direct medical services and administrative costs.*

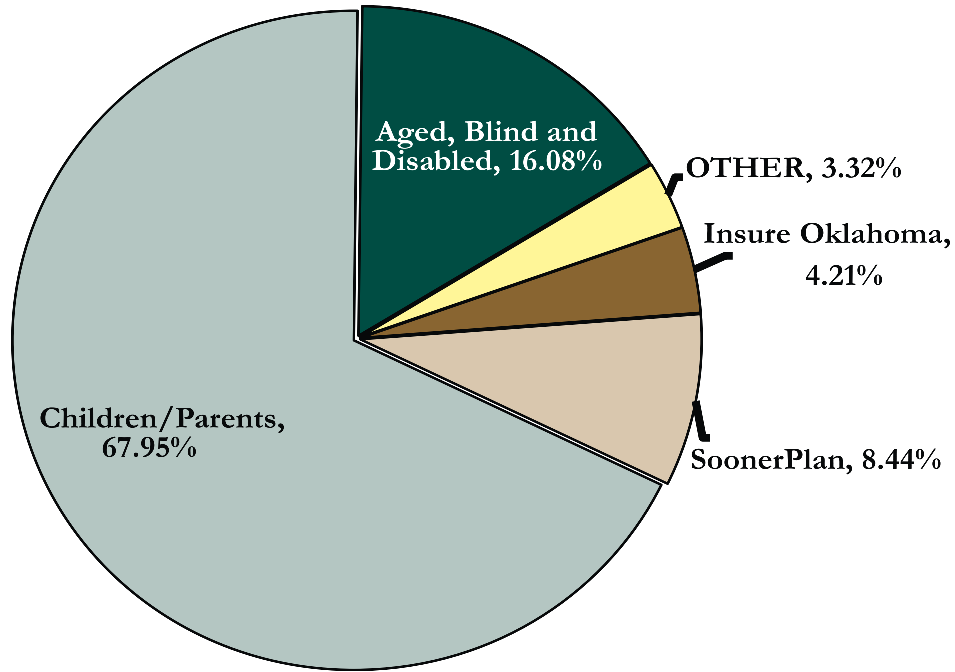
Federal Medical Assistance

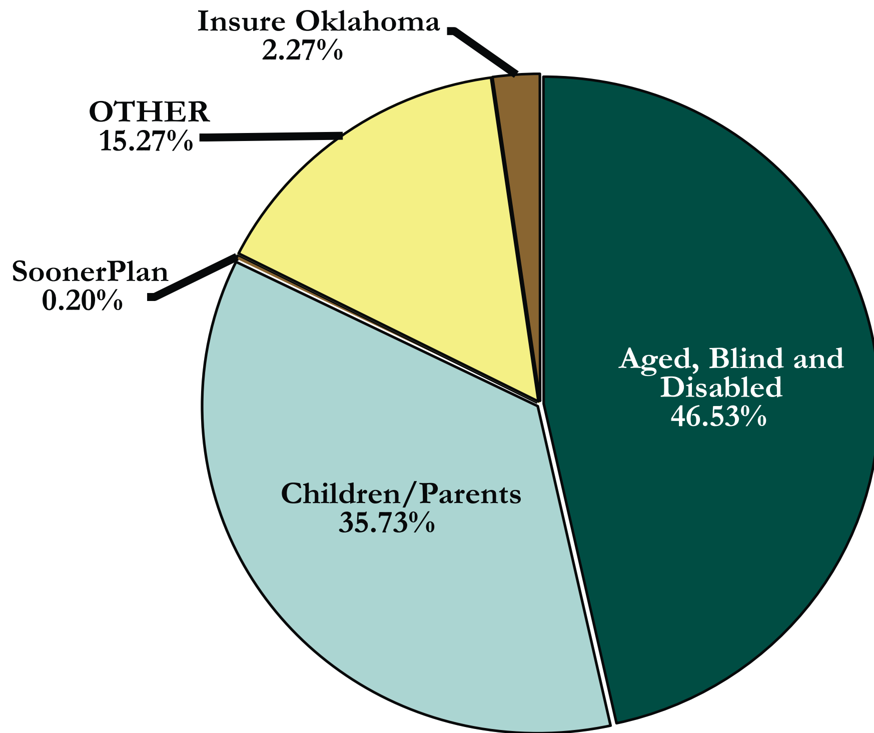
The federal and state governments share Medicaid costs. For program administration costs, the federal government contributes 50 percent for each state, with enhanced funding provided for some administrative activities, such as fiscal agent operations. For medical services provided under the program, the federal matching rate varies between states. Each year the federal matching rate, known as the Federal Medical Assistance Percentage (FMAP) is adjusted. States having lower per capita incomes receive a higher federal match. Oklahoma must use state or local tax dollars (called "state matching dollars") to meet its share of SoonerCare costs.

Figure 9 Federal Medical Assistance Percentage for Oklahoma — Federal Fiscal Year 2005 - 2015

*FMAP rates for the fiscal years through 2011. The FMAP rates in this table reflect the rates as they are calculated annually pursuant to Sections 1905(b) and 1101(a)(8)(B) of the Social Security Act. They do not reflect any adjustments made as the result of quarterly, annual, or period recalculations resulting from the American Recovery and Reinvestment Act of 2009 (ARRA) or the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA).

FIGURE 10 SOONERCARE ENROLLEES AND EXPENDITURES BY AID CATEGORY PERCENTAGES



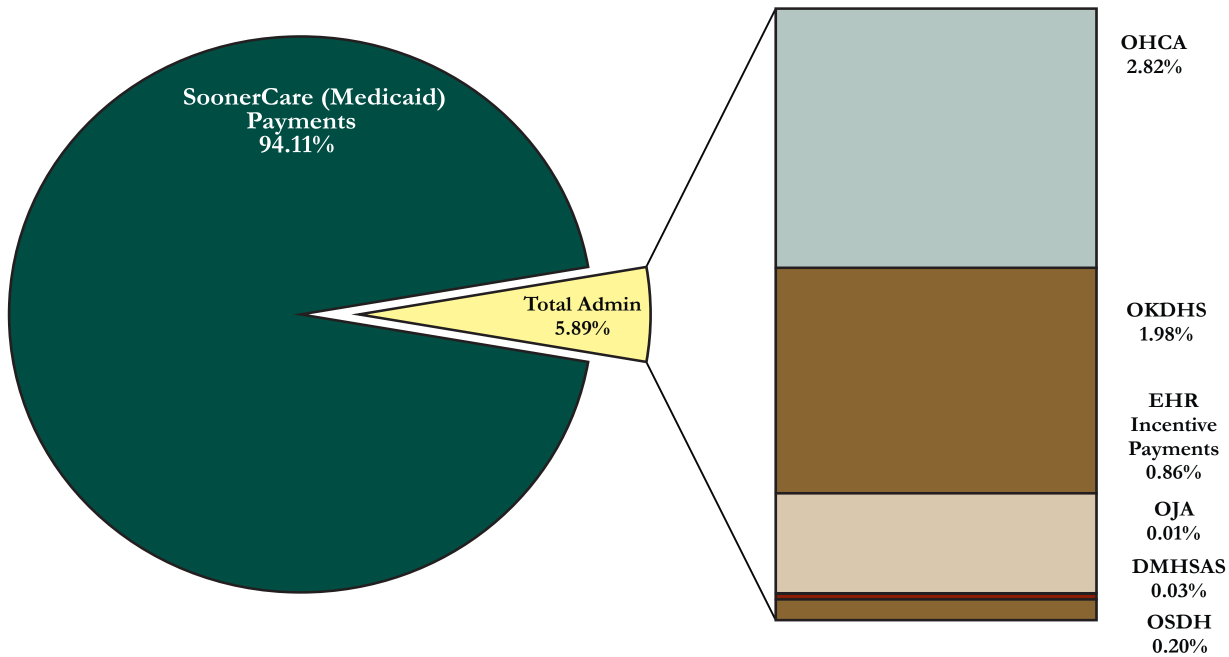


Other enrollees and expenditures include — Refuge, Phenylketonuria, Qualifying Individual Group One, Service Limited Medicare Beneficiary, Developmental Disabilities Services Division, Supported Living, Soon-to-be Sooners and Tuberculosis members. Children/Parents include child custody. Aged, Blind, Disabled include Tax Equity and Financial Responsibility Act enrollees and expenditures. Other expenditures also include Supplemental Hospital Offset Payment, GME/IME/DSH and Hospital Supplemental payments.

Administering the SoonerCare Program

The administrative cost of the SoonerCare program is divided among the Oklahoma Health Care Authority (OHCA), the Oklahoma Department of Human Services (OKDHS), the Oklahoma State Department of Health (OSDH), the Office of Juvenile Affairs (OJA), Electronic Health Record (EHR) incentive payments, and the Department of Mental Health and Substance Abuse Services (DMHSAS).

Figure 11 OHCA SoonerCare Expenditure and Administrative Percentages



Finally, OHCA's administrative expenses are divided between direct operating expenses and vendor contracts. Of the $125 million spent on administration by OHCA in SFY2013, 37 percent went to direct operation expenses and 63 percent went toward vendor contracts.

Figure 12 Breakdown of OHCA Administrative Expenses

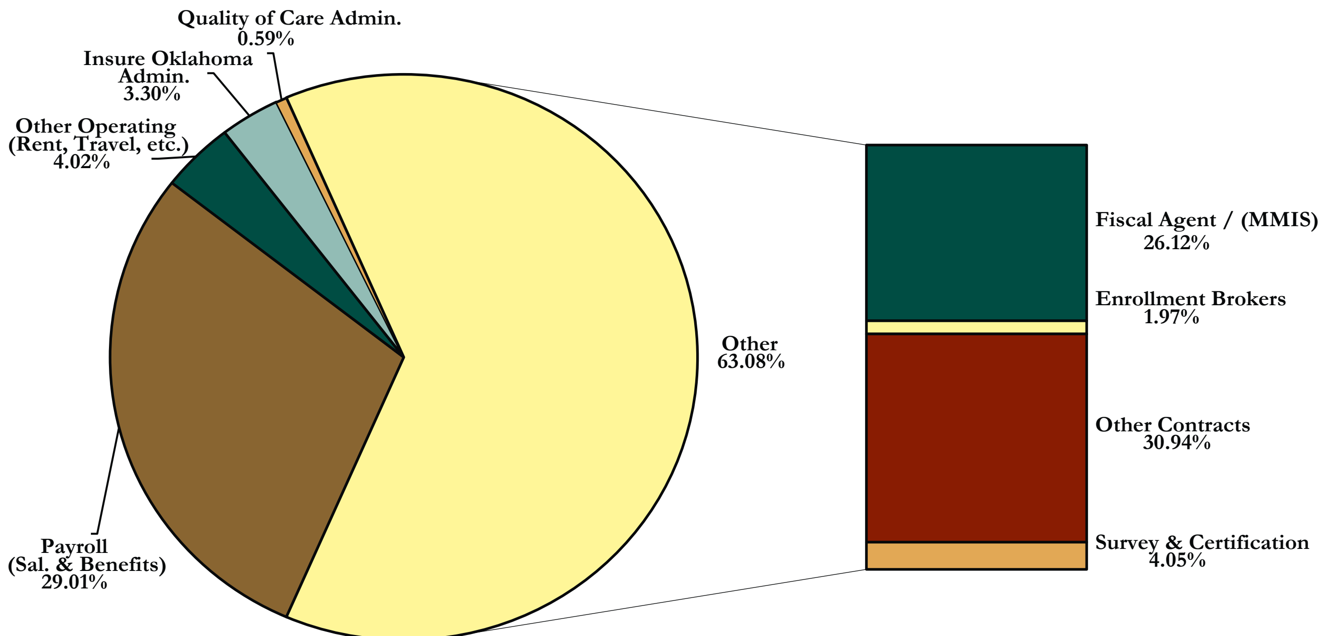
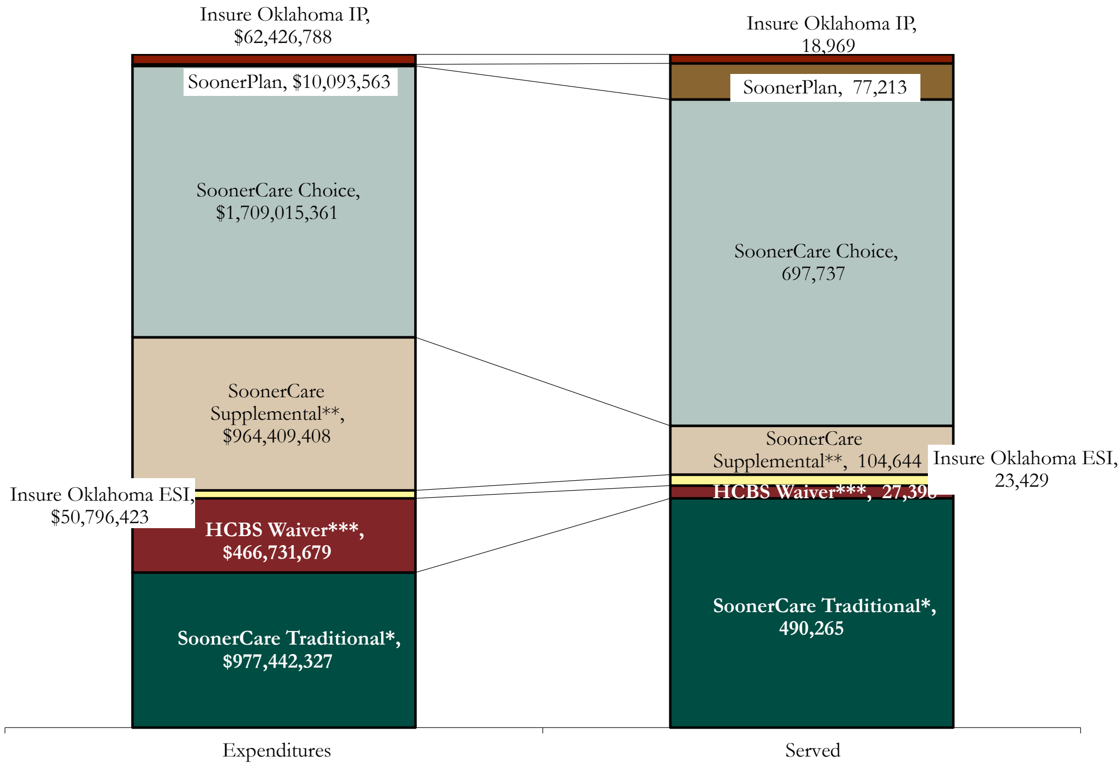
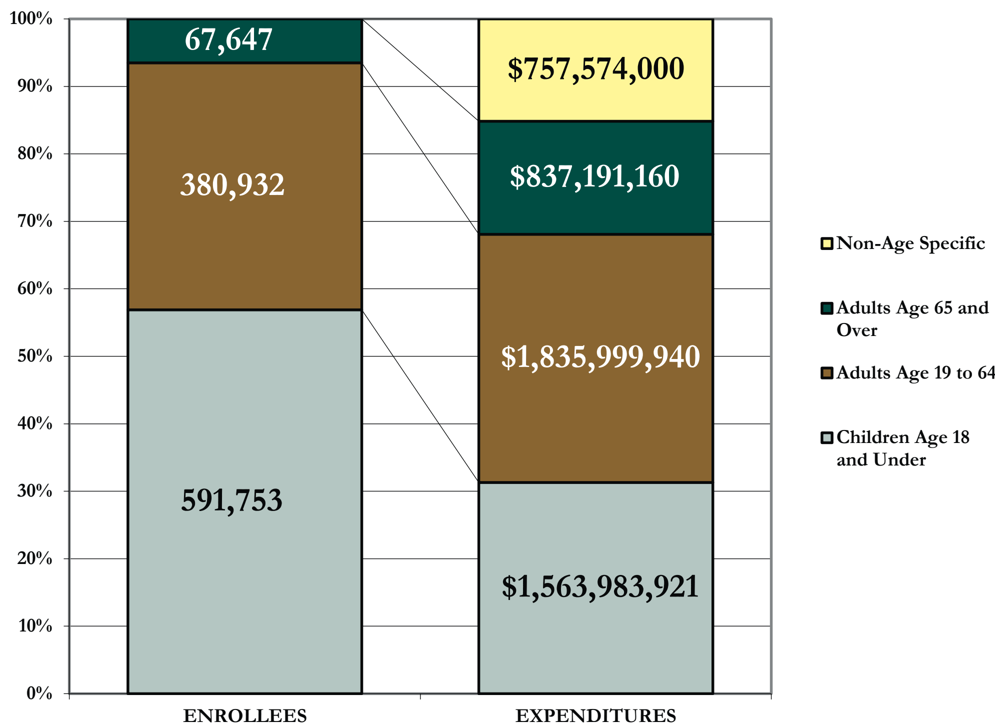


Figure 13 SoonerCare Expenditures and Served by Benefit Plan



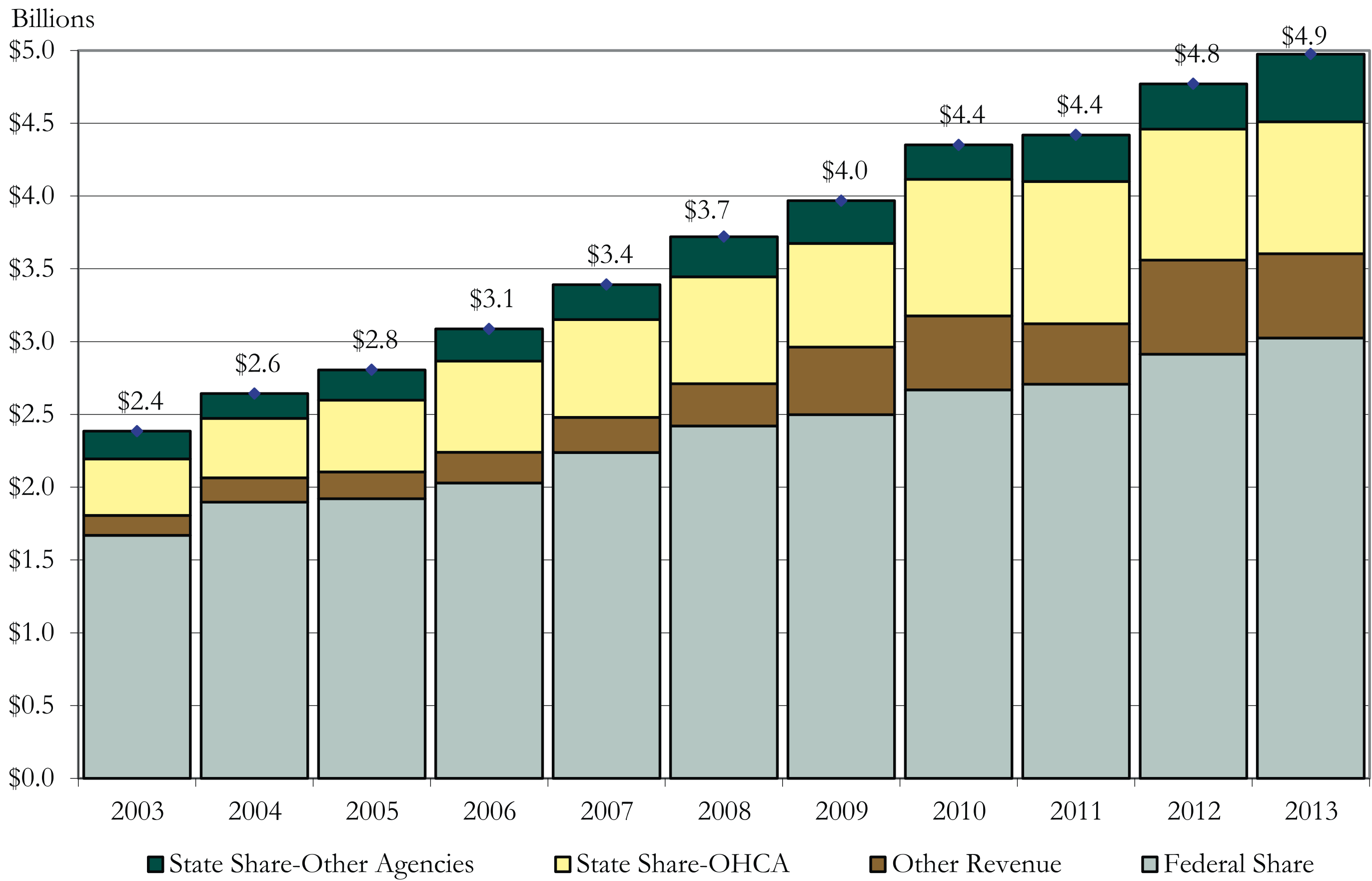
*SoonerCare Choice members will be enrolled/served under SoonerCare Traditional until their SoonerCare Choice becomes effective. Therefore, members may be counted in both categories. **SoonerCare Supplemental and ***Home and Community-Based Services (HCBS) waiver served members may also be included in the SoonerCare Traditional counts. HCBS Waiver expenditures are for all services to waiver members, including services not paid with waiver funds. In order to provide a more accurate average cost per member, non-member specific supplemental payments have been removed from the above. Those payments include $352,893,974 in Supplemental Hospital Offset payments; $228,621,903 in Hospital Supplemental payments; $93,666,695 in GME payments; $38,517,566 in EHR payments and $40,133,334 in Outpatient Behavioral Health Supplemental payments.

Figure 14 SoonerCare Enrollees and Expenditures by Age



Non-age specific payments include $352,893,974 in Supplemental Hospital Offset payments; $228,621,903 in Hospital Supplemental Payments (HSP) (includes HSP, DSH, GME and IME); $40,133,334 in Outpatient Behavioral Health Supplemental payments; $3,623,655 in SoonerExcel payments; $38,517,566 in EHR incentive payments; $93,666,695 in GME payments to Medical schools; and $116,872 in non-member specific provider adjustments. $131,025,519 in Medicare Part A & B (Buy-In) payments and $77,694,210 in Medicare Part D (clawback) payments are included in Ages 65 and over.

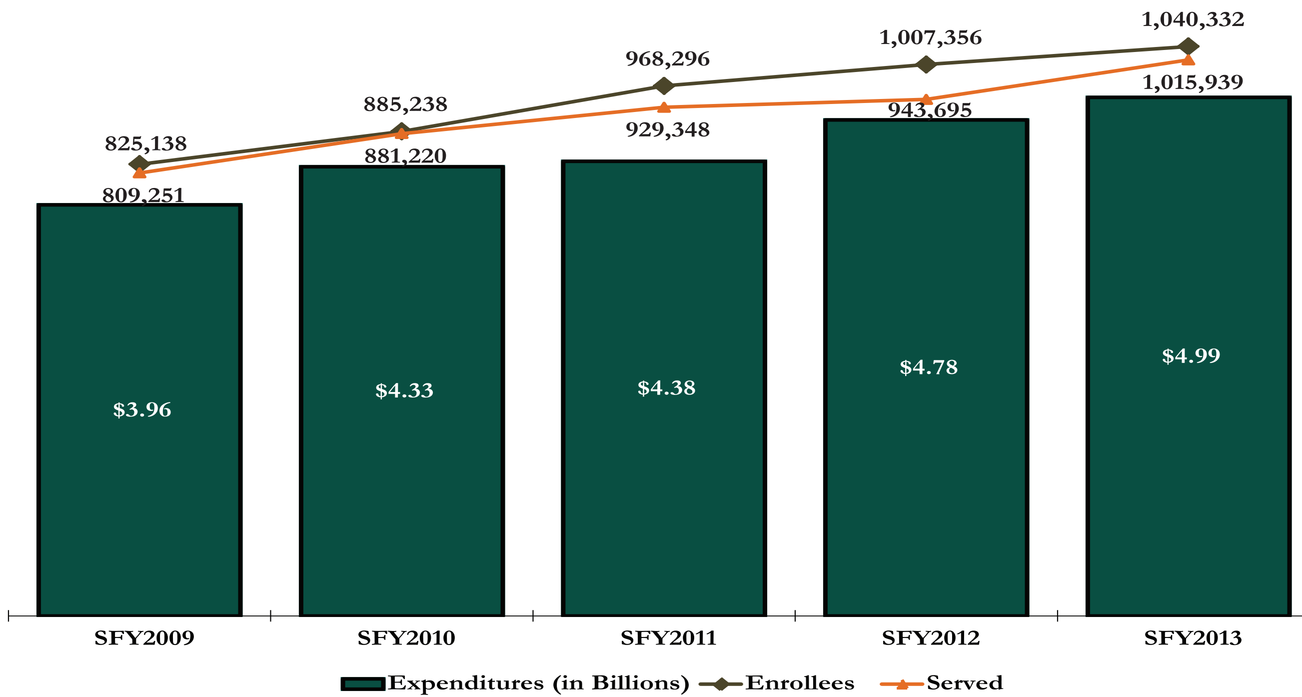
Figure 15 Summary of Expenditures and Revenue Sources — Federal Fiscal Year 2003 - 2013



Federal Fiscal Year	Total Expenditures	Federal Share	Other Revenue	State Share — OHCA	State Share — Other Agencies
2003	$2,384,136,980	$1,669,197,685	$136,781,999	$388,181,072	$189,976,224
2004	$2,642,481,484	$1,897,667,825	$166,596,539	$408,889,974	$169,327,146
2005	$2,805,599,500	$1,920,731,328	$183,584,054	$492,641,139	$208,642,979
2006	$3,086,916,991	$2,029,524,772	$210,005,646	$626,418,336	$220,968,237
2007	$3,391,417,550	$2,238,775,881	$240,533,188	$671,201,181	$240,907,299
2008	$3,719,999,267	$2,419,909,782	$290,956,731	$734,195,329	$274,937,424
2009	$3,967,791,899	$2,498,199,599	$463,954,197	$712,114,305	$293,523,798
2010	$4,350,788,295	$2,667,539,569	$508,946,267	$938,718,686	$235,583,773
2011	$4,419,400,740	$2,707,196,795	$414,614,124	$978,015,721	$319,574,101
2012	$4,770,055,106	$2,912,698,984	$647,058,594	$898,907,968	$311,389,560
2013	$4,974,580,067	$3,024,867,483	$577,749,094	$906,983,007	$464,980,484

Source: OHCA Financial Services Division. Federal fiscal years are between October 1 and September 30. Financial statement data represents actual cash expenditures as reported to the Office of State Finance while MMIS data warehouse expenditure data is net of overpayments and adjustments. For revenue details go to page 41 of this report.

FIGURE 16 HISTORIC SOONERCARE ENROLLEES, SERVED AND EXPENDITURES — STATE FISCAL YEAR 2009 - 2013



OHCA earned a Merit award as a Certified Healthy Business

The battle against the bulge and unhealthy conditions in Oklahoma continues to be fiercely fought by health champions and leaders who were recognized for their efforts at the Certified Healthy Oklahoma awards luncheon in Oklahoma City.

The program honored award recipients from across the state in February at the Cox Convention Center. Award recipients represent businesses, restaurants, schools, communities, college campuses and career technology centers that have responded to the challenge to Eat Better, Move More and Be Tobacco Free.

This year, 755 award winners received the annual "Certified Healthy" status. The awards ceremony was an opportunity to recognize and celebrate those individuals who have worked to improve employee health, child health and community health in Oklahoma. Among the special guests who attended were Gov. Mary Fallin, Blue Cross and Blue Shield of Oklahoma President M. Ted Haynes, and State Health Commissioner Dr. Terry Cline.

The Certified Healthy Oklahoma programs are a partnership effort of the Oklahoma State Department of Health, the State Chamber, the Oklahoma Academy for State Goals, the Oklahoma Turning Point Council and numerous other partners who are helping to shape our future and shape the future of all Oklahomans.

OHCA Staff Receive Awards

Often OHCA staff efforts are heralded through calls and letters. Occasionally, outstanding efforts are recognized through awards.

The National Association of Government Communications annually recognizes superior government communication products and those who produce them. The National Association of Government Communicators honored Jennie Melendez with the 2013 Blue Pencil & Gold Screen Award for her contribution to the *Provider Update* newsletter. The *Provider Update* is a SoonerCare newsletter that is distributed electronically to the OHCA provider community. The award was officially presented in Arlington, Virginia, on April 17.

OHCA strives to keep our 30,000 contracted providers as informed as possible. The quarterly *Provider Update* newsletter is one of the communication vehicles used to relay important updates, news and resources to provider groups. The newsletter is sent out electronically to 10,000 unduplicated email addresses from a provider database. Five hundred hard copies of each newsletter are also printed for the Provider Services team to take on provider site visits. The list of providers who benefit from these newsletters include pharmacies, long-term care facilities, durable medical equipment, dentists, behavioral health and all physicians and other practitioners.

OHCA 2013 Quality Oklahoma Team Day Awards

OHCA highlighted several projects at the 2013 Quality Oklahoma Team Day at the state capitol. Projects receiving a Governor's Commendation for Excellence award are included below.

In June 2011, state Medicaid agencies were encouraged by the Centers for Medicare & Medicaid Services to collaborate to provide financial support to cover services of tobacco helplines for individuals covered by Medicaid. Due to the long-standing and positive working relationship between OHCA and Tobacco Settlement Endowment Trust (TSET), Oklahoma was uniquely poised to be one of the first states in the nation to accomplish this mission. OHCA and TSET expanded their partnership to allow federal administrative matching funds to cover 50 percent of the cost of helpline services for SoonerCare members. This partnership has been a cost effective approach for Oklahoma. OHCA support for the Oklahoma Tobacco Helpline has resulted in a cost savings of nearly $400,000 state dollars.

The Oklahoma Durable Medical Equipment Reuse Program (OKDMERP) was created to allow DME that is no longer needed to be picked up from SoonerCare members or donated from private sources and refurbished for reuse. This refurbished equipment will then be reassigned to a SoonerCare member, a non-SoonerCare eligible person with disabilities or an elderly individual. OHCA has contracted with ABLE Tech to manage and operate the OKDMERP program. This program not only allows the SoonerCare program to make the most of available resources, but provides the opportunity for Oklahomans without other resources to receive the DME equipment they need.

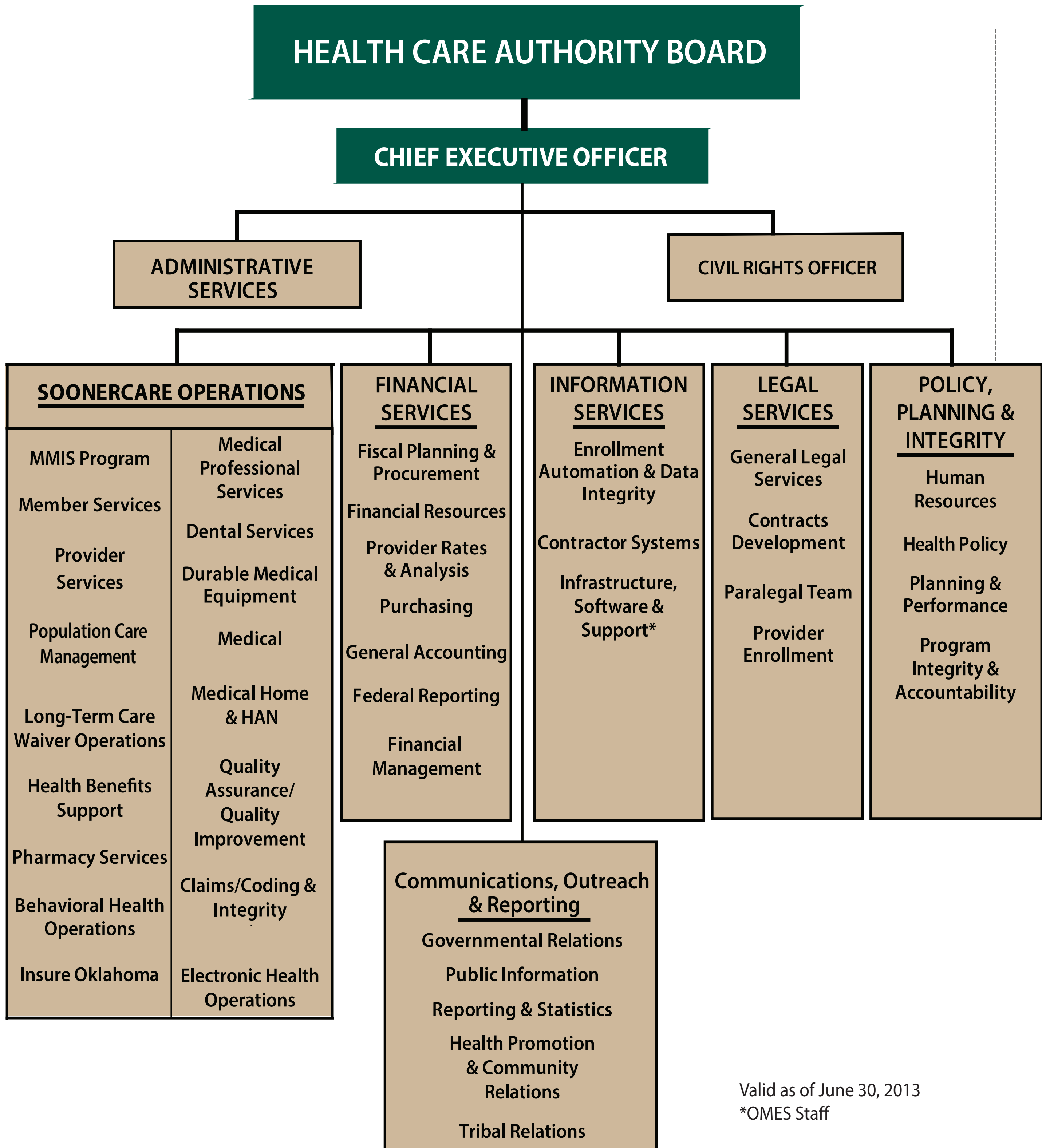
The Medically Fragile waiver program was presented with a Governor's Commendation award during the Team Day event held at the state's capitol. The cost and savings produced quarterly by the Oklahoma Health Care Authority are based on savings from institutions with a blended rate of nursing facility and technology – dependent care.

The Letter Generator/Mail Consolidation effort by OHCA Information Services and Hewlett-Packard (HP) enterprise services continues to show savings for the State of Oklahoma. As of May 2013, HP suppressed 12,943 mailings and entered 27,840 returned mail records for 2013. At an average cost of $0.384 per mailing, Oklahoma has saved $4,970 since Jan. 8, 2013. That savings is in addition to the 2012 elimination of $174,313 in costs for third party pick-up and zip code sort, recognized by a commendation from Gov. Mary Fallin. Information services continues to look for ways to consolidate member letters into single mailings, reducing postage and paper usage and to encourage SoonerCare providers to get their letters online, making this one of OHCA's green initiatives.

197%

Since the implementation of the SoonerCare qualification expansion programs in 1997, the number of children enrolled in SoonerCare has increased more than 197 percent.

Figure 17 OHCA Organizational Chart



OHCA contact information can be found on the inside back cover.

Appendix A Summary of Revenue Sources and Recoveries

Figure A Revenue Source Summary

Revenue Source	Actual Revenues
State Appropriations	$906,983,007
Federal Funds—OHCA	$2,222,815,090
Federal Funds for Other State Agencies	$870,974,463
Refunds from Other State Agencies	$541,202,861
Tobacco Tax Funds	$105,833,081
Drug Rebate	$195,082,200
Medical Refunds	$52,075,414
Quality of Care Fees	$64,679,143
SHOPP Assessment Fees	$157,912,299
Prior Year Carryover	$55,575,735
Other Revenue	$24,426,050
Total Revenue	**$5,197,559,343**

Source: Oklahoma Health Care Authority (OHCA) Financial Services Division, October 2013. Financial statement data represents actual cash expenditures as reported to the Office of State Finance while MMIS data warehouse expenditure data is net of overpayments and adjustments. SHOPP signifies Supplemental Hospital Offset Payment Program.

Figure B Post-Payment Review Recoveries

Provider Type	SFY2013
Behavioral Health	$245,286
Dental Services	$199,650
Electronic Health Record Incentive Payments	$361,250
Hospital	$1,266,209
Long-Term Care Facilities	$109,980
Non-Emergency Transportation	$147,014
Personal Care	$34,700
Pharmacy/Prescription Drugs	$62,034
Physicians and Other Practitioners	$483,360
School-Based Providers	$11,986
Vision	$483,298
Total - OHCA Recoveries	**$3,404,767**
MFCU - National Settlements	$37,589,025
MFCU - Other	$829,444
Total SoonerCare Recoveries	**$41,823,236**

OHCA recovery figures are a combination of amounts recovered from Program Integrity, Pharmacy, Provider Audits, contractor and External Quality Review Report reviews.

For a full accounting of agency recovery and cost avoidance efforts refer to the Service Efforts and Accomplishments report at www.okhca.org/reports.

Appendix B Statewide Figures

Figure I SoonerCare Expenditures by Payor

Category of Service	Total	Health Care Authority	Other State Agencies
ADvantage Waiver	$177,994,016	$0	$177,994,016
Ambulatory Clinics	$10,448,374	$9,953,816	$0
Behavioral Health - Case Management	$8,157,277	$0	$8,157,277
Behavioral Health - Inpatient	$23,805,769	$12,403,158	$10,765,179
Behavioral Health - Outpatient	$21,991,697	$0	$21,991,697
Behavioral Health - PRTF	$98,945,793	$0	$98,945,793
Behavioral Health - Psychiatrist	$7,697,398	$7,697,398	$0
Behavioral Health Facility- Rehab	$279,337,419	$0	$279,337,419
Clinic Services	$110,953,733	$96,070,821	$13,113,403
CMS Payments	$208,719,729	$206,896,874	$0
Dentists	$145,340,702	$137,133,043	$0
EHR Incentive Payments	$38,968,791	$38,968,791	$0
Family Planning/Family Planning Waiver	$11,236,581	$0	$11,236,581
GME/IME/DME	$126,057,898	$0	$126,057,898
Home and Community-Based Waiver	$163,083,612	$0	$163,083,612
Home Health Care	$21,263,525	$21,240,612	$0
Homeward Bound Waiver	$87,888,659	$0	$87,888,659
ICF/ID Private	$58,151,524	$47,298,309	$0
ICF/ID Public	$53,223,008	$0	$53,223,008
In-Home Support Waiver	$22,902,226	$0	$22,902,226
Inpatient Acute Care	$747,350,743	$545,615,673	$137,471,965
Lab & Radiology	$62,977,747	$58,755,615	$0
Medical Supplies	$51,429,126	$48,005,691	$0
Mid Level Practitioners	$3,890,770	$3,794,676	$0
Miscellaneous Medical Payments	$282,981	$276,465	$0
Money Follows the Person	$3,507,431	$1,568,962	$1,938,469
Nursing Facilities	$535,973,299	$320,183,243	$0
Other Practitioners	$65,373,269	$63,632,878	$0
Outpatient Acute Care	$278,802,215	$263,433,838	$0
Personal Care Services	$12,543,813	$0	$12,543,813
Physicians	$529,917,964	$405,212,266	$40,614,548
Premium Assistance*	$51,290,007	$0	$0
Prescription Drugs	$416,190,550	$348,780,378	$0
Residential Behavioral Management	$19,330,239	$0	$19,330,239
SHOPP Payments**	$352,893,974	$352,893,974	$0
SoonerCare Choice	$34,068,753	$33,595,682	$0
Targeted Case Management	$69,776,470	$0	$69,776,470
Therapeutic Foster Care	$2,420,685	$2,420,685	$0
Transportation	$60,392,297	$54,624,111	$0
Total SoonerCare Expenditures	**$4,974,580,067**	**$3,080,456,958**	**1,356,372,273**

Appendix B Statewide Figures

Figure I SoonerCare Expenditures by Payor

Category of Service	Quality of Care Fund	Medicaid Program Fund	HEEIA	BCC Revolving Fund
ADvantage Waiver	$0	$0	$0	$0
Ambulatory Clinics	$0	$0	$468,805	$25,753
Behavioral Health - Case Management	$0	$0	$0	$0
Behavioral Health - Inpatient	$0	$0	$637,431	$0
Behavioral Health - Outpatient	$0	$0	$0	$0
Behavioral Health - PRTF	$0	$0	$0	$0
Behavioral Health - Psychiatrist	$0	$0	$0	$0
Behavioral Health Facility- Rehab	$0	$0	$0	$99,458
Clinic Services	$0	$0	$1,498,766	$270,743
CMS Payments	$1,822,855	$0	$0	$0
Dentists	$0	$8,075,106	$83,811	$48,742
EHR Incentive Payments	$0	$0	$0	$0
Family Planning/Family Planning Waiver	$0	$0	$0	$0
GME/IME/DME	$0	$0	$0	$0
Home and Community-Based Waiver	$0	$0	$0	$0
Home Health Care	$0	$0	$35	$22,878
Homeward Bound Waiver	$0	$0	$0	$0
ICF/ID Private	$10,023,001	$830,214	$0	$0
ICF/ID Public	$0	$0	$0	$0
In-Home Support Waiver	$0	$0	$0	$0
Inpatient Acute Care	$486,687	$51,724,464	$9,985,733	$2,066,221
Lab & Radiology	$0	$0	$3,455,321	$766,812
Medical Supplies	$2,582,415	$0	$780,264	$60,757
Mid Level Practitioners	$0	$0	$91,215	$4,880
Miscellaneous Medical Payments	$0	$0	$1,527	$4,989
Money Follows the Person	$0	$0	$0	$0
Nursing Facilities	$175,152,041	$40,620,312	$0	$17,702
Other Practitioners	$446,364	$1,016,493	$262,533	$15,001
Outpatient Acute Care	$41,604	$0	$10,487,997	$4,838,776
Personal Care Services	$0	$0	$0	$0
Physicians	$58,101	$63,282,105	$14,043,328	$6,707,618
Premium Assistance*	$0		$51,290,007	$0
Prescription Drugs	$0	$45,728,022	$19,995,903	$1,686,247
Residential Behavioral Management	$0	$0	$0	$0
SHOPP Payments**	$0	$0	$0	$0
SoonerCare Choice	$0	$0	$453,837	$19,235
Targeted Case Management	$0	$0	$0	$0
Therapeutic Foster Care	$0	$0	$0	$0
Transportation	$2,564,264	$3,144,992	$0	$58,930
Total SoonerCare Expenditures	**$193,177,331**	**$214,421,708**	**$113,536,514**	**$16,714,742**

Source: OHCA Financial Services Division, October 2013. HEEIA includes *$50,917,023 paid out of Fund 245 and **$352,893,974 paid out of Fund 205. Financial statement data represents actual cash expenditures as reported to the Office of State Finance while MMIS data warehouse expenditure data is net of overpayments and adjustments. The Medicaid Program fund, the HEEIA Fund and the BCC (Oklahoma Cares) Revolving Fund are all funded by tobacco tax collections.

Appendix B Statewide Figures (continued)

Figure II Statewide SoonerCare Figures by County

County	Population Proj. July 2012*	Rank	Unduplicated SoonerCare Enrollees**	Rank	Percent Population Enrolled in SoonerCare	Rank
ADAIR	22,286	39	10,401	30	47%	1
ALFALFA	5,666	69	1,050	70	19%	71
ATOKA	14,007	48	4,414	50	32%	31
BEAVER	5,591	70	955	72	17%	73
BECKHAM	23,081	38	6,155	41	27%	50
BLAINE	9,785	59	3,333	56	34%	23
BRYAN	43,399	23	15,189	16	35%	15
CADDO	29,678	33	10,489	29	35%	14
CANADIAN	122,560	5	19,664	8	16%	75
CARTER	48,085	17	16,401	12	34%	22
CHEROKEE	48,150	16	14,683	18	30%	35
CHOCTAW	15,182	45	6,498	40	43%	3
CIMARRON	2,385	77	694	75	29%	41
CLEVELAND	265,638	3	44,644	3	17%	74
COAL	5,963	68	2,082	64	35%	17
COMANCHE	126,390	4	30,245	4	24%	56
COTTON	6,155	66	1,703	66	28%	46
CRAIG	14,748	47	4,967	46	34%	24
CREEK	70,651	10	20,844	7	30%	40
CUSTER	28,536	34	6,986	38	24%	53
DELAWARE	41,441	24	12,571	24	30%	36
DEWEY	4,783	71	1,030	71	22%	63
ELLIS	4,104	73	627	77	15%	76
GARFIELD	61,189	12	16,738	11	27%	47
GARVIN	27,297	35	8,521	34	31%	32
GRADY	53,118	13	11,626	27	22%	62
GRANT	4,516	72	895	73	20%	69
GREER	6,082	67	1,799	65	30%	39
HARMON	2,906	76	1,147	69	39%	5
HARPER	3,676	75	823	74	22%	60
HASKELL	12,938	51	4,971	45	38%	7
HUGHES	13,836	49	4,487	49	32%	29
JACKSON	26,237	36	7,799	36	30%	38
JEFFERSON	6,377	65	2,422	63	38%	9
JOHNSTON	11,003	57	4,209	52	38%	8
KAY	45,831	19	16,039	13	35%	16
KINGFISHER	15,005	46	3,449	55	23%	59
KIOWA	9,310	61	3,087	57	33%	25
LATIMER	11,019	56	3,769	54	34%	19
LEFLORE	49,873	15	17,034	10	34%	21
LINCOLN	34,189	30	8,947	32	26%	52
LOGAN	43,666	22	8,916	33	20%	66

Appendix B Statewide Figures (continued)

Figure II Statewide SoonerCare Figures by County (continued)

County	Expenditures	Rank	Annual Per Est. Population	Rank	Monthly Average Per Enrollee	Rank
ADAIR	$36,073,780	32	$1,619	10	$289	53
ALFALFA	$3,218,378	72	$568	72	$255	69
ATOKA	$17,864,068	50	$1,275	30	$337	28
BEAVER	$2,302,504	74	$412	76	$201	74
BECKHAM	$23,232,627	43	$1,007	45	$315	40
BLAINE	$11,343,588	57	$1,159	39	$284	55
BRYAN	$55,977,384	19	$1,290	28	$307	42
CADDO	$31,623,293	34	$1,066	43	$251	70
CANADIAN	$70,804,180	10	$578	71	$300	48
CARTER	$64,112,612	13	$1,333	26	$326	33
CHEROKEE	$64,616,492	12	$1,342	25	$367	16
CHOCTAW	$28,586,318	38	$1,883	3	$367	17
CIMARRON	$988,059	77	$414	75	$119	77
CLEVELAND	$157,178,715	3	$592	70	$293	50
COAL	$9,466,848	61	$1,588	11	$379	14
COMANCHE	$88,752,998	7	$702	65	$245	72
COTTON	$5,592,799	67	$909	51	$274	63
CRAIG ‡	$27,557,140	39	$1,869	4	$462	4
CREEK	$90,111,729	6	$1,275	29	$360	19
CUSTER	$24,061,192	42	$843	54	$287	54
DELAWARE	$47,586,977	26	$1,148	40	$315	39
DEWEY	$3,463,125	71	$724	62	$280	58
ELLIS	$1,413,465	76	$344	77	$188	75
GARFIELD ‡	$95,095,423	5	$1,554	14	$473	3
GARVIN ‡	$57,084,702	17	$2,091	2	$558	1
GRADY	$42,795,540	29	$806	57	$307	43
GRANT	$3,712,534	70	$822	55	$346	25
GREER	$7,346,298	65	$1,208	36	$340	27
HARMON	$4,847,511	69	$1,668	7	$352	22
HARPER	$2,396,700	73	$652	68	$243	73
HASKELL	$19,065,619	48	$1,474	19	$320	37
HUGHES	$20,453,859	45	$1,478	18	$380	13
JACKSON	$25,775,340	41	$982	48	$275	62
JEFFERSON	$8,499,655	64	$1,333	27	$292	51
JOHNSTON	$18,077,271	49	$1,643	8	$358	21
KAY	$53,808,466	21	$1,174	38	$280	59
KINGFISHER	$11,078,057	58	$738	61	$268	65
KIOWA	$13,561,381	56	$1,457	20	$366	18
LATIMER	$15,698,566	52	$1,425	22	$347	24
LEFLORE	$68,477,885	11	$1,373	24	$335	30
LINCOLN	$29,733,977	36	$870	52	$277	61
LOGAN	$37,227,093	31	$853	53	$348	23

Appendix B Statewide Figures (continued)

Figure II Statewide SoonerCare Figures by County (continued)

County	Population Proj. July 2012*	Rank	Unduplicated SoonerCare Enrollees**	Rank	Percent Population Enrolled in SoonerCare	Rank
LOVE	9,558	60	2,976	59	31%	33
MCCLAIN	35,613	29	7,956	35	22%	61
MCCURTAIN	33,203	31	14,317	19	43%	2
MCINTOSH	20,584	41	6,657	39	32%	30
MAJOR	7,683	64	1,636	68	21%	64
MARSHALL	15,957	44	5,206	43	33%	27
MAYES	41,168	26	13,364	21	32%	28
MURRAY	13,663	50	3,782	53	28%	45
MUSKOGEE	70,596	11	25,067	5	36%	13
NOBLE	11,522	54	2,761	61	24%	55
NOWATA	10,611	58	3,010	58	28%	43
OKFUSKEE	12,358	52	4,615	48	37%	11
OKLAHOMA	741,781	1	207,071	1	28%	44
OKMULGEE	39,625	27	13,542	20	34%	20
OSAGE	47,917	18	7,045	37	15%	77
OTTAWA	32,236	32	12,914	23	40%	4
PAWNEE	16,474	43	5,097	44	31%	34
PAYNE	78,399	7	15,609	15	20%	68
PITTSBURG	45,048	20	12,974	22	29%	42
PONTOTOC	37,958	28	11,455	28	30%	37
POTTAWATOMIE	70,760	9	23,254	6	33%	26
PUSHMATAHA	11,205	55	4,216	51	38%	10
ROGER MILLS	3,774	74	674	76	18%	72
ROGERS	88,367	6	18,121	9	21%	65
SEMINOLE	25,450	37	9,393	31	37%	12
SEQUOYAH	41,398	25	15,997	14	39%	6
STEPHENS	44,779	21	12,085	26	27%	48
TEXAS	21,498	40	5,772	42	27%	49
TILLMAN	7,822	63	2,728	62	35%	18
TULSA	613,816	2	163,489	2	27%	51
WAGONER	75,030	8	15,166	17	20%	67
WASHINGTON	51,633	14	12,146	25	24%	57
WASHITA	11,622	53	2,792	60	24%	54
WOODS	8,832	62	1,646	67	19%	70
WOODWARD	20,548	42	4,811	47	23%	58
OUT OF STATE			4,630			
OTHER ◊			4,055			
TOTAL	**3,814,820**		**1,040,332**		**27%**	

*Source: Population Division, U.S. Census Bureau. Estimates rounded to nearest 100. American Fast Fact Finder PEPANNRES table using the advanced search options. **Enrollees listed above are the unduplicated count per last county on the enrollee record for the entire state fiscal year (July-June).

Appendix B Statewide Figures (continued)

Figure II Statewide SoonerCare Figures by County (continued)

County	Expenditures	Rank	Annual Per Est. Population	Rank	Monthly Average Per Enrollee	Rank
LOVE	$9,409,655	62	$984	47	$263	68
MCCLAIN	$26,657,773	40	$749	60	$279	60
MCCURTAIN	$51,777,320	22	$1,559	13	$301	47
MCINTOSH	$31,159,944	35	$1,514	16	$390	8
MAJOR	$5,173,435	68	$673	67	$264	67
MARSHALL	$20,012,406	46	$1,254	31	$320	36
MAYES	$50,976,267	23	$1,238	34	$318	38
MURRAY	$15,545,756	53	$1,138	42	$343	26
MUSKOGEE	$115,357,160	4	$1,634	9	$383	10
NOBLE	$14,106,315	55	$1,224	35	$426	5
NOWATA	$15,269,283	54	$1,439	21	$423	6
OKFUSKEE ‡	$28,627,242	37	$2,316	1	$517	2
OKLAHOMA	$775,125,823	1	$1,045	44	$312	41
OKMULGEE	$62,693,962	14	$1,582	12	$386	9
OSAGE	$32,318,717	33	$674	66	$382	11
OTTAWA	$45,009,193	27	$1,396	23	$290	52
PAWNEE	$20,457,224	44	$1,242	33	$334	31
PAYNE	$55,790,008	20	$712	64	$298	49
PITTSBURG	$56,067,973	18	$1,245	32	$360	20
PONTOTOC	$57,811,893	16	$1,523	15	$421	7
POTTAWATOMIE	$84,763,468	8	$1,198	37	$304	45
PUSHMATAHA	$19,266,652	47	$1,719	5	$381	12
ROGER MILLS	$1,985,776	75	$526	73	$246	71
ROGERS	$70,871,647	9	$802	58	$326	32
SEMINOLE	$42,608,984	30	$1,674	6	$378	15
SEQUOYAH	$61,559,362	15	$1,487	17	$321	35
STEPHENS	$44,123,426	28	$985	46	$304	44
TEXAS	$9,672,263	59	$450	74	$140	76
TILLMAN	$8,901,218	63	$1,138	41	$272	64
TULSA	$592,555,682	2	$965	49	$302	46
WAGONER	$48,578,490	25	$647	69	$267	66
WASHINGTON	$49,056,006	24	$950	50	$337	29
WASHITA	$9,479,703	60	$816	56	$283	56
WOODS	$6,389,684	66	$723	63	$323	34
WOODWARD	$16,302,624	51	$793	59	$282	57
OUT OF STATE	$1,774,329					
OTHER ◊	$17,512,634				$360	
TOTAL	**$3,975,413,445**		**$1,042**		**$318**	

‡Garfield and Garvin counties have public institutions and Okfuskee and Craig counties have private institutions for the intellectually disabled causing the average dollars per SoonerCare enrollee to be higher than the norm.
◊ Non-member specific payments include $352,893,974 in SHOPP payments; $228,621,903 in Hospital Supplemental payments; $131,025,519 in Medicare Part A & B (Buy-In) payments; $77,694,210 in Medicare Part D (clawback) payments; $93,666,695 in GME payments to medical schools; $50,107,558 in Insure Oklahoma ESI premiums; $688,863 in Insure Oklahoma ESI Out-Of Pocket payments; $38,517,566 in EHR incentive payments; $40,133,334 in Outpatient Behavioral Health Supplemental payments; $3,555,623 in SoonerExcel payments; $3,885,990 in Health Access Network payments and -$1,455,659 in non-member specific provider adjustments.

Appendix B Statewide Figures (continued)

Figure III Expenditures Paid to Providers and Members by County

County	Total Dollars Paid by Provider County	Total Dollars Paid by Member County	% of Dollars Staying in County
ADAIR	$13,935,190	$36,073,780	39%
ALFALFA	$1,200,317	$3,218,378	37%
ATOKA	$11,365,857	$17,864,068	64%
BEAVER	$1,186,123	$2,302,504	52%
BECKHAM	$16,904,728	$23,232,627	73%
BLAINE	$6,444,658	$11,343,588	57%
BRYAN	$58,068,194	$55,977,384	104%
CADDO	$15,975,521	$31,623,293	51%
CANADIAN	$40,317,065	$70,804,180	57%
CARTER	$60,613,081	$64,112,612	95%
CHEROKEE	$65,365,194	$64,616,492	101%
CHOCTAW	$18,415,827	$28,586,318	64%
CIMARRON	$302,941	$988,059	31%
CLEVELAND	$142,443,190	$157,178,715	91%
COAL	$3,736,747	$9,466,848	39%
COMANCHE	$84,266,997	$88,752,998	95%
COTTON	$3,434,261	$5,592,799	61%
CRAIG	$21,230,161	$27,557,140	77%
CREEK	$57,815,082	$90,111,729	64%
CUSTER	$21,034,288	$24,061,192	87%
DELAWARE	$31,017,798	$47,586,977	65%
DEWEY	$1,647,921	$3,463,125	48%
ELLIS	$1,834,724	$1,413,465	130%
GARFIELD	$84,985,253	$95,095,423	89%
GARVIN	$42,104,345	$57,084,702	74%
GRADY	$26,537,360	$42,795,540	62%
GRANT	$1,831,629	$3,712,534	49%
GREER	$3,294,595	$7,346,298	45%
HARMON	$3,193,339	$4,847,511	66%
HARPER	$1,719,905	$2,396,700	72%
HASKELL	$16,796,061	$19,065,619	88%
HUGHES	$11,187,292	$20,453,859	55%
JACKSON	$19,597,189	$25,775,340	76%
JEFFERSON	$2,890,509	$8,499,655	34%
JOHNSTON	$16,045,572	$18,077,271	89%
KAY	$42,591,834	$53,808,466	79%
KINGFISHER	$5,616,594	$11,078,057	51%
KIOWA	$9,704,696	$13,561,381	72%
LATIMER	$8,865,887	$15,698,566	56%
LEFLORE	$45,356,891	$68,477,885	66%
LINCOLN	$12,448,918	$29,733,977	42%

Appendix B Statewide Figures (continued)

Figure III Expenditures Paid to Providers and Members by County (continued)

County	Total Dollars Paid by Provider County	Total Dollars Paid by Member County	% of Dollars Staying in County
LOGAN	$18,735,560	$37,227,093	50%
LOVE	$3,035,466	$9,409,655	32%
MCCLAIN	$12,391,260	$26,657,773	46%
MCCURTAIN	$27,423,916	$51,777,320	53%
MCINTOSH	$30,841,182	$31,159,944	99%
MAJOR	$2,286,004	$5,173,435	44%
MARSHALL	$7,441,935	$20,012,406	37%
MAYES	$18,315,716	$50,976,267	36%
MURRAY	$8,992,340	$15,545,756	58%
MUSKOGEE	$99,562,572	$115,357,160	86%
NOBLE	$7,568,966	$14,106,315	54%
NOWATA	$5,482,040	$15,269,283	36%
OKFUSKEE	$16,755,020	$28,627,242	59%
OKLAHOMA	$1,124,023,357	$775,125,823	145%
OKMULGEE	$33,162,045	$62,693,962	53%
OSAGE	$10,863,831	$32,318,717	34%
OTTAWA	$34,061,384	$45,009,193	76%
PAWNEE	$11,840,456	$20,457,224	58%
PAYNE	$38,922,367	$55,790,008	70%
PITTSBURG	$42,387,846	$56,067,973	76%
PONTOTOC	$65,155,869	$57,811,893	113%
POTTAWATOMIE	$54,964,990	$84,763,468	65%
PUSHMATAHA	$26,537,080	$19,266,652	138%
ROGER MILLS	$257,754	$1,985,776	13%
ROGERS	$44,873,784	$70,871,647	63%
SEMINOLE	$22,354,901	$42,608,984	52%
SEQUOYAH	$41,496,717	$61,559,362	67%
STEPHENS	$37,508,090	$44,123,426	85%
TEXAS	$7,032,769	$9,672,263	73%
TILLMAN	$4,604,026	$8,901,218	52%
TULSA	$834,158,041	$592,555,682	141%
WAGONER	$15,100,676	$48,578,490	31%
WASHINGTON	$33,255,383	$49,056,006	68%
WASHITA	$5,404,946	$9,479,703	57%
WOODS	$3,966,289	$6,389,684	62%
WOODWARD	$11,430,334	$16,302,624	70%
OUT OF STATE	$150,084,358	$1,774,329	
OTHER ◊	$1,049,146,017	$1,019,335,576	
TOTAL	**$4,994,749,021**	**$4,994,749,021**	

◊ In prior fiscal years EHR was included in the data by county but is footnoted in both Provider County and Member County in SFY2013. Non-member specific payments include $352,893,974 in SHOPP payments; $228,621,903 in Hospital Supplemental payments; $131,025,519 in Medicare Part A & B (Buy-In) payments; $77,694,210 in Medicare Part D (clawback) payments; $93,666,695 in GME payments to medical schools; $50,107,558 in O-EPIC premiums; $688,863 in O-EPIC Out-Of Pocket payments; $38,517,566 in EHR incentive payments; $40,133,334 in Outpatient Behavioral Health Supplemental payments; $27,407,209 in Non-Emergency Transportation payments $3,555,623 in SoonerExcel payments; $3,885,990 in Health Access Network payments and $947,573 in non-member specific provider adjustments.

Appendix B Statewide Figures (continued)

Figure IV Expenditures by Type of Service Percent of Change SFY2012 vs. SFY2013

Type of Service	SFY2012			SFY2013			Percent Change		
	Expenditures	Members	Avg Per Member	Expenditures	Members	Avg Per Member	Expend-itures	Mem-bers	Aver-age
Adult Day Care	$4,230,302	798	$5,301	$4,452,096	808	$5,510	5%	1%	4%
Advanced Practice Nurse	$3,930,715	18,925	$208	$3,357,358	15,110	$222	-15%	-20%	7%
ADvantage Home Delivered Meals	$14,313,991	12,700	$1,127	$15,221,754	13,527	$1,125	6%	7%	0%
Ambulatory Surgical Services	$10,476,823	19,117	$548	$10,137,760	18,015	$563	-3%	-6%	3%
Architectural Modification	$334,018	156	$2,141	$352,790	152	$2,321	6%	-3%	8%
Audiology Services	$125,030	1,249	$100	$139,404	1,375	$101	11%	10%	1%
Behavioral Health Services	$218,301,718	93,567	$2,653	$247,522,841	105,563	$2,345	13%	13%	-12%
Capitated Services	$34,892,889	684,831	$51	$36,296,235	726,510	$50	4%	6%	-2%
Chiropractic Services	$6,194	110	$56	$8,039	124	$65	30%	13%	15%
Clinic	$77,725,905	123,860	$628	$86,173,922	138,706	$621	11%	12%	-1%
Clinics - OSA Services	$10,210,359	102,088	$100	$11,081,354	103,871	$107	9%	2%	7%
Community Mental Health	$33,417,000	34,437	$970	$33,701,277	35,295	$955	1%	2%	-2%
Dental	$138,706,697	309,246	$449	$138,731,535	323,313	$429	0%	5%	-4%
Direct Support	$189,596,031	4,291	$44,185	$191,652,574	4,291	$44,664	1%	0%	0%
Employee Training Specialist	$27,687,871	2,760	$10,032	$28,031,755	2,753	$10,182	1%	0%	1%
End-Stage Renal Disease	$6,885,850	2,180	$3,159	$6,628,633	2,171	$3,053	-4%	0%	-3%
Eye Care and Exams	$20,082,617	131,174	$153	$21,712,636	136,558	$159	8%	4%	4%
Eyewear	$7,103,053	52,110	$136	$7,072,915	51,551	$137	0%	-1%	1%
Self-Directed Care	$5,274,737	648	$8,140	$5,542,651	702	$7,896	5%	8%	-3%
Group Home	$20,562,645	631	$32,587	$21,413,896	640	$33,459	4%	1%	3%
Home Health	$19,695,715	6,951	$2,834	$20,188,669	6,796	$2,971	3%	-2%	5%
Homemaker Services	$1,648,767	396	$4,164	$1,928,639	394	$4,895	17%	-1%	18%
Hospice	$998,752	120	$8,323	$1,101,671	133	$8,283	10%	11%	0%
ICF-ID Services	$113,041,471	1,764	$64,082	$111,373,096	1,748	$63,715	-1%	-1%	-1%
Inpatient Services	$613,532,956	133,378	$4,600	$610,325,795	140,884	$4,332	-1%	6%	-6%
Laboratory Services	$43,741,352	266,021	$164	$48,572,305	264,861	$183	11%	0%	12%
Medicare Part A & B (Buy-In) Payments	$135,220,625	-	$0	$131,025,519	-	$0	-3%	0%	0%
Medicare Part D Payments	$76,193,984	-	$0	$77,694,210	-	$0	2%	0%	0%
Mid-Level Practitioner	$641,810	4,321	$149	$437,677	2,951	$148	-32%	-32%	0%
Medical Supplies/DMEPOS	$68,076,998	88,653	$768	$70,600,955	94,173	$750	4%	6%	-2%
Nursing Facility	$488,657,238	19,454	$25,119	$536,153,689	19,703	$27,212	10%	1%	8%
Nursing Services	$7,971,955	19,479	$409	$8,462,738	19,342	$438	6%	-1%	7%
Nutritionist Services	$918,901	846	$1,086	$947,811	781	$1,214	3%	-8%	12%
Insure Oklahoma ESI Out-of-Pocket	$447,029	-	$0	$688,863	-	$0	54%	0%	0%
Insure Oklahoma ESI Premium	$54,800,820	25,491	$2,150	$50,107,558	23,429	$2,139	-9%	-8%	-1%
Other Practitioner	$5,578	50	$112	$3,846	31	$124	-31%	-38%	11%
Outpatient	$261,977,082	446,387	$587	$281,943,483	478,968	$589	8%	7%	0%

Appendix B Statewide Figures (continued)

Figure IV Expenditures by Type of Service Percent of Change SFY2012 vs. SFY2013 (continued)

	SFY2012			SFY2013			Percent Change		
Type of Service	Expenditures	Members	Avg Per Member	Expenditures	Members	Avg Per Member	Expend-itures	Mem-bers	Aver-age
Personal Care	$95,534,686	22,103	$4,322	$94,684,936	21,728	$4,358	-1%	-2%	1%
Physician	$535,526,206	698,205	$767	$562,856,420	734,533	$766	5%	5%	0%
Podiatry	$2,877,320	14,301	$201	$3,248,078	14,998	$217	13%	5%	8%
Prescribed Drugs	$393,711,219	592,284	$665	$406,788,858	625,305	$651	3%	6%	-2%
Psychiatric Services	$101,451,651	5,192	$19,540	$107,745,675	6,945	$15,514	6%	34%	-21%
Residential Behavior Mgmt	$24,087,827	2,241	$10,749	$22,599,397	2,063	$10,955	-6%	-8%	2%
Respite Care	$450,916	283	$1,593	$476,358	311	$1,532	6%	10%	-4%
Room and Board	$721,861	1,009	$715	$280,953	594	$473	-61%	-41%	-34%
School-Based Services	$7,075,931	8,519	$831	$7,007,613	8,201	$854	-1%	-4%	3%
Specialized Foster Care/ID Services	$3,706,723	243	$15,254	$3,675,506	234	$15,707	-1%	-4%	3%
Targeted Case Manager	$94,667,472	44,523	$2,126	$107,255,067	45,802	$2,342	13%	3%	10%
Therapy Services	$13,268,797	12,092	$1,097	$13,348,060	13,166	$1,014	1%	9%	-8%
Transportation - Emergency	$42,346,035	81,195	$522	$41,990,407	84,700	$496	-1%	4%	-5%
Transportation - Non-Emergency	$27,558,246	852,219	$32	$27,099,967	888,251	$31	-2%	4%	-6%
X-Ray Services	$20,019,418	230,572	$87	$19,875,088	239,078	$83	-1%	4%	-4%
Uncategorized Services	$1,079,494	17,646	$61	$1,195,214	92,545	$13	11%	424%	-79%
Total	**$4,075,519,279**	**943,695**	**$4,319**	**$4,240,915,548**	**1,015,939**	**$4,174**	**2%**	**2%**	**1%**

Non-Member Specific Payments									
HSP - Indirect Medical Education (IME)	$29,677,651	-	-	$30,449,271	-	-	3%	-	-
HSP - Graduate Medical Education (GME)	$12,181,449	-	-	$20,302,415	-	-	67%	-	-
HSP - Acute DSH	$62,471,736	-	-	$42,696,630	-	-	-32%	-	-
HSP - Supplemental Payments	$128,916,359	-	-	$135,173,587	-	-	5%	-	-
HSP - SHOPP	$342,365,712	-	-	$352,893,974	-	-	3%	-	-
Behavioral Health Supplemental Payments	$29,934,653	-	-	$40,133,334	-	-	34%	-	-
EHR Incentive Payments	$43,998,795	-	-	$38,517,566	-	-	-12%	-	-
Capitated Services - GME to Medical Schools	$52,279,093	-	-	$93,666,695	-	-	79%	-	-
Total	**4,777,344,727**	**943,695**	**$4,319**	**4,994,749,021**	**1,015,939**	**$4,174**	**150%**	**8%**	**-3%**

Source: OHCA Financial Service Division, October 2013. Graduate Medical Education (GME) payments are made on a quarterly base, due to the availability of funds and other factors (GME) payments may be processed for prior fiscal years. The increase in the Behavioral Health Supplemental payment is due to a payment for SFY2012 in the amount of $6,018,072 being processed in SFY2013. The increase in GME to Medical Schools is due to payments for SFY2012 being processed in SFY2013.

Claim dollars were extracted from the MMIS claims history file for claims paid within the fiscal year. Financial statement data represents actual cash expenditures as reported to the Office of State Finance while MMIS data warehouse expenditure data is net of overpayments and adjustments.

Member Served figures are the unduplicated counts of members that received a service. If a member received services from multiple service type providers, they would be counted once for each type of service; the total count is the unduplicated count overall.

Appendix B Statewide Figures (continued)

Figure V Expenditures by Type of Service by Adult and Child

SFY2013	Adult Totals			Children Totals		
Type of Service	Expenditures	Members Served	Avg. per Adult	Expenditures	Members Served	Avg. per Child
Adult Day Care	$4,412,556	796	$5,543	$39,540	12	$3,295
Advanced Practice Nurse	$896,939	3,784	$237	$2,460,419	11,326	$217
ADvantage Home Delivered Meals	$15,221,754	13,527	$1,125	$0	-	$0
Ambulatory Surgical Services	$4,008,061	8,134	$493	$6,129,699	9,881	$620
Architectural Modification	$349,563	148	$2,362	$3,226	4	$807
Audiology Services	$12,769	271	$47	$126,635	1,104	$115
Behavioral Health Services	$61,995,562	25,761	$2,407	$185,527,279	79,802	$2,325
Capitated Services	$9,271,700	158,300	$59	$27,024,535	568,210	$48
Chiropractic Services	$8,039	124	$65	$0	-	$0
Clinic	$34,515,402	48,618	$710	$51,658,521	90,088	$573
Clinics - OSA Services	$2,848,116	22,946	$124	$8,233,238	80,925	$102
Community Mental Health	$18,245,685	19,926	$916	$15,455,591	15,369	$1,006
Dental	$19,086,525	36,955	$516	$119,645,010	286,358	$418
Direct Support	$178,829,510	3,678	$48,621	$12,823,064	613	$20,919
Employee Training Specialist	$27,286,308	2,623	$10,403	$745,446	130	$5,734
End-Stage Renal Disease	$6,602,470	2,153	$3,067	$26,162	18	$1,453
Eye Care and Exams	$1,646,394	18,932	$87	$20,066,242	117,626	$171
Eyewear	$27,753	215	$129	$7,045,163	51,336	$137
Self-Directed Care	$5,542,651	702	$7,896	$0	-	$0
Group Home	$20,558,446	617	$33,320	$855,451	23	$37,194
Home Health	$4,430,367	4,336	$1,022	$15,758,303	2,460	$6,406
Homemaker Services	$1,637,070	314	$5,214	$291,569	80	$3,645
Hospice	$1,055,198	122	$8,649	$46,473	11	$4,225
ICF-ID Services	$107,877,707	1,664	$64,830	$3,495,389	84	$41,612
Inpatient Services	$356,757,138	78,743	$4,531	$253,568,658	62,141	$4,081
Laboratory Services	$32,447,016	118,761	$273	$16,125,289	146,100	$110
Medicare Part A & B (Buy-In) Payments	$131,025,519	-	$0	$0	-	$0
Medicare Part D Payments	$77,694,210	-	$0	$0	-	$0
Mid-Level Practitioner	$118,182	464	$255	$319,495	2,487	$128
Medical Supplies/DMEPOS	$51,064,378	59,359	$860	$19,536,577	34,814	$561
Nursing Facility	$535,555,458	19,681	$27,212	$598,231	22	$27,192
Nursing Services	$8,462,738	19,342	$438	$0	-	$0
Nutritionist Services	$935,481	735	$1,273	$12,330	46	$268
Insure Oklahoma ESI Out-of-Pocket	$688,863	-	$0	$0	-	$0
Insure Oklahoma ESI Premium	$50,107,558	23,429	$2,139	$0	-	$0
Other Practitioner	$3,064	21	$146	$782	10	$78

Appendix B Statewide Figures (continued)

Figure V Expenditures by Type of Service by Adult and Child (continued)

SFY2013	Adult Totals			Children Totals		
Type of Service	Expenditures	Members Served	Avg. per Adult	Expenditures	Members Served	Avg. per Child
Outpatient	$156,365,215	193,732	$807	$125,578,268	285,236	$440
Personal Care	$94,053,406	21,608	$4,353	$631,530	120	$5,263
Physician	$270,113,156	252,644	$1,069	$292,743,264	481,889	$607
Podiatry	$2,318,200	12,684	$183	$929,878	2,314	$402
Prescribed Drugs	$199,570,873	192,858	$1,035	$207,217,985	432,447	$479
Psychiatric Services	$361,968	449	$806	$107,383,706	6,496	$16,531
Residential Behavior Mgmt	$0	-	$0	$22,599,397	2,062	$10,960
Respite Care	$398,046	273	$1,458	$78,313	38	$2,061
Room and Board	$100,469	180	$558	$180,485	414	$436
School-Based Services	$0	-	$0	$7,007,613	8,201	$854
Specialized Foster Care/ID Services	$2,463,706	149	$16,535	$1,211,800	85	$14,256
Targeted Case Manager	$77,429,687	25,939	$2,985	$29,825,380	19,863	$1,502
Therapy Services	$1,504,710	3,070	$490	$11,843,349	10,096	$1,173
Transportation - Emergency	$31,069,119	61,373	$506	$10,921,288	23,327	$468
Transportation - Non-Emergency	$21,433,893	264,820	$81	$5,666,074	623,431	$9
X-Ray Services	$15,005,122	129,547	$116	$4,869,966	109,531	$44
Uncategorized Services	$844,023	82,967	$10	$351,192	9,578	$37
Total	**$2,644,257,745**	**367,448**	**$7,196**	**$1,596,657,803**	**657,658**	**$2,428**

Non-Member Specific Payments						
HSP - Indirect Medical Education (IME)	$30,449,271	-	-	$0	-	-
HSP - Graduate Medical Education (GME)	$10,151,208	-	-	$10,151,208	-	-
HSP - Acute DSH	$0	-	-	$42,696,630	-	-
HSP - Supplemental Payments	$0	-	-	$135,173,587	-	-
HSP - SHOPP	$0	-	-	$352,893,974	-	-
Behavioral Health Supplemental Payments	$0			$40,133,334		
EHR Incentive Payments	$0	-	-	$38,517,566	-	-
Capitated Services - GME to Medical Schools	$0	-	-	$93,666,695	-	-
Total	**$2,684,858,224**			**$2,309,890,797**		

Source: OHCA Financial Service Division, October 2013. Children are under age 21. Claim dollars were extracted from the MMIS claims history file for claims paid within the fiscal year. Financial statement data represents actual cash expenditures as reported to the Office of State Finance while MMIS data warehouse expenditure data is net of overpayments and adjustments.

Member Served figures are the unduplicated counts of members that received a service. If a member received services from multiple service type providers, they would be counted once for each type of service; the total count is the unduplicated count overall. A member may have claims under children and adult categories.

Appendix B Statewide Figures (continued)

Figure VI Expenditures by Type of Service by Benefit Type

Type of Service	SoonerCare Traditional	SoonerCare Choice	Insure Oklahoma IP & ESI*	SoonerPlan	SoonerCare Supplemental	HCBS Waivers**
Adult Day Care	$0	$0	$0	$0	$0	$4,452,096
Advanced Practice Nurse	$377,154	$2,860,179	$75,131	$5,148	$39,747	$0
ADvantage Home Delivered Meals	$0	$0	$0	$0	$0	$15,221,754
Ambulatory Surgical Services	$1,431,521	$7,239,017	$463,056	$61,370	$942,311	$483
Architectural Modification	$0	$0	$0	$0	$0	$352,790
Audiology Services	$19,751	$114,752	$990	$0	$3,911	$0
Behavioral Health Services	$49,182,735	$166,394,276	$429,213	$44	$25,833,556	$5,683,017
Capitated Services	$3,563,238	$28,855,095	$310,797	$0	$3,567,104	$0
Chiropractic Services	$0	$0	$0	$0	$8,039	$0
Clinic	$18,795,645	$62,598,278	$1,445,476	$856,962	$2,477,553	$8
Clinics - OSA Services	$2,025,620	$7,208,563	$23,877	$1,760,851	$62,443	$0
Community Mental Health	$5,911,787	$19,801,820	$181,275	$82	$7,805,946	$366
Dental	$21,745,276	$111,880,426	$71,847	$0	$4,240,394	$793,593
Direct Support	$0	$0	$0	$0	$0	$191,652,574
Employee Training Specialist	$0	$0	$0	$0	$0	$28,031,755
End-Stage Renal Disease	$2,341,832	$1,986,455	$7,147	$0	$2,292,637	$562
Eye Care and Exams	$3,828,542	$17,192,903	$101,025	$154	$589,987	$25
Eyewear	$1,187,008	$5,853,119	$390	$0	$32,399	$0
Self-Directed Care	$0	$0	$0	$0	$0	$5,542,651
Group Home	$0	$0	$0	$0	$0	$21,413,896
Home Health	$8,096,974	$11,309,545	$35	$0	$593,716	$188,399
Homemaker Services	$0	$0	$0	$0	$0	$1,928,639
Hospice	$40,994	$32,563	$0	$0	$0	$1,028,114
ICF-ID Services	$32,870,996	$70,417	$0	$0	$78,431,683	$0
Inpatient Services	$283,787,623	$284,006,342	$10,803,251	$10,017	$31,712,332	$6,231
Laboratory Services	$12,994,848	$31,544,970	$2,237,486	$1,055,651	$739,349	$0
Medicare Part A & B (Buy-In) Payments	$0	$0	$0	$0	$131,025,519	$0
Medicare Part D Payments	$0	$0	$0	$0	$77,694,210	$0
Mid-Level Practitioner	$53,482	$370,244	$12,754	$215	$982	$0
Medical Supplies/DMEPOS	$12,083,759	$23,028,105	$759,891	$2,274	$13,137,563	$21,589,363
Nursing Facility	$64,344,230	$664,980	$0	$0	$470,882,065	$262,414
Nursing Services	$0	$0	$0	$0	$0	$8,462,738
Nutritionist Services	$82,005	$7,819	$579	$0	$179,034	$678,373
Insure Oklahoma ESI Out-of-Pocket	$0	$0	$688,863	$0	$0	$0
Insure Oklahoma ESI Premium	$0	$0	$50,107,558	$0	$0	$0
Other Practitioner	$365	$3,134	$0	$0	$347	$0
Outpatient	$66,982,319	$190,010,418	$11,322,247	$967,500	$12,659,399	$1,600
Personal Care	$859,320	$2,433,647	$0	$0	$8,126,451	$83,265,518

Appendix B Statewide Figures (continued)

Figure VI Expenditures by Type of Service by Benefit Type (continued)

Type of Service	SoonerCare Traditional	SoonerCare Choice	Insure Oklahoma IP & ESI*	SoonerPlan	SoonerCare Supplemental	HCBS Waivers**
Physician	$117,732,403	$382,939,461	$14,770,629	$1,973,195	$43,354,242	$2,086,490
Podiatry	$546,444	$1,690,017	$145,214	$80	$866,299	$25
Prescribed Drugs	$93,333,990	$281,305,758	$18,010,045	$3,355,639	$3,777,348	$7,006,078
Psychiatric Services	$96,021,378	$11,460,999	$9,316	$0	$253,981	$0
Residential Behavior Mgmt	$22,494,205	$105,192	$0	$0	$0	$0
Respite Care	$0	$0	$0	$0	$0	$476,358
Room and Board	$82,393	$156,903	$0	$0	$41,657	$0
School-Based Services	$1,481,376	$5,520,551	$0	$0	$5,685	$0
Specialized Foster Care/ID Services	$0	$0	$0	$0	$0	$3,675,506
Targeted Case Manager	$34,282,455	$2,010,099	$0	$0	$18,137,606	$52,824,907
Therapy Services	$2,082,616	$9,865,696	$5,751	$984	$309,404	$1,083,609
Transportation - Emergency	$9,934,384	$16,784,164	$1,527	$426	$6,658,418	$8,611,488
Transportation - Non-Emergency	$2,015,360	$10,312,987	$0	$34,371	$14,737,248	$0
X-Ray Services	$4,243,118	$11,338,326	$1,102,143	$8,600	$3,182,788	$114
Uncategorized Services	$585,181	$58,141	$135,696	$0	$6,054	$410,144
Total	**$977,442,327**	**$1,709,015,361**	**$113,223,210**	**$10,093,563**	**$964,409,408**	**$466,731,679**
Unduplicated Members Served	490,265	697,737	42,398	77,213	104,644	27,398
Average Cost Per Member Served	$1,994	$2,449	$2,670	$131	$9,216	$17,035

Source: OHCA Financial Service Division, October 2013. *Insure Oklahoma IP and ESI includes $688,863 Insure Oklahoma ESI Out-of-Pocket; $54,800,820 Insure Oklahoma ESI Premium payments. ** HCBS expenditures include all services paid to waiver members. HCBS members may receive services paid through Title XIX funds.

In order to provide a more accurate average cost per member, non-member specific supplemental payments have been removed from the above. Those payments include $352,893,974 in Supplemental Hospital Offset Payment Program (SHOPP); $228,621,903 in hospital supplemental payments (includes hospital supplemental payments, DSH, GME and IME); $93,666,695 in GME payments; $38,517,566 in EHR payments; and $40,133,334 in outpatient behavioral health supplemental payments.

Claim dollars were extracted from the MMIS claims history file for claims paid within the fiscal year. Financial statement data represents actual cash expenditures as reported to the Office of State Finance while MMIS data warehouse expenditure data is net of overpayments and adjustments.

Member Served figures are the unduplicated counts of members per benefit plan that received a service. A member may be counted in more than one benefit plan.

State Fiscal Year Average Cost Per Member Served with Supplemental Payments Removed*	SoonerCare Traditional **	SoonerCare Choice	Insure Oklahoma IP & ESI	SoonerPlan	SoonerCare Supplemental	HCBS Waivers
SFY2009	$2,606	$2,383	$1,695	$241	$9,965	$15,860
SFY2010	$2,370	$2,421	$2,326	$273	$8,013	$16,647
SFY2011	$2,327	$2,325	$2,406	$270	$9,008	$16,950
SFY2012	$1,907	$2,422	$2,677	$291	$8,896	$16,597
SFY2013	$1,994	$2,449	$2,670	$131	$9,216	$17,035

Source: OHCA Financial Service Division, October 2013. *Non-member specific supplemental payments have been removed to obtain actual per member served costs. **The SoonerCare Traditional unduplicated member served count in prior Annual Reports was inflated due to members belonging to multiple benefit packages. Additionally, in previous Annual Reports, Medicare Part A & B and D costs were in the Traditional category and later moved to SoonerCare Supplemental; SoonerCare Supplemental was redefined and all dual eligible services were moved to the SoonerCare Supplemental category in 2011. To be comparable, all per member served costs above have been adjusted to the current categories. A historic comparison with the corrected data is presented above.

Appendix B Statewide Figures (continued)

Figure VII Expenditures by Type of Service by Aid Category

Type of Service	Aged	Blind / Disabled	TANF/ Parents & Children	Oklahoma Cares	Sooner-Plan	TEFRA	Other Total*
Adult Day Care	$1,963,855	$2,488,241	$0	$0	$0	$0	$0
Advanced Practice Nurse	$18,169	$457,667	$2,787,675	$4,617	$5,148	$293	$83,791
ADvantage Home Delivered Meals	$8,022,422	$7,199,332	$0	$0	$0	$0	$0
Ambulatory Surgical Services	$538,974	$1,930,195	$7,106,500	$29,272	$61,370	$6,685	$464,764
Architectural Modification	$60,807	$291,983	$0	$0	$0	$0	$0
Audiology Services	$1,624	$20,604	$116,017	$0	$0	$94	$1,064
Behavioral Health	$4,492,676	$65,323,446	$177,084,790	$66,809	$44	$56,612	$498,464
Capitated Services	$3,876,312	$2,625,934	$29,444,112	$22,283	$0	$16,795	$310,797
Chiropractic Services	$3,126	$4,912	$0	$0	$0	$0	$0
Clinic	$1,098,667	$14,682,974	$66,109,488	$273,762	$856,962	$13,172	$3,138,896
Clinics - OSA Services	$217	$722,279	$8,455,578	$31,869	$1,760,851	$62,663	$47,897
Community Mental Health	$657,282	$16,603,855	$16,179,795	$44,949	$82	$2,708	$212,605
Dental	$887,479	$12,305,462	$125,344,841	$52,191	$0	$32,641	$108,920
Direct Support	$5,545,035	$186,107,540	$0	$0	$0	$0	$0
Employee Training Specialist	$525,724	$27,506,031	$0	$0	$0	$0	$0
End-Stage Renal Disease	$796,759	$5,541,283	$283,238	$205	$0	$0	$7,147
Eye Care and Exams	$352,984	$1,821,112	$19,417,578	$4,829	$154	$5,963	$110,016
Eyewear	$15,005	$509,242	$6,533,668	$0	$0	$11,763	$3,237
Self Directed Care	$2,510,541	$3,032,110	$0	$0	$0	$0	$0
Group Home	$1,022,877	$20,391,019	$0	$0	$0	$0	$0
Home Health	$390,624	$14,430,253	$3,160,957	$26,246	$0	$2,180,554	$35
Homemaker Services	$15,633	$1,913,006	$0	$0	$0	$0	$0
Hospice	$63,819	$1,010,033	$24,551	$0	$0	$3,267	$0
ICF-ID Services	$7,569,039	$103,586,982	$214,193	$0	$0	$2,881	$0
Inpatient Services	$21,610,596	$248,284,727	$325,618,868	$2,305,592	$10,017	$255,326	$12,240,668
Laboratory Services	$445,612	$11,283,551	$32,006,307	$480,453	$1,055,651	$10,199	$3,290,533
Medicare Part A & B (Buy-In) Payments	$120,872,488	$10,153,032	$0	$0	$0	$0	$0
Medicare Part D Payments	$77,694,210	$0	$0	$0	$0	$0	$0
Mid-Level Practitioner	$2,101	$76,709	$344,970	$870	$215	$58	$12,754
Medical Supplies/DMEPOS	$16,081,574	$42,482,379	$10,496,063	$68,427	$2,274	$690,412	$779,826
Nursing Facility	$403,648,933	$132,197,580	$288,679	$18,498	$0	$0	$0
Nursing Services	$1,874,171	$6,588,567	$0	$0	$0	$0	$0
Nutritionist Services	$41,591	$896,691	$8,259	$0	$0	$690	$579
Insure Oklahoma ESI Out-of-Pocket	$0	$0	$0	$0	$0	$0	$688,863
Insure Oklahoma ESI Premium	$0	$0	$0	$0	$0	$0	$50,107,558
Other Practitioner	$0	$438	$3,409	$0	$0	$0	$0
Outpatient	$5,919,752	$73,350,104	$184,956,891	$4,561,935	$967,500	$266,646	$11,920,657
Personal Care	$51,476,370	$43,159,753	$16,733	$0	$0	$32,081	$0
Physician	$21,080,106	$130,915,624	$383,812,964	$6,831,289	$1,973,195	$710,651	$17,532,592
Podiatry	$495,683	$1,410,224	$1,184,596	$11,603	$80	$434	$145,458
Prescribed Drugs	$3,773,097	$180,593,441	$198,273,639	$1,423,630	$3,355,639	$1,016,907	$18,352,504
Psychiatric Services	$328,781	$25,883,393	$81,263,362	$0	$0	$238,801	$31,338

Appendix B Statewide Figures (continued)

Figure VII Expenditures by Type of Service by Aid Category (continued)

Type of Service	Aged	Blind / Disabled	TANF/ Parents & Children	Oklahoma Cares	Sooner-Plan	TEFRA	Other Total*
Residential Behavior Mgmt	$0	$1,304,837	$21,272,024	$0	$0	$0	$22,536
Respite Care	$230,799	$245,559	$0	$0	$0	$0	$0
Room and Board	$8,034	$73,631	$193,491	$5,798	$0	$0	$0
School-Based Services	$0	$2,955,239	$3,857,443	$0	$0	$194,931	$0
Specialized Foster Care/ID Services	$72,650	$3,602,856	$0	$0	$0	$0	$0
Targeted Case Manager	$29,885,730	$51,164,195	$26,192,352	$0	$0	$437	$12,355
Therapy Services	$165,284	$3,699,743	$9,181,635	$2,393	$984	$292,270	$5,751
Transportation - Emergency	$3,913,630	$23,061,370	$14,887,982	$64,391	$426	$7,483	$55,126
Transportation - Non-Emergency	$7,355,722	$17,121,917	$2,501,095	$3,955	$34,371	$74,558	$8,349
X-Ray Services	$1,610,291	$7,383,025	$9,316,812	$364,065	$8,600	$5,602	$1,186,693
Uncategorized Services	$48,986	$412,602	$17,093	$5	$0	$0	$716,531
Total	**$809,065,839**	**$1,508,806,684**	**$1,767,957,646**	**$16,699,936**	**$10,093,563**	**$6,193,577**	**$122,098,302**
Unduplicated Members Served	55,507	128,006	761,688	2,344	77,213	518	52,276
Average Cost Per Member Served	$14,576	$11,787	$2,321	$7,125	$131	$11,957	$2,336

Source: OHCA Financial Service Division, October 2013. *Other includes $352,893,974 in Supplemental Hospital Offset Payment Program (SHOPP) and $228,621,903 in hospital supplemental payments (includes hospital supplemental payments, DSH, GME and IME); and $40,133,134 in outpatient behavioral health supplemental payments. $93,666,695 in GME payments; $38,517,566 in EHR payments; $688,863 Insure Oklahoma ESI Out-of-Pocket; $54,800,821 Insure Oklahoma ESI Premium payments; and $64,151,645 in Insure Oklahoma IP payments; and $10,835,471 in other/misc. aid categories. Claim dollars were extracted from the MMIS claims history file for claims paid within the fiscal year. Financial statement data represents actual cash expenditures as reported to the Office of State Finance while MMIS data warehouse expenditure data is net of overpayments and adjustments.

Member Served figures are the unduplicated counts of members per aid category that received a service. A member may be counted in more than one aid category.

Appendix B Statewide Figures (continued)

Figure VIII Children (Under 21) Expenditures by Type of Service by Aid Category

Type of Service	Blind/ Disabled/ TEFRA	State Custody	CHIP	TANF	Other Aid Categories*
Adult Day Care	$28,277	$11,263	$0	$0	$0
Advanced Practice Nurse	$82,104	$88,219	$308,371	$1,977,431	$4,295
Ambulatory Surgical Services	$274,512	$389,594	$782,630	$4,678,899	$4,064
Architectural Modification	$2,301	$926	$0	$0	$0
Audiology Services	$12,186	$13,619	$12,902	$87,854	$73
Behavioral Health Services	$18,038,103	$30,284,440	$19,228,743	$117,881,521	$94,472
Capitated Services	$934,806	$22,764	$3,481,865	$22,570,942	$14,157
Clinic	$2,027,221	$2,508,972	$7,625,743	$39,090,534	$406,051
Clinics - OSA Services	$644,014	$624,588	$654,031	$5,918,492	$392,112
Community Mental Health	$2,105,365	$2,210,119	$1,902,613	$9,204,185	$33,309
Dental	$4,757,581	$7,474,791	$21,246,443	$86,106,379	$59,816
Direct Support	$6,180,336	$6,642,728	$0	$0	$0
Employee Training Specialist	$532,148	$213,298	$0	$0	$0
End-Stage Renal Disease	$15,099	$0	$0	$11,064	$0
Eye Care and Exams	$939,030	$1,492,142	$3,664,518	$13,956,342	$14,211
Eyewear	$458,727	$551,036	$1,180,741	$4,851,422	$3,237
Group Home	$582,142	$273,308	$0	$0	$0
Home Health	$12,178,920	$1,581,442	$247,691	$1,750,250	$0
Homemaker Services	$137,301	$154,268	$0	$0	$0
Hospice	$27,703	$0	$354	$18,416	$0
ICF-ID Services	$2,908,167	$519,972	$0	$67,250	$0
Inpatient Services	$38,473,839	$35,370,866	$12,655,302	$166,575,507	$493,144
Laboratory Services	$799,399	$668,678	$1,484,387	$12,745,757	$427,067
Mid-Level Practitioner	$11,753	$14,920	$49,577	$243,228	$18
Medical Supplies/DMEPOS	$10,212,183	$2,006,883	$1,347,159	$5,945,206	$25,147
Nursing Facility	$417,464	$122,597	$0	$58,170	$0
Nutritionist Services	$4,855	$1,689	$1,985	$3,802	$0
Other Practitioner	$150	$90	$0	$541	$0
Outpatient	$9,867,589	$6,501,957	$16,187,666	$92,650,217	$370,840
Personal Care	$593,555	$28,034	$563	$9,378	$0
Physician	$22,961,022	$18,505,817	$33,509,321	$216,870,083	$897,021
Podiatry	$84,507	$59,618	$184,774	$599,369	$1,611
Prescribed Drugs	$50,019,670	$23,552,547	$25,837,812	$106,995,557	$812,399
Psychiatric Services	$23,243,195	$25,770,329	$8,466,528	$49,872,316	$31,338
Residential Behavior Mgmt	$78,537	$22,061,142	$0	$445,547	$14,171
Respite Care	$5,948	$72,365	$0	$0	$0
Room and Board	$13,139	$5,149	$13,067	$149,130	$0
School-Based Services	$2,872,496	$804,630	$623,218	$2,707,270	$0

Appendix B Statewide Figures (continued)

Figure VIII Children (under 21) Expenditures by Type of Service by Aid Category (continued)

Type of Service	Blind/ Disabled/ TEFRA	State Custody	CHIP	TANF	Other Aid Categories*
Specialized Foster Care/ID Services	$425,900	$785,900	$0	$0	$0
Targeted Case Manager	$1,951,867	$25,283,205	$357,144	$2,222,718	$10,446
Therapy Services	$2,584,943	$1,126,464	$1,342,238	$6,789,545	$160
Transportation - Emergency	$1,275,200	$868,896	$826,478	$7,931,829	$18,886
Transportation - Non-Emergency	$2,975,825	$332,806	$371,141	$1,985,408	$894
X-Ray Services	$397,299	$260,936	$744,489	$3,438,149	$29,092
Uncategorized Services	$241,067	$32,196	$6,701	$12,764	$58,464
Grand Total	**$222,377,444**	**$219,295,201**	**$164,346,196**	**$986,422,471**	**$4,216,492**
Unduplicated Members Served	24,963	43,492	149,163	575,253	12,755
Average Cost Per Member Served	$8,908	$5,042	$1,102	$1,715	$331

Source: OHCA Financial Service Division, October 2013. Child figures are for individuals under the age of 21.

*Other Aid Categories include Oklahoma Cares, SoonerPlan, STBS and Insure Oklahoma college members and dependents younger than age 21. Supplemental payments not listed in the above table include $581,515,877 in Supplemental Hospital Offset Payment Program (SHOPP)/GME/DSH and hospital supplemental payments and $40,133,334 in outpatient behavioral health supplemental payments. $93,666,695 in GME payments; $38,517,566 in EHR payments. Claim dollars were extracted from the MMIS claims history file for claims paid within the fiscal year. Financial statement data represents actual cash expenditures as reported to the Office of State Finance while MMIS data warehouse expenditure data is net of overpayments and adjustments.

**Member Served figures are the unduplicated counts of members per aid category that received a service. A member may be counted in more than one aid category.

Appendix B Statewide Figures (continued)

Figure IX Home and Community-Based Services Waiver Expenditures by Type of Service

Home and Community-Based Services (HCBS)*	Total	ADvantage	Community	Homeward Bound	In-Home Support
Adult Day Care	$4,452,096	$2,503,935	$1,307,286	$462	$635,876
ADvantage Home Delivered Meals	$15,221,754	$15,080,273	$0	$0	$0
Ambulatory Surgical Services	$483	$483	$0	$0	$0
Architectural Modification	$352,790	$159,006	$90,452	$41,924	$17,961
Behavioral Health	$5,683,017	$328	$4,569,506	$927,071	$148,149
Clinic	$8	$8	$0	$0	$0
Community Mental Health	$366	$110	$21	$0	$235
Dental	$793,593	$0	$404,878	$314,320	$68,762
Direct Support	$191,652,574	$0	$97,883,235	$76,329,702	$16,831,674
Employee Training Specialist	$28,031,755	$0	$20,248,224	$4,316,419	$3,303,342
End Stage Renal Disease	$562	$562	$0	$0	$0
Eye Care and Exam	$25	$25	$0	$0	$0
Self-Directed Care	$5,542,651	$5,505,362	$0	$0	$0
Group Home	$21,413,896	$0	$20,353,534	$104,671	$0
Home Health Services	$188,399	$0	$0	$0	$0
Homemaker Services	$1,928,639	$0	$1,640,030	$188,220	$100,388
Hospice	$1,028,114	$989,602	$0	$0	$0
Inpatient Services	$6,231	$6,231	$0	$0	$0
Medical Supplies/DMEPOS	$21,589,363	$17,272,776	$2,542,211	$771,525	$663,223
Nursing Facility	$262,414	$262,414	$0	$0	$0
Nursing Services	$8,462,738	$3,547,773	$2,120,492	$1,451,486	$0
Nutritionist Services	$678,373	$0	$446,404	$221,299	$5,760
Outpatient	$1,600	$1,575	$25	$0	$0
Personal Care	$83,265,518	$81,754,728	$0	$0	$0
Physician	$2,086,490	$9,275	$1,440,863	$544,103	$56,823
Podiatry	$25	$25	$0	$0	$0
Prescribed Drugs	$7,006,078	$5,473,922	$929,360	$155,337	$300,147
Respite Care	$476,358	$323,339	$140,583	$5,292	$900
Specialized Foster Care/ID Services	$3,675,506	$0	$3,585,556	$89,950	$0
Targeted Case Manager	$52,824,907	$51,663,920	$0	$0	$0
Therapy Services	$1,083,609	$4,198	$711,909	$300,822	$57,573
Transportation Services	$8,611,488	$330	$5,432,748	$2,499,790	$633,288
X-Ray Services	$114	$114	$0	$0	$0
Uncategorized Services	$410,144	$0	$6,959	$0	$400,785
Total	**$466,731,679**	**$184,560,314**	**$163,854,275**	**$88,262,394**	**$23,224,886**
Unduplicated Members Served	$27,398	$21,681	$2,849	$709	$1,742
Average Cost Per Member Served	$17,035	$8,513	$57,513	$124,489	$13,332

Source: OHCA Financial Service Division, October 2013. Claim dollars were extracted from the MMIS claims history file for claims paid within the fiscal year. Financial statement data represents actual cash expenditures as reported to the Office of State Finance while MMIS data warehouse expenditure data is net of overpayments and adjustments.

*Services above are all services paid with HCBS waiver funds. Members may receive services paid through Title XIX funds.

**Unduplicated Member Served figures are the unduplicated counts of members that received a service.

Appendix B Statewide Figures (continued)

Figure IX Home and Community-Based Services Waiver Expenditures by Type of Service (continued)

Home and Community-Based Services (HCBS)*	Living Choice	Medically Fragile	My Life, My Choice	Sooner Seniors
Adult Day Care	$4,536	$0	$0	$0
ADvantage Home Delivered Meals	$63,040	$9,287	$48,585	$20,569
Ambulatory Surgical Services	$0	$0	$0	$0
Architectural Modification	$41,521	$1,925	$0	$0
Behavioral Health	$37,964	$0	$0	$0
Clinic	$0	$0	$0	$0
Community Mental Health	$0	$0	$0	$0
Dental	$5,632	$0	$0	$0
Direct Support	$607,964	$0	$0	$0
Employee Training Specialist	$163,770	$0	$0	$0
End Stage Renal Disease	$0	$0	$0	$0
Eye Care and Exam	$0	$0	$0	$0
Self-Directed Care	$0	$37,289	$0	$0
Group Home	$955,691	$0	$0	$0
Home Health Services	$0	$188,399	$0	$0
Homemaker Services	$0	$0	$0	$0
Hospice	$0	$38,512	$0	$0
Inpatient Services	$0	$0	$0	$0
Medical Supplies/DMEPOS	$109,333	$146,150	$55,044	$29,102
Nursing Facility	$0	$0	$0	$0
Nursing Services	$60,905	$1,237,820	$33,245	$11,016
Nutritionist Services	$4,911	$0	$0	$0
Outpatient	$0	$0	$0	$0
Personal Care	$529,414	$367,698	$442,494	$171,184
Physician	$35,425	$0	$0	$0
Podiatry	$0	$0	$0	$0
Prescribed Drugs	$48,521	$63,222	$33,299	$2,271
Respite Care	$534	$3,103	$1,969	$639
Specialized Foster Care/ID Services	$0	$0	$0	$0
Targeted Case Manager	$778,452	$126,161	$178,904	$77,469
Therapy Services	$8,175	$933	$0	$0
Transportation Services	$45,332	$0	$0	$0
X-Ray Services	$0	$0	$0	$0
Uncategorized	$2,400	$0	$0	$0
Total	**$3,503,519**	**$2,220,500**	**$793,540**	**$312,251**
Unduplicated Members Served	$240	$50	$86	$41
Average Cost Per Member Served	$14,598	$44,410	$9,227	$7,616

Source: OHCA Financial Service Division, October 2013. For more information on each waiver, visit the *Primer*. Claim dollars were extracted from the MMIS claims history file for claims paid within the fiscal year. Financial statement data represents actual cash expenditures as reported to the Office of State Finance while MMIS data warehouse expenditure data is net of overpayments and adjustments.

*Services above are all services paid with HCBS waiver funds. Members may receive services paid through Title XIX funds.

**Unduplicated Member Served figures are the unduplicated counts of members that received a service.

Appendix B Statewide Figures (continued)

Figure X Behavioral Health Expenditures by Type of Service by Children and Adults

Children Younger than Age 21 Type of Service	Expenditures[1]	Members Served[2]	Average per Member Served
Inpatient (Acute - General)	$3,006,581	1,474	$2,040
Inpatient (Acute - Freestanding)	$7,867,960	2,348	$3,351
Psychiatric Residential Treatment Facility (PRTF)	$99,017,054	4,656	$21,267
Outpatient	$187,032,444	78,684	$2,377
Psychologist	$9,103,532	12,727	$715
Psychiatrist	$3,482,303	9,075	$384
Residential Behavior Management Services (Group)	$6,846,970	990	$6,916
Residential Behavior Management Services (TFC)	$13,072,032	1,177	$11,106
Targeted Case Management (TCM)	$5,038,898	15,839	$318
Other Outpatient Behavioral Health Services	$468,812	287	$1,633
Psychotropic Drugs[3]	$71,135,473	57,619	$1,235
Total[4]	**$406,072,058**	**90,336**	**$4,495**

Adults Aged 21 and Older Type of Service	Expenditures[1]	Members Served[2]	Average per Member Served
Inpatient (Acute - General)	$9,413,293	2,822	$3,336
Inpatient (Acute - Freestanding)	$913,060	42	$21,740
Psychiatric Residential Treatment Facility (PRTF)	$0	-	$0
Outpatient	$72,347,401	37,690	$1,920
Psychologist	$2,362,185	1,797	$1,315
Psychiatrist	$3,781,924	11,306	$335
Residential Behavior Management Services (Group)	$0	-	$0
Residential Behavior Management Services (TFC)	$0	-	$0
Targeted Case Management (TCM)	$3,155,549	16,634	$190
Other Outpatient Behavioral Health Services	$2,971,991	1,082	$2,747
Psychotropic Drugs[3]	$43,823,222	83,576	$524
Total[4]	**$138,768,625**	**47,899**	**$2,897**
Total Behavioral Health Services Listed Above[4]	**$544,840,683**	**137,789**	**$3,954**

Source: OHCA Financial Service Division, October 2013. Claim dollars were extracted from the MMIS claims history file for claims paid within the fiscal year. Financial statement data represents actual cash expenditures as reported to the Office of State Finance while MMIS data warehouse expenditure data is net of overpayments and adjustments. Residential behavior management services (TFC) represents therapeutic foster care.

1. Categories reported above do not include all potential expenditures/costs related to a behavioral health diagnosis. Physician, emergency room care, etc. are not included in any of the above figures.

2. Member Served figures are the unduplicated counts of members that received a service. If a member received services from multiple service type providers, they would be counted once for each type of service; the total count is the unduplicated count overall.

3. Prescription claims are not coded with diagnostic information and drugs used to treat behavioral health conditions may be used for some physical health conditions as well. This figure includes all uses of the drugs included within the behavioral health categories.

4. Psychotropic drug expenditures and member counts are not included in totals.

Appendix C SoonerCare Provider Network

Provider Network	SFY2013
Adult Day Care	52
Advance Practice Nurse	1,557
Advantage Home Delivery Meal	18
Ambulatory Surgical Center (ASC)	55
Anesthesiology Assistant	4
Audiologist	109
Behavioral Health Provider	10,425
Capitation Provider - IHS (Indian Health Services) Case Manager	89
Capitation Provider - PACE (Program of All-Inclusive Care for the Elderly)	2
Case Manager	59
Certified Registered Nurse Anesthetist (CRNA)	995
Chiropractor	37
Clinic - Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	3
Clinic - Family Planning Clinic	4
Clinic - Federally Qualified Health Clinic (FQHC)	60
Clinic - Native American	61
Clinic - Rural Health	13
Clinic - Tuberculosis	2
Community Mental Health Center (CMHC)	112
County/City Health Department	3
DDSD - Architectural Modification	35
DDSD - Community Transition Services	52
DDSD - Employee Training Specialist	89
DDSD - Group Home	43
DDSD - Homemaker Services	109

Provider Network	SFY2013
DDSD - Volunteer Transportation Provider	289
Dentist	1,448
Direct Support Services	271
DME/Medical Supply Dealer	1,283
End-Stage Renal Disease Clinic	112
Extended Care and Skilled Nursing Facilities	275
Extended Care Facility - Facility Based Respite Care	106
Extended Care Facility - ICF/ID	89
Genetic Counselor	9
Home Health Agency	216
Hospital - Acute Care	966
Hospital - Critical Access	129
Hospital - Native American	7
Hospital - Psychiatric	19
Hospital - Resident Treatment Center	49
Laboratory	257
Lactation Consultant	49
Long-Term Care Authority Hospice	66
Maternal/Child Health LCSW	14
Nursing Agency - Non-Skilled	48
Nursing Agency - Skilled	55
Nutritionist	169
Optician	62
Optometrist	654
Outpatient Behavioral Health Agency	524
Personal Care Services	1,001
Pharmacy	1,238
Physician - Allergist	44
Physician - Anesthesiologist	1,312

Provider Network	SFY2013
Physician Assistant	1,131
Physician - Cardiologist	684
Physician - General/Family Medicine	2,880
Physician - General Pediatrician	1,740
Physician - General Surgeon	797
Physician - Internist	2,231
Physician - Obstetrician/ Gynecologist	771
Physician - Other Specialist	6,081
Physician - Pediatric Specialist	1,518
Physician - Radiologist	1,726
Preadmission Screening and Resident Review (PASRR)	7
Program for Assertive Community Treatment (PACT)	14
Psychologist	374
Residential Behavior Management Services (RBMS)	19
Respite Care	102
Room and Board	20
School Corporation	250
Specialized Foster Care/ID	210
Therapist - Occupational	229
Therapist - Physical	558
Therapist - Speech/Hearing	653
Transportation Provider	319
X-Ray Clinic	50

* Provider Network is providers who contracted to provide health care services by locations, programs, types, and specialties. Providers are being count multiple times if they have multiple locations, programs, types, and specialties. Whether the provider is an individual or an institution, if the provider has multiple location code (last digit of the provider ID) they are being counted that many times. The term "contracted" is defined as a provider that was enrolled with Oklahoma SoonerCare within SFY2013, it does not necessarily indicate participation or that a provider has provided services. Some of the above provider counts are grouped by the subcategory of provider specialty; therefore, a provider may be counted multiple times if they have multiple provider types and/or specialties.

Due to federal regulations, the OHCA must have an approved agreement on file for all providers providing care to our members. To meet this requirement we are directly contracting with providers that refer/order services, prescribing prescription and provider that had previously billed through a group or agency. The Behavioral Health Providers contributed to the increase in the provider counts.

Appendix D Board-Approved Rules

Board Approval Date	Rule Description	Estimated Savings/Total Cost/State Share	Effective Date
6/14/2012	Rules are amended to provide exceptions for members of the Homeward Bound Waiver for Habilitation Training Specialist (HTS) services exceeding 40 hours per week, when the HTS resides in the same home as the member. APA WF# 12-01A	Budget neutral	Jul-20-2012
6/14/2012	The rule revision will allow the HTS to provide more than 40 hours of service per week, when the HTS resides in the same home as the member. The rule revision is promulgated as the result of a lawsuit filed on behalf of class members of the Homeward Bound waiver. APA WF# 12-01B	Budget neutral	Jul-20-2012
11/1/2012	Rules are amended to increase the income cap for the Medicaid Income Pension Trust (or Miller Trust) to the average monthly cost of nursing home care. This change affects financial eligibility rules for all long term care programs, including the 1915(c) waiver programs for Home and Community Based Services. APA WF# 12-06	Budget neutral	Dec-13-2012
12/13/2012	Agency policy on therapy services is revised to comply with federal law, which requires a prescription or referral from a physician or practitioner of the healing arts before therapy services are rendered. Policy is also revised to require a prior authorization for speech therapy services. APA WF# 12-07	Budget savings of approximately $25,000	Jan-14-2013
12/13/2012	Policy is amended to match state law and current agency operational requirements that parental or legal guardian consent must be given prior to rendering services to a minor child. APA WF# 12-08	Budget neutral	Jan-14-2013
12/13/2012	Policy will be amended to allow 100% payment of Medicare Crossover deductibles and coinsurance at skilled nursing facilities. Current policy allows payment at the Medicaid rate, which was previously adjusted to 0%. The rationale behind current policy is based on a federal policy that allowed federal reimbursement/write-offs for bad debts. That federal policy is no longer in effect and has prompted the policy amendment request. APA WF# 12-09	Budget neutral	Jan-28-2013
12/13/2012	Over the past two years, the Agency has observed a dramatic increase in the amount of Behavioral Health Rehabilitation Services delivered to SoonerCare members, prompting the Agency to examine the appropriateness and quality of the services being delivered. It was discovered that an overwhelming amount of Psychosocial Rehabilitation Services (PSR), a type of BHR, were being delivered to children under the age of 6 while research shows that PSR is not an effective treatment modality for children in this age range experiencing emotional or behavioral disorders. The Agency is proposing rule revisions to deny reimbursement for PSR services for children below age 6 unless services are medically necessary and required pursuant to Federal Early and Periodic Screening Diagnostic and Treatment (EPSDT) laws. The Agency is also proposing rule revisions which will control utilization of Rehabilitation services by imposing limits on the number of units that qualified providers will be reimbursed. The utilization limits will be prior authorized by OHCA or its designated agent and will be directly correlated to the individual member's level of need. APA WF# 12-19	$1.2 million in state savings (ODMHSAS), $4 million in federal savings, $5.2 million total savings	Jan-14-2013
3/14/2013	Revising rules to allow the HTS to provide more than 40 hours of service per week, when the HTS resides in the same home as the member. The rule revision is promulgated as the result of a lawsuit filed on behalf of class members of the Homeward Bound waiver. APA WF# 12-01A	Budget neutral	Jul-1-2013

Appendix D Board-Approved Rules (continued)

Board Approval Date	Rule Description	Estimated Savings/Total Cost/State Share	Effective Date
3/14/2013	The rule revision will allow the HTS to provide more than 40 hours of service per week, when the HTS resides in the same home as the member. The rule revision is promulgated as the result of a lawsuit filed on behalf of class members of the Homeward Bound waiver. APA WF# 12-01B	Budget neutral	Jul-1-2013
3/14/2013	Rules are amended to increase the income cap for the Medicaid Income Pension Trust (or Miller Trust) to the average monthly cost of nursing home care. This change affects financial eligibility rules for all long term care programs, including the waiver programs for Home and Community Based Services. APA WF# 12-06	$4.3 million state share, $7.7 million federal share, $12 million total	Jul-1-2013
3/14/2013	Agency policy on therapy services is revised to comply with federal law, which requires a prescription or referral from a physician or practitioner of the healing arts before therapy services are rendered. Policy is also revised to require a prior authorization for speech therapy services. APA WF# 12-07	Budget neutral	Jul-1-2013
3/14/2013	Policy is amended to allow 100% payment of Medicare Crossover deductibles and coinsurance at skilled nursing facilities. Current policy allows payment at the Medicaid rate, which was previously adjusted to 0%. The rationale behind current policy is based on a federal policy that allowed federal reimbursement/write-offs for bad debts. That federal policy is no longer in effect and has prompted the policy amendment request. APA WF# 12-09	Budget neutral	Jul-1-2013
3/14/2013	Over the past two years, the Agency has observed a dramatic increase in the amount of Behavioral Health Rehabilitation Services delivered to SoonerCare members, prompting the Agency to examine the appropriateness and quality of the services being delivered. It was discovered that an overwhelming amount of Psychosocial Rehabilitation Services (PSR), a type of BHR, were being delivered to children under the age of 6 while research shows that PSR is not an effective treatment modality for children in this age range experiencing emotional or behavioral disorders. The Agency is proposing rule revisions to deny reimbursement for PSR services for children below age 6 unless services are medically necessary and required pursuant to Federal Early and Periodic Screening Diagnostic and Treatment (EPSDT) laws. The Agency is also proposing rule revisions which will control utilization of Rehabilitation services by imposing limits on the number of units that qualified providers will be reimbursed. The utilization limits will be prior authorized by OHCA or its designated agent and will be directly correlated to the individual member's level of need. APA WF# 12-19	$1.2 million in state savings (ODMHSAS), $4 million in federal savings, $5.2 million total savings	Jul-1-2013
3/14/2013	Rural Health Clinics policy is revised to allow RHC's to bill lab services separately, as they can under Medicare. RHC policy is also updated to eliminate language that is inapplicable to OHCA's current operational practices. APA WF# 12-03	Budget neutral	Jul-1-2013
3/14/2013	OHCA rules for the ADvantage Waiver are revised to establish a maximum annual reimbursement cap for Hospice services in order to prevent members from exceeding the individual waiver cost limit. Currently hospice service expenditures are the primary basis for members exceeding the individual ADvantage Waiver cost limit. Rules are also revised to disallow an active Power of Attorney from being a paid caregiver for members self-directing their services, increase the maximum hours of Adult Day Health Services from six hours per day to eight hours per day and add Skilled Nursing as an allowable service. APA WF# 12-04A	Budget neutral	Jul-1-2013

Appendix D Board-Approved Rules (continued)

Board Approval Date	Rule Description	Estimated Savings/Total Cost/State Share	Effective Date
3/14/2013	OHCA rules for the ADvantage Waiver are revised to add Skilled Nursing as an allowable service within the waiver. Currently Skilled Nursing services are only available as a part of the member's limited home health benefit. The addition of Skilled Nursing services will be used to address member acute care needs, potentially lowering the rate of hospitalization among members. Finally, rules are revised to clarify criteria for member health and safety, clarify the member/provider dispute resolution process and include other minor policy clarifications. APA WF# 12-04B	$193,539 state share, $344,404 federal share, $537,943 total	Jul-1-2013
3/14/2013	OHCA rules for the Living Choice demonstration program are revised to include clarification for the billing of Institutional Case Management Transition services and the inclusion of additional services for persons with physical disabilities and long term illnesses. Additional services added are Assisted Living Services and Private Duty Nursing. Assisted Living Services are services such as personal care and other supportive services furnished to members in an OHCA certified assisted living center. Rules are also revised to add an option for self-direction. Self-direction allows members, as the employer of record, to hire individual providers for Personal Care services, Advanced Supportive/Restorative services and Respite services. APA WF# 12-05	$5800 state share, $26,320 federal share, $32,120 total	Jul-1-2013
3/14/2013	Agency policy is revised to remove references to the ICD-9 International Classification of Diseases diagnosis coding, which is being replaced by a new system of coding, ICD-10. APA WF# 12-13	Budget neutral	Jul-1-2013
3/14/2013	Rules for Nurse Midwifes and Birthing Center services are being revised to align with current obstetric policy. Proposed changes include clarification concerning the type of nurse midwife approved to provide SoonerCare coverage, and the coverage the nurse midwife can provide to eligible members. Additionally, proposed revisions include clean-up to remove language that references outdated practices concerning enrollment, and format changes for consistency and clarity purposes. APA WF# 12-14	Budget neutral	Jul-1-2013
3/14/2013	Rules for Telemedicine are being revised to include specific provider responsibilities to assure compliance with HIPAA guidelines. Current policy is silent to appropriate HIPAA compliant applications, guidelines, devices, and/or safeguards concerning telemedicine services. The proposed revisions include additional conditions that apply to services rendered via telemedicine, provider responsibilities, and additional network standards as they relate to assuring HIPAA compliance during telemedicine related transmissions. APA WF# 12-20	Budget neutral	Jul-1-2013
3/14/2013	Rules are revised to update ambulance transportation policy for clarity and consistency. Proposed revisions add a definition for emergency, and include language that will require a prior authorization for out of state transports. Additional revisions include clean-up to remove outdated policy to align with current practice and to clarify medically necessity requirements for air ambulance services. APA WF# 12-22	Budget neutral	Jul-1-2013
3/14/2013	SoonerCare transportation and subsistence rules are revised to clarify OHCA's current policy concerning meals and lodging, and eligibility. Proposed revisions include eligibility requirements for escorts if SoonerCare member is removed from his/her home and appointed a temporary guardian. APA WF# 12-23B	Budget neutral	Jul-1-2013

Appendix D Board-Approved Rules (continued)

Board Approval Date	Rule Description	Estimated Savings/Total Cost/State Share	Effective Date
3/14/2013	Rules are revised to align policy with federal requirements; additionally rules are revised to align adult outpatient behavioral health services with children outpatient behavioral health services in the Individual Plan. APA WF# 12-24	Budget savings of $99,692	Jul-1-2013
3/14/2013	SoonerCare dental rules are revised to update pulp cap language to align with current practice and language contained in OAC 317:30-5-699. In addition, OAC 317:30-5-700 (C) Orthodontic rules are revised to align OHCA current verification of continuing education policy with the Oklahoma Board of Dentistry prerequisite licensing requirement. The amendment change to OHCA policy will require all General and Pediatric dentists providing orthodontic care to complete 60 hours of continuing education hours and at least 20 hours of continuing education in the field of orthodontics every (3) three year cycle. APA WF# 12-25	Budget neutral	Jul-1-2013
3/14/2013	Rules for SoonerCare Home and Community Based Waiver Services (HCBS) programs for persons with intellectual disabilities are amended to clarify responsibilities for Agency Companion providers and Specialized Foster Care providers regarding reporting requirements when there are allegations of member maltreatment. The rules clarify that the Office of Client Advocacy must be contacted in the event of allegations of maltreatment involving an adult and an abuse hotline must be utilized in the event that the maltreatment involves a child. Rules are also amended to clarify that the Agency Companion must obtain prior approval from the member's representative payee before making purchases over $50 on behalf of the member. APA WF# 12-27	Budget neutral	Jul-1-2013
3/14/2013	Rules are amended to clarify that a member receiving Home and Community Based Services (HCBS) (such as ADvantage) is considered a community spouse for the purpose of calculating the community spouse allowance when his/her spouse is in a nursing facility. This amendment brings the rules into compliance with Federal law and regulation and the State Plan. It allows the spouse in the nursing facility to deem income to the spouse who remains at home, regardless of whether that spouse is receiving HCBS, before the vendor payment owed to the nursing facility is calculated. APA WF# 12-29	$500,000 state share, $800,000 federal share, $1.3 million total	Jul-1-2013
3/14/2013	SoonerCare non-emergency transportation rules are revised to clarify OHCA's current policy concerning meals and lodging, and eligibility. Proposed revisions will move meals and lodging policy to "General Medical Program Information" for clarification purposes. Additional revisions include updating outdated reference to the code of federal regulation concerning non-emergency transportation. Proposed revisions will define lodging for clarification purposes, and include eligibility requirements for escorts if SoonerCare member is removed from his/her home and appointed a temporary guardian. APA WF# 12-23A	Budget neutral	Jul-1-2013
3/14/2013	Rules are revised to add Institutional Transition Services and Self-Directed Goods and Services to the Medically Fragile Waiver Program. Additional revisions include removing language that does not align with program practices, for consistency and clarity purposes. APA WF# 12-30	Budget neutral	Jul-1-2013
3/14/2013	Rules are revised to add Institutional Transition Services, Assisted Living and Self-Directed Goods and Services to the My Life; My Choice Waiver Program. Additional revisions include removing language that does not align with program practices, for consistency and clarity purposes. APA WF# 12-31	Budget neutral	Jul-1-2013

Appendix D Board-Approved Rules (continued)

Board Approval Date	Rule Description	Estimated Savings/Total Cost/State Share	Effective Date
3/14/2013	Rules are revised to add Institutional Transition Services, Assisted Living and Self-Directed Goods and Services to the Sooner Seniors Waiver Program. Additional revisions include removing language that does not align with program practices, for consistency and clarity purposes. APA WF# 12-32	Budget neutral	Jul-1-2013
3/14/2013	SHOPP rules are revised to clarify overpayment and recoupment procedures, if it is determined due to appeal, penalty, or other reason that additional allocation/ recoupment fund is necessary. APA WF# 12-33	Budget neutral	Jul-1-2013
3/14/2013	Rules for State Plan Personal Care are revised to clarify compliance with the Long Term Care Security Act regarding background checks for providers of long term care services. Personal Care is assistance to a qualifying SoonerCare member in carrying out activities of daily living, such as bathing, grooming and toileting, or in carrying out instrumental activities of daily living, such as preparing meals and doing laundry or errands directly related to the member's personal care needs. Personal Care is provided to assure personal health and safety of the member or to prevent or minimize physical health regression or deterioration. Background checks are required for all Personal Care providers prior to the provision of services. APA WF# 12-34	Budget neutral	Jul-1-2013
3/14/2013	Agency policy is amended to allow for reimbursement of a separately payable administration fee for vaccines given to adults. Further, the policy clarifies Vaccine for Children Program administration fee rules. APA WF# 12-35	$60,000 state share, $110,000 federal share, $170,000 total	Jul-1-2013
3/14/2013	Policy is amended to expand genetic counseling services to all members that are eligible for medically necessary genetic testing. Currently, we only cover genetic counseling for members with a pregnancy at high risk of genetic abnormalities. APA WF# 12-37	$42,500 state share, $82,500 federal share, $125,000 total	Jul-1-2013
3/14/2013	Policy on the Oklahoma Electronic Health Records Incentive Program will be updated to account for changes in federal rules on the program. Changes include adding additional options for patient volume calculation, expanding the definition of a Children's Hospital, adding an exception to the hospital-based eligible professional criteria, and allowing CMS to take over administrative appeals for cases in which they are they auditor on meaningful use provisions. APA WF# 12-38	Budget neutral	Jul-1-2013
3/14/2013	Policy will be amended to define the circumstances under which genetic testing will be covered by OHCA. Both the volume and cost of genetic testing are growing, and the growth rates are expected to rise significantly going forward. Currently, OHCA has no written policy addressing the medical necessity of genetic testing, although claims are being paid through nonspecific laboratory codes. Policy will set medical necessity criteria similar to other states' Medicaid programs and private insurance, which requires the member to undergo a genetic risk assessment or display clinical evidence indicating a chance of a genetic abnormality AND that those results change treatment, change health monitoring, provide prognosis, or provide information needed for genetic counseling for the patient. APA WF# 12-39	Budget neutral	Jul-1-2013

Appendix D Board-Approved Rules (continued)

Board Approval Date	Rule Description	Estimated Savings/Total Cost/State Share	Effective Date
3/14/2013	Agency Inpatient Psychiatric Hospital rules are being revised to clarify the medical necessity criteria required for admission and continued stays in psychiatric residential treatment facility (PRTF) and acute levels of care. Changes are also being proposed to the rules regarding Individual Plans of Care to ensure early parent/guardian involvement in the treatment of children under the age of 18 receiving inpatient psychiatric services as well as to revise the "active treatment" requirements for individuals 18-21 years of age receiving services in an acute psychiatric hospital by making the requirements less proscriptive for this age group since they typically do not receive services in children's psychiatric units, so these facilities should not be held to the same requirements. Active treatment requirements for children under 18 are further revised to provide more clarity in areas that have been identified as causing provider confusion. Proposed revisions will also revise Inspection of Care (IOC) rules to provide the pro-rating timeline used when reviewing clinical documentation for compliance with active treatment requirements as well as to clarify that certain "critical documents" cannot be substituted with other evaluations/assessments. Rules are also revised to make clean-up changes to certain provisions that are outdated or no longer applicable. APA WF# 12-40	Budget neutral	Jul-1-2013
3/14/2013	Obsolete eligibility rules included in the Provider Manual (Chapter 30) are revoked. All topics covered in the obsolete sections are already covered in Chapter 35 of agency rules. APA WF# 12-41A		Jul-1-2013
3/14/2013	Eligibility rules are amended to provide that eligibility for children, pregnant women, and parents and caretaker relatives is determined using the Modified Adjusted Gross Income (MAGI) methodology, as mandated by federal law. Rules are amended to add two eligibility groups mandated by federal law: former foster care children aged 19-26 and CHIP children who would lose eligibility as a result of the MAGI method. Rules regarding eligibility determination procedures are amended to establish the passive renewal process mandated by federal law, as well as the federal rule that medical verification of pregnancy can only be required when the individual's declaration that she is pregnant is not reasonably compatible with other information available to the agency. Eligibility rules are also amended to add the mandatory eligibility group of children receiving Kinship Guardianship Assistance. Because the State has established a kinship guardianship assistance program, SoonerCare eligibility is mandated by federal laws and regulations. These amendments will provide eligibility coverage whether the child receives the assistance through the program established by OKDHS or through kinship guardianship programs that may be established by tribes in the future. In addition, eligibility rules are amended to eliminate presumptive eligibility (PE) for pregnant women. Under the PE program, certain qualified SoonerCare providers used to determine pregnant women presumptively eligible for SoonerCare; the women then had 30 days to apply and be fully determined eligible or ineligible. The purpose of PE was to give pregnant women access to care quickly. PE is no longer used because pregnant women can now have their eligibility fully determined in real-time through Online Enrollment. APA WF# 12-41B	$1.4 million state share, $6.3 million federal share, $7.7 million total	Jul-1-2013

Appendix D Board-Approved Rules (continued)

Board Approval Date	Rule Description	Estimated Savings/Total Cost/State Share	Effective Date
3/14/2013	The proposed rule change amends rules regarding Long Term Care (LTC) Sub-Acute Hospitals in order to update reimbursement language from a prospective per diem methodology to a cost based methodology. This revision is proposed to bring policy in alignment with the approved Medicaid State Plan reimbursement methodology and current practice. Additionally, the proposed rule change clarifies cost reporting requirements related to the reimbursement methodology for these facilities. APA WF# 12-42	$97,785 state share, $173,000 federal share, $270,725 total	Jul-1-2013
3/14/2013	The proposed rule change adds language clarifying that all program requirements set out in State Statute and Oklahoma Health Care Authority policy regarding wage enhancements for certain nursing facility employees have been met. The proposed rule change also clarifies that the Quality of Care fee assessed by the Oklahoma Health Care Authority is authorized through the Medicaid State Plan and clarifies that part of the fee structure is based on a waiver of uniformity as approved by the Centers for Medicare and Medicaid Services (CMS). Finally, proposed revisions include the removal of language incorrectly stating that rates for public ICF's/MR are set through a public rate setting process rather than the current practice of reimbursement based on cost reports. Other minor policy clarifications are also included as a part of the proposed rule change. APA WF# 12-43	Budget neutral	Jul-1-2013
	Agency staff has estimated that the revisions would provide a total budget savings of $5,324,692 for the remainder of State Fiscal Year 2013, with a state share savings of $1,200,000.	Total budget savings of $5,324,692 for SFY2013; state share savings of $1,200,000	

Important Telephone Numbers

OHCA Main Number	*405-522-7300*
SoonerCare Helpline	*800-987-7767*
SoonerRide	*877-404-4500*

Member Services	405-522-7171 or 800-522-0310
1 — OKDHS	4 — Pharmacy Inquiries
2 — Claim Status	5 —Enrollment Questions
3 — SoonerCare Member Services	

Provider Services	405-522-6205 or 800-522-0114
1 — Claim Status/Eligibility	4 — Pharmacy Help Desk
2 — PIN Resets/EDI/SoonerCare Secure Site Assistance	5 — Provider Contracts
3 — Adjustments or Third Party Liability	6 — Prior Authorizations

OHCA Internet Resources

Oklahoma Health Care Authority	www.okhca.org
Insure Oklahoma	www.insureoklahoma.org
Oklahoma Department of Human Services	www.okdhs.org
Medicaid Fraud Control Unit	www.oag.state.ok.us
Oklahoma State Department of Health	www.ok.gov/health
Oklahoma State Auditor and Inspector	www.sai.state.ok.us
Centers for Medicare & Medicaid Services	www.cms.gov
Office of Inspector General of the Department of Health and Human Services	www.oig.hhs.gov

OHCA Report References

Fast Fact Reports	www.okhca.org/fast-facts
Reports	www.okhca.org/reports
Studies	www.okhca.org/CAHPS