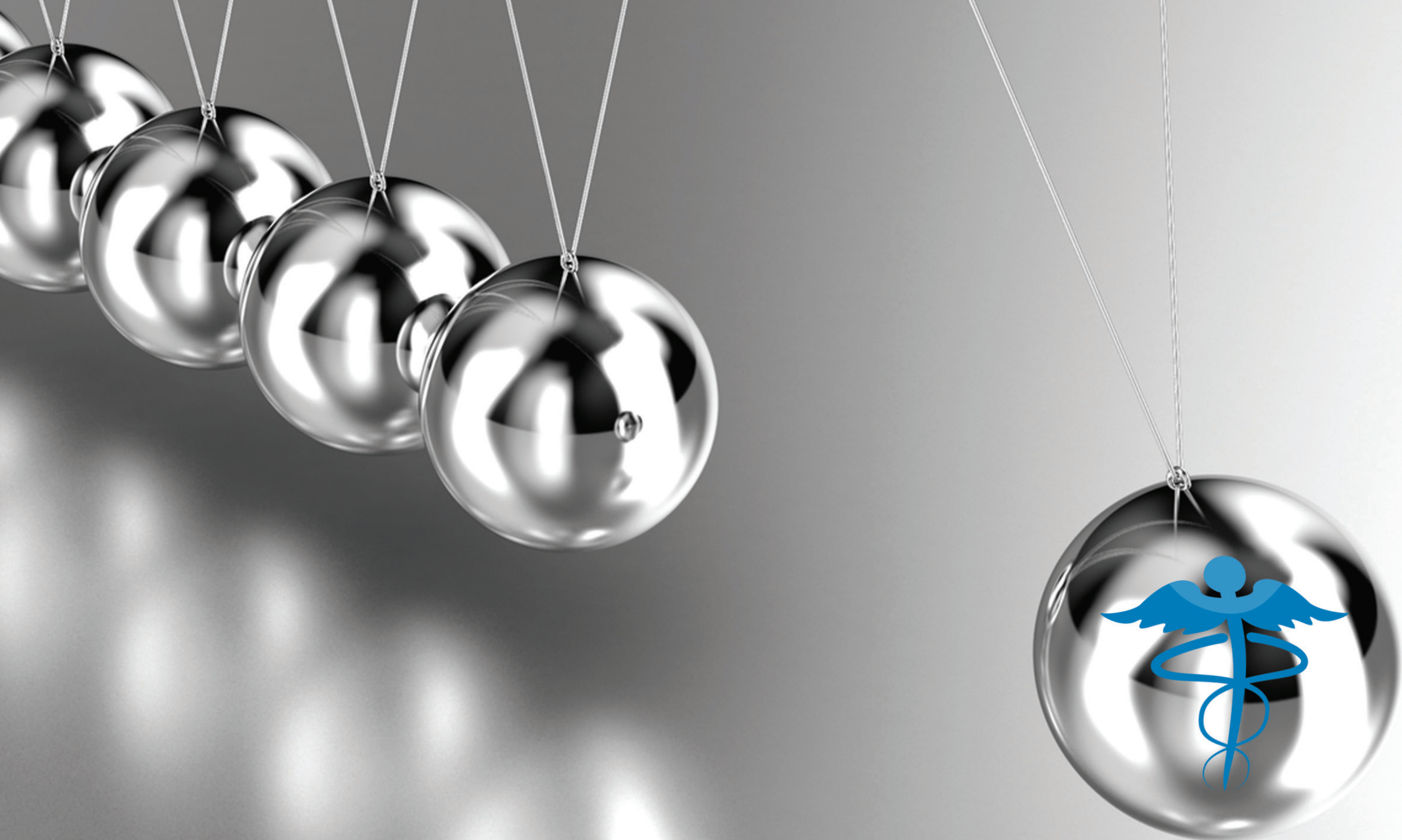
SoonerCare *In Motion*



Oklahoma Health Care Authority

Annual Report 2014

On the cover: Oklahoma Health Care Authority (OHCA) is dedicated to ensuring Oklahomans' access to quality health care to help keep Oklahoma healthy. SoonerCare provides basic health care coverage essential to protect and sometimes save the lives of those who are enrolled. More than one million Oklahomans benefitted from OHCA services during state fiscal year 2014.

Oklahoma Health Care Authority offices are located at:

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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.

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

Terry Cline, Ph.D.
Secretary of Health & Human Services

LEGISLATIVE BRANCH

1st Session of the 54th Legislature

Brian Bingman
President Pro Tempore, State Senate

Jeff Hickman
Speaker, House of Representatives

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of June 2014

Vice-Chairman
Anthony (Tony) Armstrong

Ann Bryant

Chairman
Charles (Ed) McFall

Melvin McVay

George Miller

Marc Nuttle

Carol Robison

Message from the Chief Executive Officer

Thank you for reading the Oklahoma Health Care Authority's (OHCA) State Fiscal Year 2014 Annual Report. It will provide you with an inside look at the agency responsible for purchasing nearly $5 billion in health care for more than one million Oklahomans this year. We take great pride in providing Oklahomans a transparent view of the agency. We hold ourselves accountable to the taxpayers that fund the programs; the state leadership 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 services.

As you will see in the following pages, OHCA leverages data in a meaningful way to not only see how well we are performing, but to also guide us in our decisions to improve the quality of care for our members. While we are not perfect, we want to be the best managed state Medicaid program in the nation. It is that motivation that allows us to pursue innovative ideas such as Insure Oklahoma, Patient-Centered Medical Homes, Health Access Networks and the Health Management Program. We will continue to improve our existing programs and innovating new ones as we work to make significant contributions to improve the health of Oklahoma children and families.

Another reflection you will see in this report is our focus on collaboration. We are joining other state leaders as part of the Oklahoma Health Improvement Plan (OHIP) with a view to transform the health of Oklahomans by improving their physical, social and mental well-being through a high-functioning public health system. The OHCA and the Oklahoma State Department of Health (OSDH) have developed joint strategies to address the state challenges of prescription drug abuse, childhood immunizations, tobacco use, hypertension and diabetes.

Communication continues to be vital to our success as well. We desire to listen to and receive input from all who are interested in our programs; and to effectively communicate the resources and programs we have to offer. We conduct community forums across the state and meet regularly with a number of advisory committees, including one comprised of our SoonerCare members. Join us in making a difference in the health of our state. Together, we will build better, more responsive programs for the state of Oklahoma.

Joel Nico Gomez

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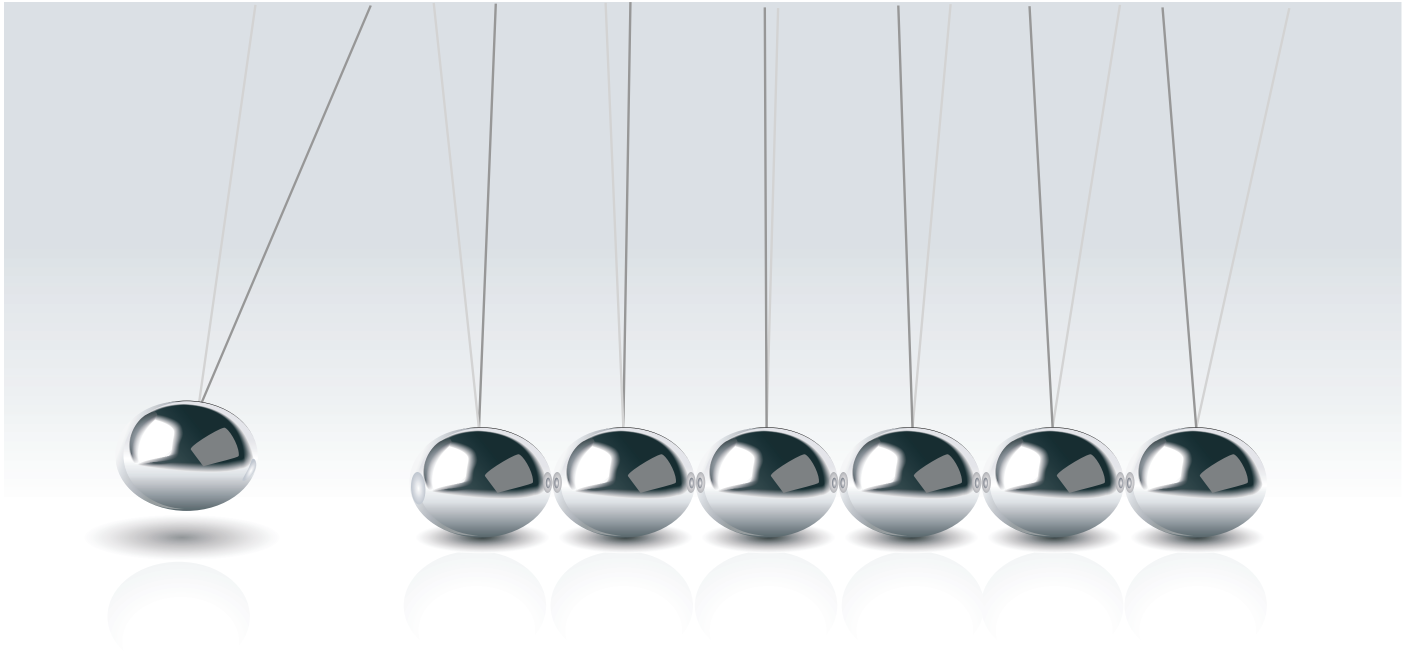

Annual Report

The Oklahoma Health Care Authority Annual Report includes updates, projects, accomplishments, awards and highlights that occurred during the 2014 state fiscal year.

Healthcare Effectiveness Data and Information Set (HEDIS®) and other quality measures are used to supply information for evaluation purposes, focus on member utilization and target key health issues. Other performance measures highlight quality improvement and quality assurance projects.

State Fiscal Year 2014 Brings Updates to SoonerCare Coverage

OHCA continuously monitors state and federal laws and regulations in order to identify upcoming requirements that must be met. SFY2014 presented many opportunities for collaboration among operational divisions as new coverage rules were adopted and went into effect. A summary of those changes includes:

- Populations Covered- Pregnant women and children categories were consolidated in OHCA policy to coincide with federal regulations. New qualifiers for parents and caretaker relatives, along with former foster care youth were established. Policy was modified to incorporate eligibility for targeted low-income children.
- Qualification Methods- Requirements for evaluating household size and income were changed to incorporate Modified Adjusted Gross Income (MAGI) methodology for applicable individuals seeking SoonerCare benefits.
- Online Enrollment- Starting October 1, 2013, applicants at mySoonerCare.org began using the new qualification methods. OHCA complied with federal requirements to assist applicants calling in to apply by telephone. In addition, OHCA established the capability to send and receive electronic account transfers from the federal Health Insurance Marketplace.
- Qualification Levels- The maximum income level for pregnant women and family planning applicants was set at 133 percent of the federal poverty level effective January 1, 2014. A benefit program covering only pregnancy-related services was expanded to include pregnant women who no longer qualified for SoonerCare full benefits because of their higher incomes, up to 185 percent of the federal poverty level.

SFY2014 OHCA Report

Primer

The Primer serves as an introduction to the SoonerCare program. Medicaid language and terms specific to the SoonerCare program are 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) report highlights OHCA's efforts in key performance areas. Performance measures are described alongside detailed year-by-year scores and future estimates. The SEAs are made available to the public to allow the ability to measure progress and assess the agency's headway towards 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 that might affect achievement of 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. These Fast Facts provide an overview of enrollment, program demographics, provider network monitoring and other subject specific details. The Fast Facts can be found at www.okhca.org/fast-facts.

SFY2014 Highlights

Members

- There were 1,033,114 unduplicated members enrolled in either SoonerCare or Insure Oklahoma during SFY2014 (July 2013 through June 2014).
- A total of 1,028,097 SoonerCare members had services paid for in SFY2014.
- Insure Oklahoma – In January 2014, the qualifying income guidelines for the Individual Plan (IP) decreased from 200 percent to 100 percent of FPL. Enrollment in the Insure Oklahoma program has decreased 38.2 percent since June 2013. As of June 2014, 18,466 enrollees and 4,299 businesses were participating.
- OHCA provided coverage to 87,838 SoonerPlan enrollees and 1,330 women needing further diagnosis or treatment for breast and/or cervical cancer through the Oklahoma Cares program.
- SoonerCare covers approximately 61.6 percent of the births in Oklahoma. For calendar year 2013, SoonerCare deliveries accounted for 32,841 of the 53,354 overall state births (Oklahoma State Department of Health final figures accessed 9/4/2014).

Expenditures

- Aged, blind or disabled enrollees made up 16.4 percent of SoonerCare. These enrollees accounted for 46.4 percent of the SoonerCare expenditures.
- SoonerCare funded 66.8 percent of Oklahoma's total long-term care occupied bed days.
- OHCA expended $15.6 million on behalf of the breast and cervical cancer enrollees and $7.9 million on SoonerPlan enrollees.
- 52,148,779 claims were processed.
- Nursing facility Quality of Care revenues totaled $77,610,030.
- Dollars recovered by OHCA through post-payment reviews totaled $30,632,945.
- Federal and state drug rebate collections, including interest, totaled $195,033,662.
- By limiting the amount paid for generic drugs, OHCA saved more than $141.5 million through the State Maximum Allowable Cost program.

Administration

- OHCA processed two emergency rules, 33 permanent rules and 19 state plan amendments.
- There were 29 group provider training sessions attended by more than 7,000 providers. OHCA and HP held 9,046 individual, on-site provider training sessions.
- OHCA received and investigated 141 SoonerCare member complaints. This represents less than 0.01 percent of the 1,033,114 SoonerCare enrollees.
- There were 58 provider and 621 member formal appeals filed.
- OHCA administrative costs comprised 5.11 percent of the total SoonerCare expenditures. OHCA operating costs represented 37 percent of OHCA administrative costs and the other 63 percent were contract costs.

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1 Million+

More than 1 million Oklahomans are enrolled in SoonerCare.

SoonerCare Members

Insure Oklahoma Extension Fast Facts

Insure Oklahoma (IO) offers state-sponsored health insurance coverage for low-income working adults. The program is comprised of an employer-sponsored plan and an individual plan.

In the Employee-Sponsored Insurance (ESI) program, businesses help provide commercial health insurance for qualified members. The premium costs are shared by SoonerCare (60 percent), the employer (25 percent) and the employee (15 percent). As of June 2014, there were 4,299 small businesses participating with 13,729 members enrolled.

All 77 Counties

Oklahoma counties have businesses that participate in the Insure Oklahoma Program.

Insure Oklahoma operates under the federal Health Insurance Flexibility and Accountability (HIFA) waiver. Oklahoma's HIFA waiver expired at the end of 2013. Waivers must be approved by the Centers for Medicare & Medicaid Services (CMS) to receive federal funding. CMS' approval for the extension of IO to December 31, 2014 was contingent on specific changes that had to be made to the Individual Plan (IP). OHCA changed eligibility income requirements to less than or equal to 100 percent of the FPL, which is a decrease from the 200 percent from years past. In addition, changes to the IP program include a decrease in pharmacy copays to $4 for generics and $8 for brand name prescriptions. Outpatient services and physician visits now carry a $4 copay (decreased from $10-$25).

Following further negotiations with our federal partners, OHCA has been granted approval to continue IO with no scheduled end date. As of June 2014, 18,466 members were enrolled in IO, with 4,737 members enrolled in IP.

Text4baby Features Enhanced Information for Mothers

Text4baby (T4B) is the nation's largest free mobile health messaging service for pregnant women and mothers of infants under age one. Text4baby participants receive three, free text messages per week through pregnancy and infant's first year, personalized to mom's due date or baby's birth date. Information packed messages contain a variety of maternal and child health topics, including safety, immunizations, well-child checks, developmental milestones and more. Oklahoma is currently 1 of 4 states creating enhanced messages with state-specific resources. The three-year pilot project aims to increase enrollment of pregnant SoonerCare members in Text4baby; customize content to include state-specific programs and resources; and assess T4B's impact on improving health quality measures including postpartum visits and tobacco cessation during pregnancy. Customized messages helped introduce the uninsured to information on SoonerCare eligibility and how to apply. After T4B provided uninsured respondents with information on how to apply, 44 percent indicated a week later that they had applied for SoonerCare.

OHCA Oklahoma Tobacco Helpline Fax Referral Initiative

OHCA receives hundreds of inbound calls a week from newly-enrolled pregnant SoonerCare members. OHCA created an internal database to easily refer pregnant SoonerCare members who would like help with quitting tobacco to the Oklahoma Tobacco Helpline (OTH). After the SoonerCare member agrees to receive services, a fax referral is sent to the OTH. Once the OTH reaches the SoonerCare member via phone, they send a confirmation report back; allowing OHCA to track the SoonerCare members who have been called and the details of their quit plan. This process allows OHCA to identify members who need extra support to help them quit permanently. The acceptance rate of OTH services among SoonerCare members involved in this initiative is 35 percent, on par with the state rate. Due to this project's success, a process evaluation was conducted and shared nationally.

OB (Pregnancy) Outreach Program

Every week OHCA mails a letter to every newly-enrolled pregnant member asking her to call the SoonerCare Helpline to receive important information concerning her SoonerCare benefits. If the member contacts the SoonerCare Helpline, the call is answered by a Member Services representative. During the discussion, the member is asked a series of 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 Population Care Management for further clinical assessment. The department received and worked 618 new OB outreach cases.

3 out of 10

CAHPS member surveys indicate that almost 30% of SoonerCare adult members smoke every day.

1,891

1,891 infants were in active care management during SFY2014.

Active Care Management

Population Care Management (PCM) provides case management in targeted counties with high infant mortality rates. Specialized population care management nurses ensure the newborn is enrolled in SoonerCare, the mother has chosen a primary care provider for her new baby and that she is taking her newborn for well-child visits. Case management continues through the at-risk infant's first birthday. PCM supplies education on safe sleep, newborn/infant home safety and cautions against tobacco usage in the home. Screening for postpartum depression is conducted on all mothers of these at-risk infants.

Care management efforts include continued coordination of care for a subgroup of the infants who were identified as having special needs after their first birthday. Population Care Management had 1,538 mothers and 1,891 infants from these targeted counties in active care management in the last fiscal year.

Beginning on July 1, 2013, PCM extended care management outreach to members aged 13-18 for one year postpartum in these same targeted counties. PCM nurses discuss information with the mother such as reproductive life planning and medical home utilization. Plans to return to school, as well as vocational training or college/career planning are also included in this innovative new project. PCM had 61 cases for this outreach last fiscal year.

Strong Start Update

The Oklahoma Health Care Authority was one of 27 national 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 aims to reduce preterm births; improve outcomes for newborns and pregnant women; and decrease the total cost of medical care during pregnancy, delivery and the first year of life for newborn SoonerCare children.

OHCA partnered with three clinic sites serving 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 Health Care Center in Talihina and the Oklahoma State University Department of Obstetrics in Tulsa. The sites began providing group prenatal care during the fall of 2013 and have reported 20 deliveries under the program.

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 the 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 programs receive Medicare and/or SoonerCare capitation payments for individuals enrolled. People not financially qualified for SoonerCare or Medicare pay the capitation amount out of pocket. The PACE benefit package for participants includes SoonerCare covered services, all Medicare covered services, as well as any service deemed necessary by the PACE program Interdisciplinary Team. There were a total of 140 PACE program participants during SFY2014.

Living Choice

The Living Choice project 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, 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 into one of the two waivers born out of the Living Choice project: My Life, My Choice for members ages 20 through 64 and Sooner Seniors for members ages 65 and older. The program covered 365 members this fiscal year.

The State of Oklahoma was awarded the MFP Tribal Initiative grant in 2014. This will allow Tribal partners, in conjunction with OHCA, to build sustainable community-based long-term services and support for tribal citizens.

My Life, My Choice

The My Life, My Choice (MLMC) waiver program offers SoonerCare members with physical disabilities the same services received through Living Choice. To qualify, members must have a disability, meet nursing facility level of care, be between the ages of 20 and 64 and have spent one year in the Living Choice program. Not only does the program promote improved quality of life in a residential setting of the member's choosing, it is very cost effective. The average cost per member for services in the MLMC waiver is $10,927 annually, compared to $28,342 per member annually in a nursing facility.

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

$17,415

Compared to a nursing facility, $17,415 was saved per person enrolled in the My Life, My Choice program.

Sooner Seniors

The Sooner Seniors waiver program is designed to assist SoonerCare members to remain in the community after completing the 365-day Living Choice demonstration. To qualify, members must be 65 or older, have a long-term illness and meet nursing facility level of care.

By building upon the delivery of services already established through Living Choice, the waiver is able to provide continuity of care and ensure that Medicaid dollars spent for members participating in the waiver were considerably less ($8,585 per waiver member) than the Medicaid dollars spent for those members receiving care in a nursing facility ($28,342 per member annually).

Self-Directed Services

Self-Directed Services (SDS) allow members to choose and have control over those who provide their personal care and how those services are provided. SDS allows the member to recruit, hire, train and supervise individuals who will provide their services. SDS applies to the MLMC program, Sooner Seniors, Living Choice and the Medically Fragile programs. Services include; personal care, advanced supportive restorative services, respite services and goods and services.

67%

SoonerCare funded 67% of the total nursing facility bed days for SFY2014.

Medically Fragile

The Medically Fragile program is a home and community-based alternative to placement in a hospital or skilled nursing unit of a nursing facility. This allows members to remain in home or residential settings of their choice. To qualify, members must have a chronic, physical condition that requires daily skilled intervention, such as a life-threatening condition requiring medical supervision; frequent and time consuming specialized treatments that are medically necessary; or the member is dependent on medical technology.

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

An average of 2,246 Part A premiums and more than 91,877 Part B premiums were paid by Medicaid each month.

Figure 1 Long-Term Care Facility Utilization and Costs

Facility	Unduplicated Members	Bed Days	Reimbursement	Yearly Average Per Person	Average Per Day
Nursing Facilities *	19,361	4,696,061	$548,728,363	$28,342	$117
ICF/ID (ALL)	1,692	543,858	$96,493,124	$57,029	$177
ICF/ID (Private)	1,423	481,561	$58,722,587	$41,267	$122
ICF/ID (Public)**	269	62,297	$37,770,537	$140,411	$606

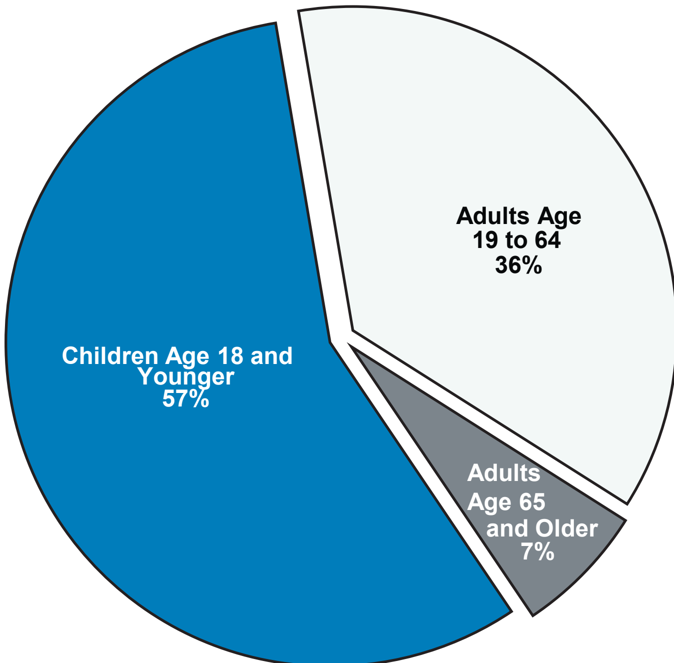
ICFs/ID = Intermediate Care Facilities for the Intellectually Disabled. *Average Per Person figures do not include the patient liability that the member pays to the nursing facility (average nursing facility $26.65/day; private $16.43 and for Public ICF/ID's $18.66).
**This does not include Crossover claims paid to nursing facilities of $24,720,426. This would add 1,747 additional unduplicated members and 338,638 days.

Figure 2 SoonerCare Children Under 21

Total unduplicated children under 21	618,643
Children qualified under Children & Parents (TANF)	543,683
Children qualified under Blind and Disabled	22,248
Children qualified under TEFRA	591
Children qualified under Insure Oklahoma	1,440
Children qualified under CHIP	147,437

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 3 Age of SoonerCare Enrollees



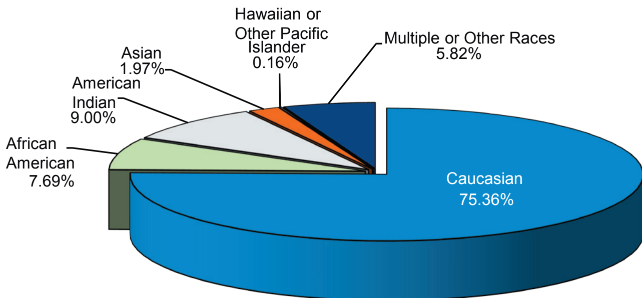
1,033,114

More than 25% of Oklahomans are enrolled in SoonerCare.

Figure 4 SoonerCare Population by Race

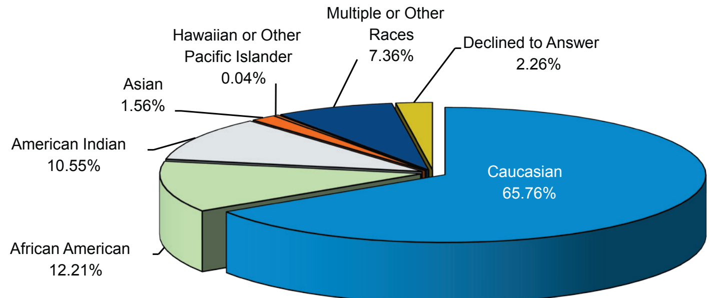
Oklahomans can declare any combination of five races. The pie charts below represent the counts of races reported alone. The bar chart below is the total SoonerCare count of each race for every reported occurrence either alone or in combination with another race.

State of Oklahoma Population 2013

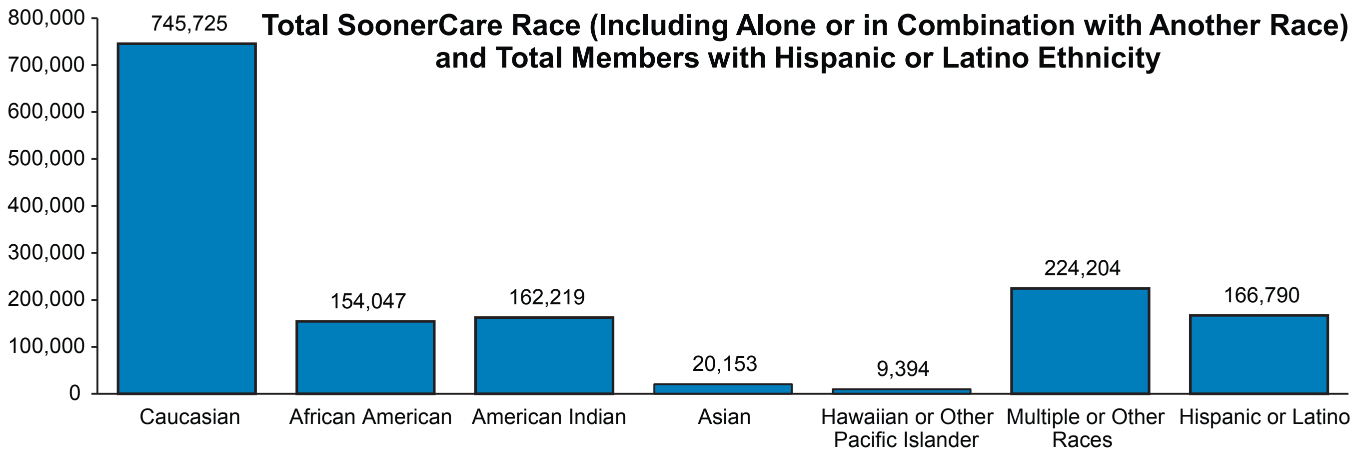


Total Estimated Population 2013 - 3,850,568 (Hispanic or Latino Ethnicity = 396,646) Oklahoma totals based on U.S. Census Bureau, 2013 Population Estimate- single race reported alone counts. Census collects Other Race, not listed in the other 5 major categories.

SoonerCare Population SFY2014



Total Enrolled in SoonerCare and/or Insure Oklahoma - 1,033,114 (Hispanic or Latino Ethnicity = 166,790).
The multiple race group has two or more races reported. Race is self-reported by members at the time of enrollment.



Oklahoma SoonerCare unduplicated single race reported alone counts based upon data extracted from member files on July 15, 2014. 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 annually conducts the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey designed for children. Only members enrolled via the Children's Health Insurance Program (CHIP) are eligible for this survey. SoonerCare rates equaled or exceeded the national 50th percentile in all nine of the 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	92.1%	90.1%
Shared Decision Making	59.8%	NA
How Well Doctors Communicate	96.6%	93.2%
Getting Needed Care	89.0%	84.7%
Customer Service	88.1%	87.8%
Rating of Health Care	85.1%	83.7%
Rating of Personal Doctor	88.3%	87.0%
Rating of Specialist	88.7%	84.0%
Rating of Health Plan	86.1%	83.5%

Children identified with Chronic Conditions (CCC) measures are reported separately. SoonerCare rates were at or exceeded the national 50th percentile in twelve of the thirteen key measures, with marks above the 90th national percentile in the areas of how well doctors communicate and access to specialized services.

CAHPS® Child Survey (CCC)

Key Measure	CHIP	Child Medicaid Quality Compass®
Getting Care Quickly	93.8%	92.6%
Shared Decision Making	57.6%	NA
How Well Doctors Communicate	95.6%	93.4%
Getting Needed Care	88.1%	86.8%
Customer Service	90.2%	89.0%
Rating of Health Care	85.6%	81.9%
Rating of Personal Doctor	88.0%	86.4%
Rating of Specialist	89.1%	84.5%
Rating of Health Plan	82.7%	82.0%

CAHPS® Child Survey (CCC)

Key Measure	CHIP	Child Medicaid Quality Compass®
Access to Prescription Medicines	93.5%	93.0%
Access to Specialized Services	86.3%	77.2%
Family-Centered Care: Personal Doctor Who Knows Child	90.6%	89.6%
Family-Centered Care: Getting Needed Information	93.5%	90.5%
Coordination of Care for Children with Chronic Conditions	74.3%	76.9%

Adult Member Satisfaction Survey

SoonerCare adult member satisfaction rates increased significantly from last year in two important categories: rating of personal doctor and rating of health plan. While customer service and shared decision making still require some focus, other key measures continue to show improvement. The displayed 2008 rate is the last adult survey conducted before the implementation of the medical home at OHCA. Current rates exceed 2008 rates in all but one category. Comprehensive CAHPS® survey results can be found at www.okhca.org/CAHPS.

CAHPS® Adult Survey

Key Measure	2008 Rate	2013 Rate	2014 Rate
Getting Needed Care	72.8%	80.0%	82.1%
Getting Care Quickly	77.1%	79.4%	82.3%
How Well Doctors Communicate	80.4%	87.1%	89.9%
Customer Service	78.1%	90.3%	82.2%
Shared Decision Making	52.7%	47.8%	50.0%
Rating of Health Care	60.6%	64.0%	68.4%
Rating of Personal Doctor	65.1%	70.7%	79.0%
Rating of Specialist	68.8%	74.5%	82.5%
Rating of Health Plan	62.1%	61.3%	73.1%

18%

Eighteen percent of adult SoonerCare smokers have used an e-cigarette or vapor device.

Experience of Care and Health Outcomes Survey

ECHO®

ECHO® Child Member Satisfaction Survey

OHCA also utilizes the Experience of Care and Health Outcomes (ECHO®) survey for children in order to assess performance and satisfaction with behavioral health services. Select SoonerCare Choice children who utilized behavioral health services were asked to complete a satisfaction survey. While there were fewer members reporting accessing 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. Members also indicated they were able to access treatment more quickly than in the past. Comprehensive ECHO® survey results can be found at www.okhca.org/CAHPS.

ECHO® Child Survey		
Key Measure	2012 Rate	2014 Rate
Getting Treatment Quickly	63.0%	73.3%
How Well Clinicians Communicate	91.4%	89.6%
Getting Treatment and Information from Plan	70.9%	62.1%
Perceived Improvement	71.8%	70.8%
Availability of Help and Support	84.5%	85.2%
Rating of Treatment	70.5%	76.0%
Rating of Health Plan	77.6%	81.8%

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 Healthcare Effectiveness Data and Information Set (HEDIS®) 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 available data from the previous year. Therefore, HEDIS® 2014 is using information claimed during the 2013 calendar year. In general, each measure uses the member age as of December 31, 2013 and includes those members who were enrolled in SoonerCare and who were not enrolled in any Home and Community-Based Services waiver. Members must have had 320 days of enrollment (this equates to allowing for any 45-day gap).

Not all increases 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 years.

Annual Dental Visit	2011	2012	2013
Aged 2-3 years	39.3%	41.0%	40.9%
Aged 4-6 years	64.6%	67.2%	66.6%
Aged 7-10 years	70.5%	72.6%	72.3%
Aged 11-14 years	68.3%	70.3%	70.2%
Aged 15-18 years	61.2%	62.9%	63.1%
Aged 19-21 years	43.2%	40.2%	40.0%
Total	61.9%	64.0%	64.1%

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	2011	2012	2013
Aged 12-24 months	97.2%	96.6%	97.0%
Aged 25 months-6 years	88.4%	90.1%	90.6%
Aged 7-11 years	90.9%	91.7%	92.4%
Aged 12-19 years	89.9%	91.6%	92.8%

Access to Preventive/ Ambulatory Health Services	2011	2012	2013
Aged 20-44 years	84.2%	83.1%	82.8%
Aged 45-64 years	91.1%	91.0%	90.8%
Aged 65+ years	92.1%	92.2%	92.3%
Total	88.8%	88.5%	88.3%

Well-Child Visits in the First 15 Months of Life

The well-child visits measure is the percentage of SoonerCare members, ages 21 and younger, who 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	2011	2012	2013
Aged <15 months 1+ visits	98.3%	98.3%	97.3%
Aged <15 months 6+ visits	59.0%	58.6%	59.6%
Aged 3-6 years 1+ visits	59.8%	57.4%	57.7%
Aged 12-21 years 1+ visits	33.5%	34.5%	31.6%

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	2011	2012	2013
Aged 2-18 years	44.8%	49.1%	53.2%

HEDIS®

Appropriate Medications for the Treatment of Asthma

Measures the appropriate medications for the treatment of asthma, 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 quality of life through proper management.

Medications for the Treatment of Asthma	2012	2013
Aged 5-11 years	90.3%	90.0%
Aged 12-18 years	85.2%	85.0%
Aged 19-50 years	60.4%	58.9%
Aged 51-64 years	56.9%	48.8%
Total	85.0%	83.3%

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	2011	2012	2013
Aged < 24 months	44.5%	44.7%	48.2%

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	2011	2012	2013
Aged 17-75 years	69.9%	68.6%	68.2%

Appropriate Treatment for Children with Upper Respiratory Infections

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

Appropriate Treatment for Children with URI	2011	2012	2013
Aged 3 months-18 years	69.5%	66.8%	73.1%

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 through hemoglobin A1c testing, LDL-C screening, eye exam (retinal) and medical attention for nephropathy.

Comprehensive Diabetes Care (Aged 18-75 years)	2011	2012	2013
Hemoglobin A1C Testing	71.1%	70.5%	71.6%
Eye Exam (Retinal)	31.8%	31.8%	32.0%
LDL-C Screening	62.9%	62.0%	63.1%
Medical Attention for Nephropathy	55.9%	56.8%	58.7%

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	2011	2012	2013
Aged 40-69 years	41.3%	36.9%	36.5%

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	2011	2012	2013
Aged 21-64 years	47.2%	42.5%	41.0%

60+

OHCA reports more than 60 quality measures annually.

Health Improvement Plan

Medicaid Quality Grant

In 2012, Oklahoma was one of 26 states that the Centers for Medicare & Medicaid Services selected for a two-year grant to support state agencies in testing and evaluating methods for the collection and reporting of the Initial Adult Core Set of Health Care Quality Measures. In addition to collecting and reporting on quality measures, OHCA's goals for the grant are to promote women's health screenings and testing for diabetic members. Two projects concentrate on quality improvement interventions for cervical cancer screenings and hemoglobin A1c testing. Various provider outreach efforts have engaged 114 providers. In addition to 1,900 telephonic member contacts, more than 31,000 postcards regarding cervical cancer screenings and hemoglobin A1c testing awareness were mailed to members. The University of Oklahoma's Department of Family and Preventative Medicine will administer a provider satisfaction survey for the two quality improvement projects. More information about the Adult Medicaid Quality Grant can be found online at www.medicaid.gov.

Health Improvement Planning for a Healthy Oklahoma

Oklahoma ranks 44th nationally in overall health, according to America's Health Rankings 2013 report. Neighboring states such as Texas, Kansas and Missouri fare better than Oklahoma in their overall health rankings. Oklahoma is facing challenges such as high rates of drug related deaths, low immunization coverage among children, obesity, smoking, cardiovascular deaths and diabetes among others. These challenges have a negative impact on Oklahoma's overall health ranking. It is imperative to overcome these challenges to improve the health of Oklahomans.

To address these challenges, state leadership has developed the Oklahoma Health Improvement Plan (OHIP) with a view to transform the health of Oklahomans by improving the physical, social and mental well-being of all Oklahomans through a high-functioning public health system. OHIP supports health improvement throughout the state by targeting children's health improvement, tobacco use prevention and obesity reduction. OHCA collaborates with other state agencies and local, private and non-profit agencies to improve the health of SoonerCare members; and build a responsive public health care delivery system that serves all Oklahomans.

The OHCA and the Oklahoma State Department of Health have developed joint strategies to address the state challenges of prescription drug abuse, childhood immunizations, tobacco use, hypertension and diabetes. Five workgroups have been created comprising subject matter experts from other agencies with each workgroup focusing on one challenge area.

Prescription Drug Abuse Workgroup

Prescription drug abuse is a major cause of drug-related deaths in Oklahoma. The prescription drug abuse workgroup's goals are: a) to develop data-driven interventions, b) to support the appropriate use of prescription drugs and c) to decrease the number of prescription drug overdose related deaths in Oklahoma. Specific data will be used to develop future interventions and strategies to reduce prescription drug abuse. The group plans to assess and report the effectiveness, successes and barriers of various current system structures and guidelines.

Hypertension Workgroup

The hypertension workgroup has a short-term goal of reducing uncontrolled hypertension (high blood pressure) and its associated economic costs in a targeted five county area in Oklahoma. Hypertension afflicts nearly 1 in 3 Americans, with Oklahoma ranking 42nd in the nation for the prevalence of hypertension. The workgroup is engaging in efforts to increase the number of Heartland OK (Million Hearts) patient referrals made by participating SoonerCare providers in a target area near McAlester from seven to 150, by December 31, 2014. The state-based Association of State and Territorial Health Officials (ASTHO) "Million Hearts" grant project is Heartland OK. The project utilizes a coordinated care approach to increase the number of patients with controlled high blood pressure within a five county target area in southeast Oklahoma, including Pittsburg, Pontotoc, Coal, Atoka and Latimer counties.

Tobacco Use Workgroup

Currently, Oklahoma ranks among the worst states in smoking. The tobacco workgroup aims to reduce the tobacco smoking rate among Oklahomans by increasing referrals to the Oklahoma Tobacco Helpline and removing barriers to obtaining tobacco cessation products for SoonerCare members. Efforts include training the staffs of targeted county health departments in the helpline referral process and increasing the number of helpline referrals for SoonerCare members.

Diabetes Workgroup

The diabetes workgroup focuses on increasing the number of joint activities in Oklahoma to support evidence-based interventions to prevent pre-diabetics from developing type 2 diabetes and reduce health care costs through the management of diabetes. Activities include conducting an existing tribal diabetes program assessment and identification of tribal partnerships to increase engagement with tribes in the development of community-based approaches to reduce diabetes prevalence.

Childhood Immunization Workgroup

The childhood immunization workgroup's aim is to increase the immunization rates for all Oklahoma children. Immunization prevents an estimated 2 to 3 million deaths worldwide each year, yet 1 in 5 children do not receive vaccinations. Oklahoma currently ranks 48th in the nation for the percentage of children who are up-to-date with their primary vaccines. The first initiative targets children 19-35 months of age in Bryan County. Bryan County had one of the lowest completion rates of targeted immunization series according to data from the Oklahoma State Immunization Information System. The workgroup's efforts include providing outreach and education to providers through face-to-face visits and education to members and the community; developing targeted educational materials highlighting the importance of childhood immunizations; issuing news releases; and providing immunization information on OHCA's website, Twitter and Facebook.

SoonerCare Providers

Dental Process Improvements

The process for submitting dental prior authorizations has been streamlined. Effective January 2014, it became possible for dental providers to submit prior authorization requests and all documentation electronically. Previously, all requests were mailed to OHCA and processed manually. This new process has reduced mailing cost and staff time for our dental providers.

Durable Medical Equipment

The Durable Medical Equipment (DME) program helps SoonerCare members by supplying medical equipment in addition to medical care.

OHCA works closely with the DME provider community, advisory boards and federal audit agencies and is responsible for overseeing the Oklahoma Durable Medical Equipment Reuse Program (OKDMERP).

Representatives from OKDMERP are available to receive donations of lightly used DME including requested items such as gently used wheelchairs, nebulizers and scooters.

Electronic Health Record Incentive Program

The Electronic Health Record (EHR) incentive program provides financial motivation to assist eligible providers with the adoption, implementation, upgrades and/or meaningful use of certified EHR technology.

Providers making the transition to electronic health records are able to more efficiently coordinate care, manage patient health records by reducing errors and duplicate services, engage patients in their own health care and much more.

Since program implementation, OHCA has issued more than $150 million in EHR incentive payments to 2,202 Eligible Professionals (EPs) and 103 Eligible Hospitals (EHs). In SFY2014, 1,032 EPs and 55 EHs received EHR incentive payments, of which 61 percent of the EPs and 98 percent of the EHs achieved meaningful use.

Medical Authorizations

This fiscal year, the Medical Authorization unit received an average of 9,819 prior authorization requests (PARs) per month. MedSolutions currently handles the high-tech imaging requests for the OHCA and effective July 2014, will begin handling all therapy-related (occupational therapy, physical therapy and speech therapy) PARs. MedSolutions received an average of 5,696 PARs per month for SFY2014.

Focus on Excellence

Focus on Excellence is 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. Measurements of quality include: evaluation of the person-centered care, direct care staffing, resident satisfaction, employee satisfaction, licensed nurse retention, certified nursing assistant retention, distance learning, peer mentoring and leadership commitment. These ratings result in a five star rating system.

The annual report for Focus on Excellence can be found at www.okhca.org/FOE and more information regarding the rating system can be found at www.oknursinghomeratings.com/metrics.php.

Provider Portal

OHCA launched a new portal that allows providers to access claim and prior authorization records, maintain provider information and receive messages from OHCA targeted specifically to the providers. In addition to the functionality of the previous version, the new provider portal is ICD-10 compatible, has predictive search and auto-fill cover sheets, as well as a new interface. The provider portal is a crucial piece in allowing providers to submit electronic attachments and look up member health history data, which in turn makes the claim and prior authorization submission a more steadfast process.

14,605

SoonerCare contracted with 14,605 physicians at some point in SFY2014.

Provider Profiles

The provider profiles offer feedback to providers for self-assessment, which can help them evaluate how well they have performed, as well as how they have performed compared to their peers.

For women's health screenings, providers received a profile on breast cancer screenings (mammograms) based on the members in the provider's panel. For mammography screenings, 195 profiles and 261 "insufficient-data" letters were mailed.

C-section profiles are sent on a quarterly basis to providers and facilities. The profiles indicate the percentage of provider specific SoonerCare member deliveries that were performed through C-section. Profiles also identify the percentage of their members that experienced a primary C-section. There were 1,279 profiles mailed.

42,514

SoonerCare had a provider network of 42,514 during SFY2014.

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 quality of 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 361 reviews of providers enrolled in PCMH during SFY2014.

Each new PCMH submits a self-assessment form which is reviewed by OHCA compliance staff. Based on this review, the PCMH is contacted for education. Formal PCMH education is also scheduled for new PCMH providers. Medical record review results this year have reflected a marked improvement in compliance.

Figure 5 SoonerCare Capitation Payments

Aged, Blind and Disabled (ABD)	Member Months	Capitation Payments
IHS Adults	14,116	$42,348
IHS Children	6,868	$20,604
Children/Parents (TANF)*	**Member Months**	**Capitation Payments**
IHS Adults	18,137	$36,274
IHS Children	177,327	$376,489
SoonerCare Choice Medical Home	**Member Months**	**Care Coordination Payments**
Medical Home - Open to All Ages	3,799,160	$20,243,886
Medical Home - Open to Children Only	1,338,373	$6,219,586
Medical Home - Open to Adults Only	35,236	$194,873
Miscellaneous Capitation (not SoonerCare Choice)	**Member Months**	**Capitation Payments**
Insure Oklahoma - Individual Plan	154,758	$464,274
Non-Emergency Transportation (ABD)	1,568,327	$23,493,538
Non-Emergency Transportation (TANF)	6,302,019	$3,277,050
Program of All-Inclusive Care for the Elderly (PACE)	1,492	$4,154,536
Health Access Network Payments	**Member Months**	**Capitation Payments**
Oklahoma State University	176,319	$881,595
Oklahoma University Tulsa	1,092,948	$5,464,740
Canadian County	41,055	$205,275

*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.

Patient-Centered Medical Home Components

The Patient-Centered Medical Home model of care, implemented in January 2009, is designed to provide SoonerCare Choice members with a comprehensive, coordinated approach to primary care. PCMHs receive additional reimbursement for each panel member enrolled for providing enhanced services and a supportive infrastructure.

The 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 only see children, providers who see all ages and providers who only see adults.

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 at www.okhca.org/feeschedules.

Figure 6 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 7 Budgeted SoonerExcel Incentive Payment Components

SoonerExcel Incentive Program	SFY2014 Payments[1]
Emergency Department Utilization	$494,420
-based on emergency department utilization of panel members	
Breast and Cervical Cancer Screenings	$346,131
-based on breast & cervical cancer screenings of panel members	
Generic Drug Prescription Rate	$491,429
-based on generic / multi-source prescribing profile	
Behavioral Health Screenings	$20,464
-based on Behavioral Health screenings of panel members	
Inpatient Admissions / Visits	$850,000
-based on inpatient admissions / visits to SoonerCare Choice members	
EPSDT & 4th DTaP- Well-Child Checks	$1,002,404
-based on meeting the EPSDT screening compliance rate and 4th DTaP administration	
Total	**$3,204,849**

Source: OHCA Financial Services Division, September 2014.
*SFY2014 payments are an estimate, at time of reporting. SFY2014 4th quarter payments had not been calculated.

Administration

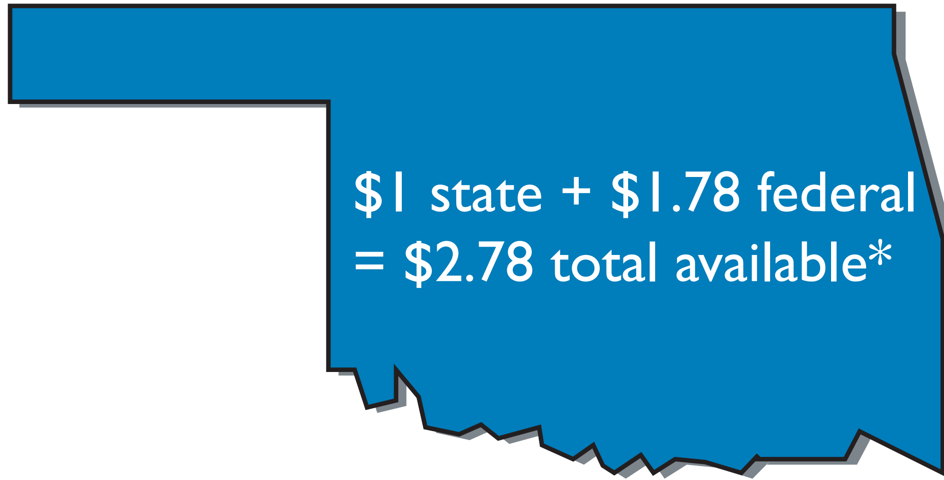
Health care services are a substantial economic presence in Oklahoma. Most people do not think of SoonerCare health care services beyond the critical role they play in meeting the needs of vulnerable and low-income Oklahomans. The health care sector affects the economy in much the same way a manufacturing 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.

Figure 8 Hospital Payments

Types of Hospital Payments	SFY2013	SFY2014
Inpatient - Acute and Critical Access	$520,580,797	$538,148,027
Inpatient Rehabilitation - Freestanding	$13,147,996	$13,874,466
Inpatient - Indian Health Services	$16,588,924	$16,190,401
Inpatient - LTAC Children's	$20,974,560	$24,357,691
Inpatient Behavioral Health - Freestanding	$8,781,020	$10,508,200
Psychiatric Residential Treatment Facilities	$99,017,054	$93,132,148
Outpatient Services[1]	$271,626,589	$279,730,503
Medicare Crossovers	$37,759,375	$38,261,386
Hospital Supplemental Payments	$135,173,587	$150,752,968
EHR Incentive Payments[2]	$27,035,482	$18,410,870
Supplemental Hospital Offset Payment Program	$352,893,974	$406,660,323
Indirect Medical Education (IME)	$30,449,271	$31,088,706
Graduate Medical Education (GME)	$20,302,415	$16,241,932
Disproportionate Share Hospitals	$42,696,630	$43,348,467
Total	**$1,597,027,673**	**$1,680,706,089**

Source: OHCA Finance Division, September 2014. 1. Includes only outpatient services preformed at a hospital. 2. EHR incentive payments to hospitals only, excludes other provider types which may have received EHR payments such as physicians.

Figure 9 SoonerCare Enrollees and Expenditures by Aid Category Percentages



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

Figure 10 Top 20 SoonerCare Expenditures

Dollars in Millions

Category	Amount
Inpatient Services	$623
Physician	$590
Nursing Facility	$573
Prescribed Drugs	$457
Outpatient Hospital	$291
Behavioral Health Services	$263
Direct Support	$210
Dental	$136
Medicare Part A & B (Buy-In) Payments	$124
Targeted Case Manager	$106
Psychiatric Services	$103
Personal Care	$98
ICF-ID Services	$95
Clinic	$89
Medicare Part D Payments	$77
Medical Supplies/DMEPOS	$67
Laboratory Services	$55
Insure Oklahoma ESI Premium	$45
Transportation - Emergency	$44
Capitated Services	$42

Axis: $0 $50 $100 $150 $200 $250 $300 $350 $400 $450 $500 $550 $600 $650 $700

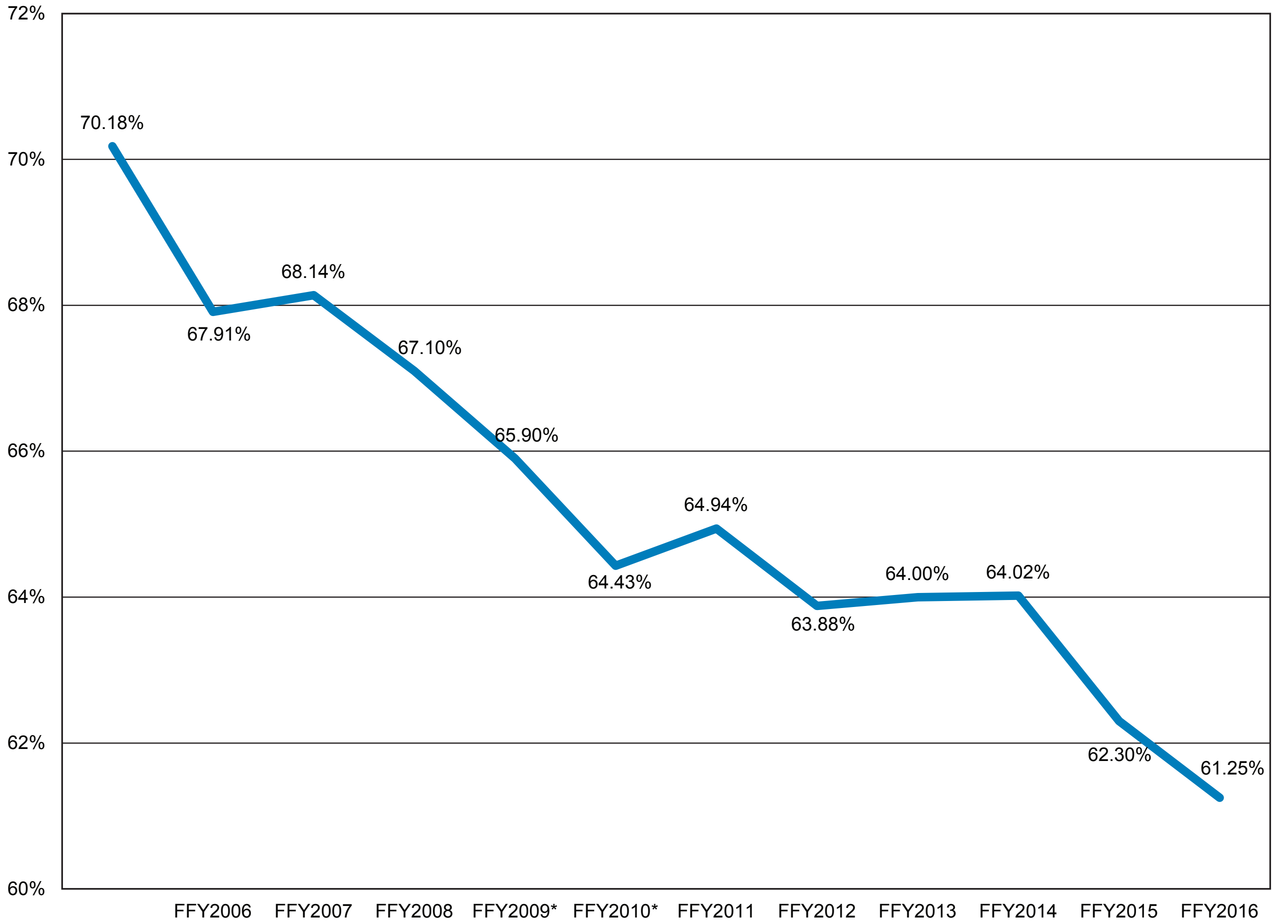
$141 M

By limiting the amount paid for generic drugs, OHCA was able to save $141,494,231 in SFY2014.

Federal Medical Assistance

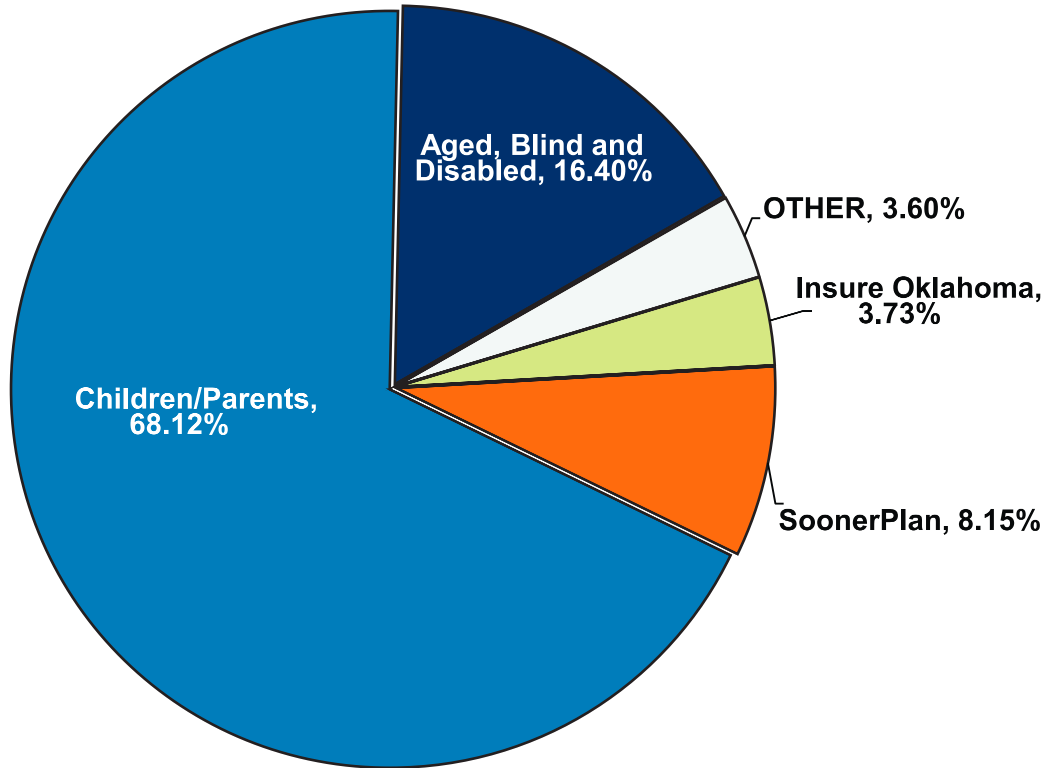
The federal and state governments share Medicaid costs. For program administration costs, the federal government contributes 50 percent for each state, with enhanced funding provided for some administrative activities, such as fiscal agent operations. For medical services provided under the program, 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.

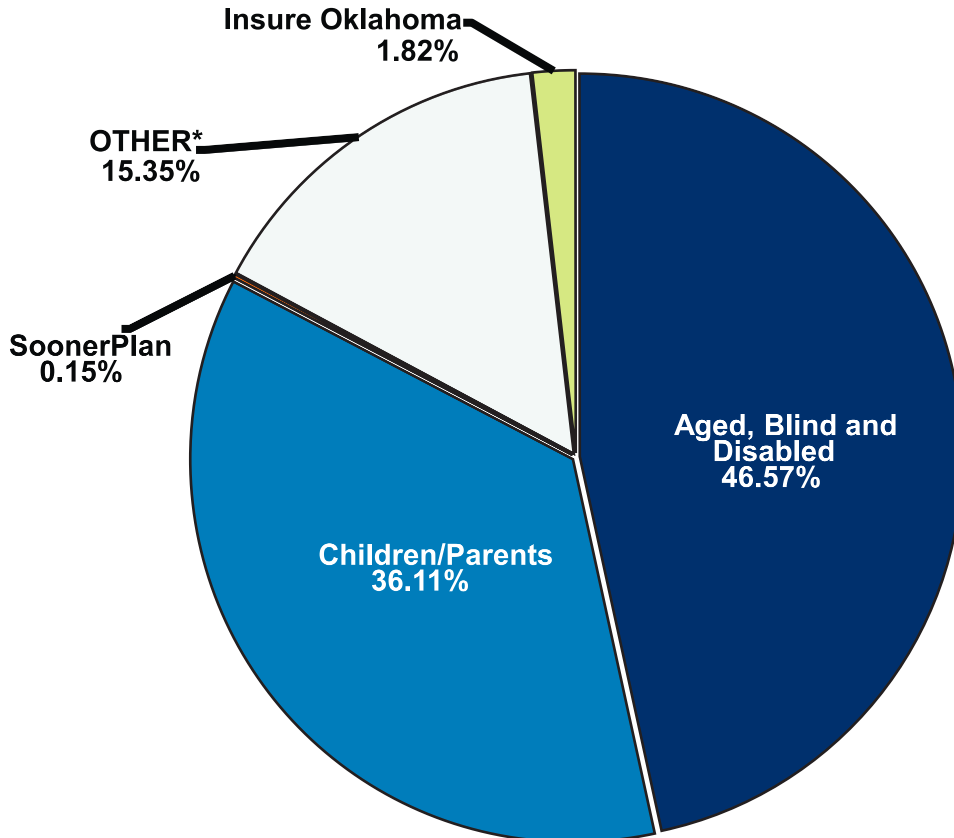
Figure 11 Federal Medical Assistance Percentage for Oklahoma — Federal Fiscal Year 2005 - 2016



*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 12 SOONERCARE ENROLLEES AND EXPENDITURES BY AID CATEGORY PERCENTAGES



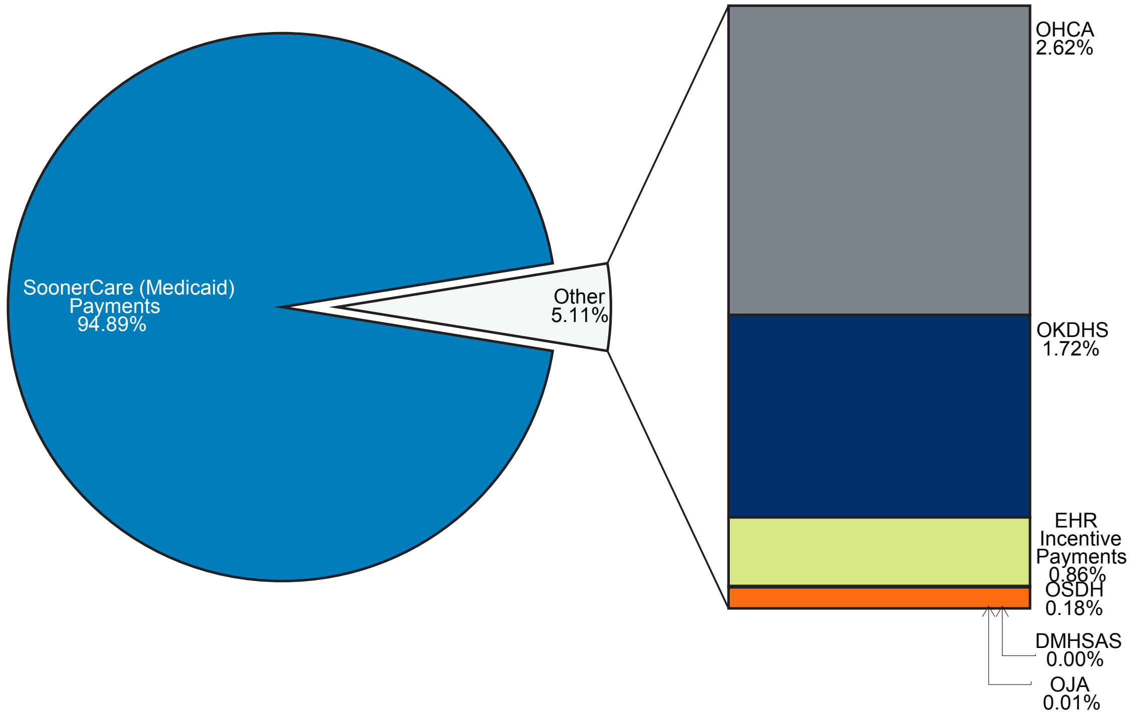


Other enrollees and expenditures include — Refugee, PKU, Qualifying Individual Group One, Service Limited Medicare Beneficiary, Developmental Disabilities Services Division, Supported Living, Soon-to-be Sooners and Tuberculosis members. Children/Parents include child custody. Aged, Blind, Disabled include 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 13 OHCA SoonerCare Expenditure and Administrative Percentages



Finally, OHCA's administrative expenses are divided between direct operating expenses and vendor contracts. Of the $143 million spent on administration by OHCA in SFY2014, 37 percent went to direct operation expenses and 63 percent went toward vendor contracts.

Figure 14 Breakdown of OHCA Administrative Expenses

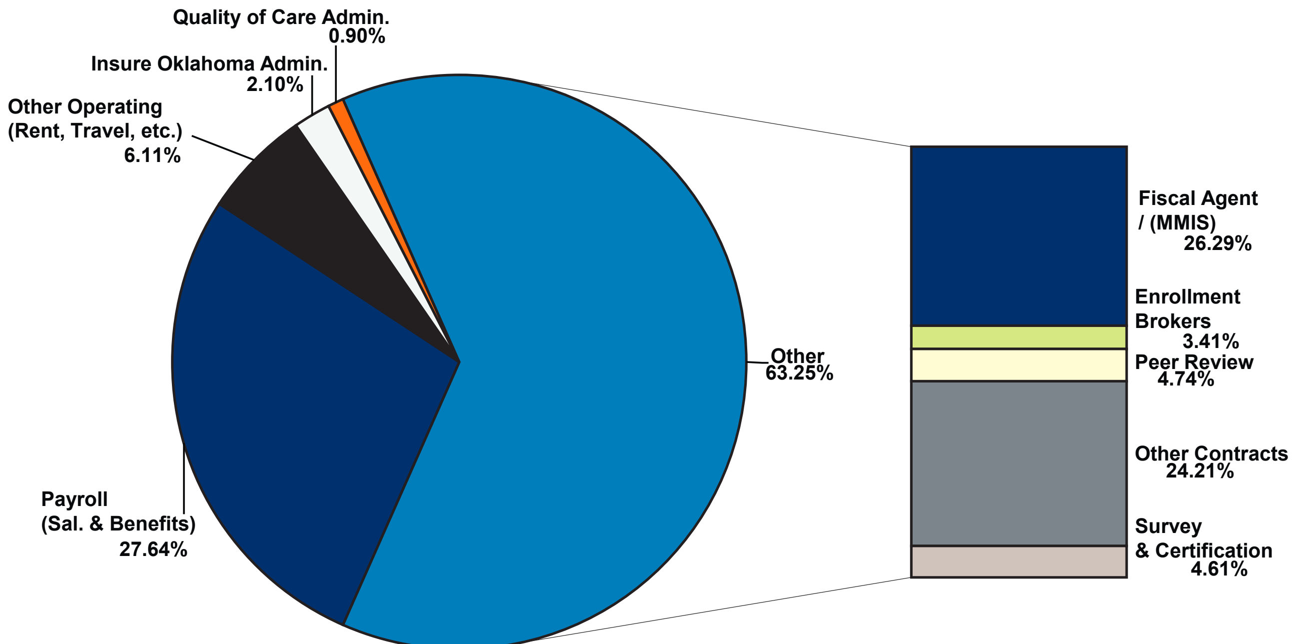
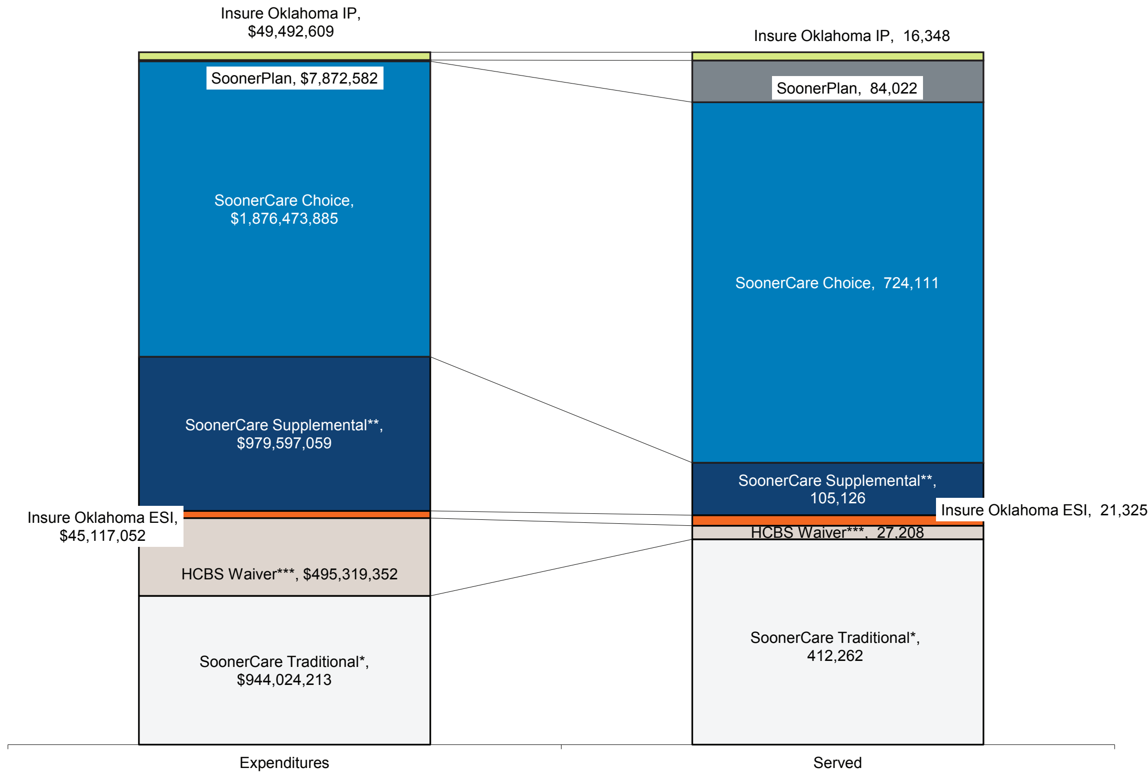
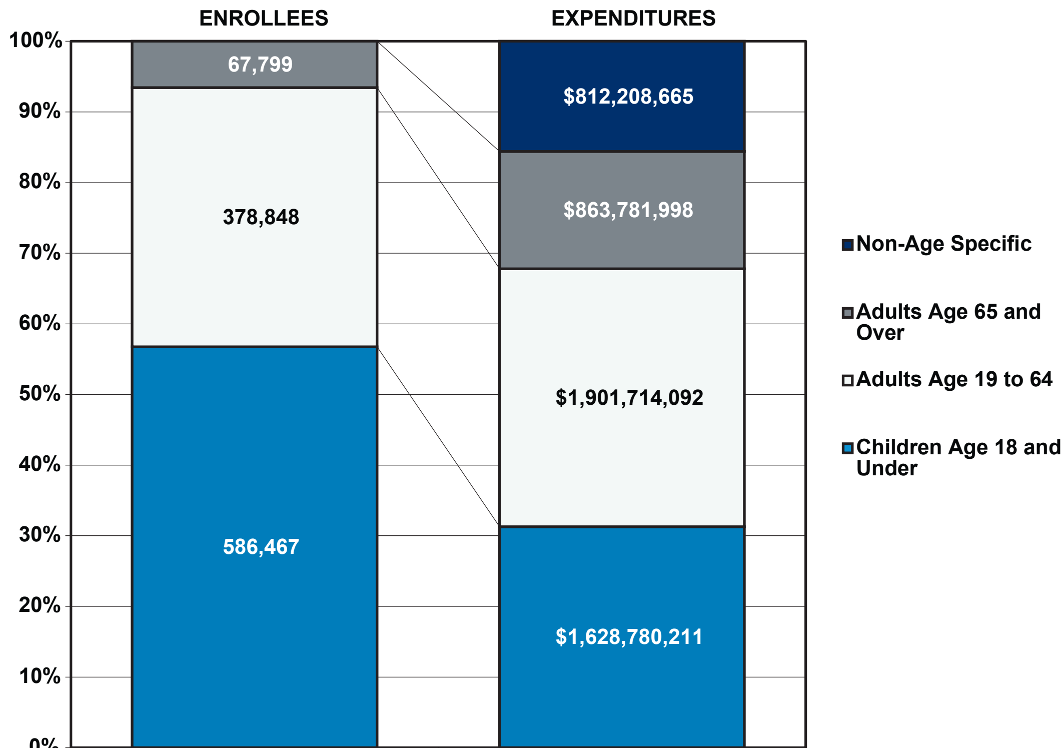


Figure 15 SoonerCare Expenditures and Served by Benefit Plan



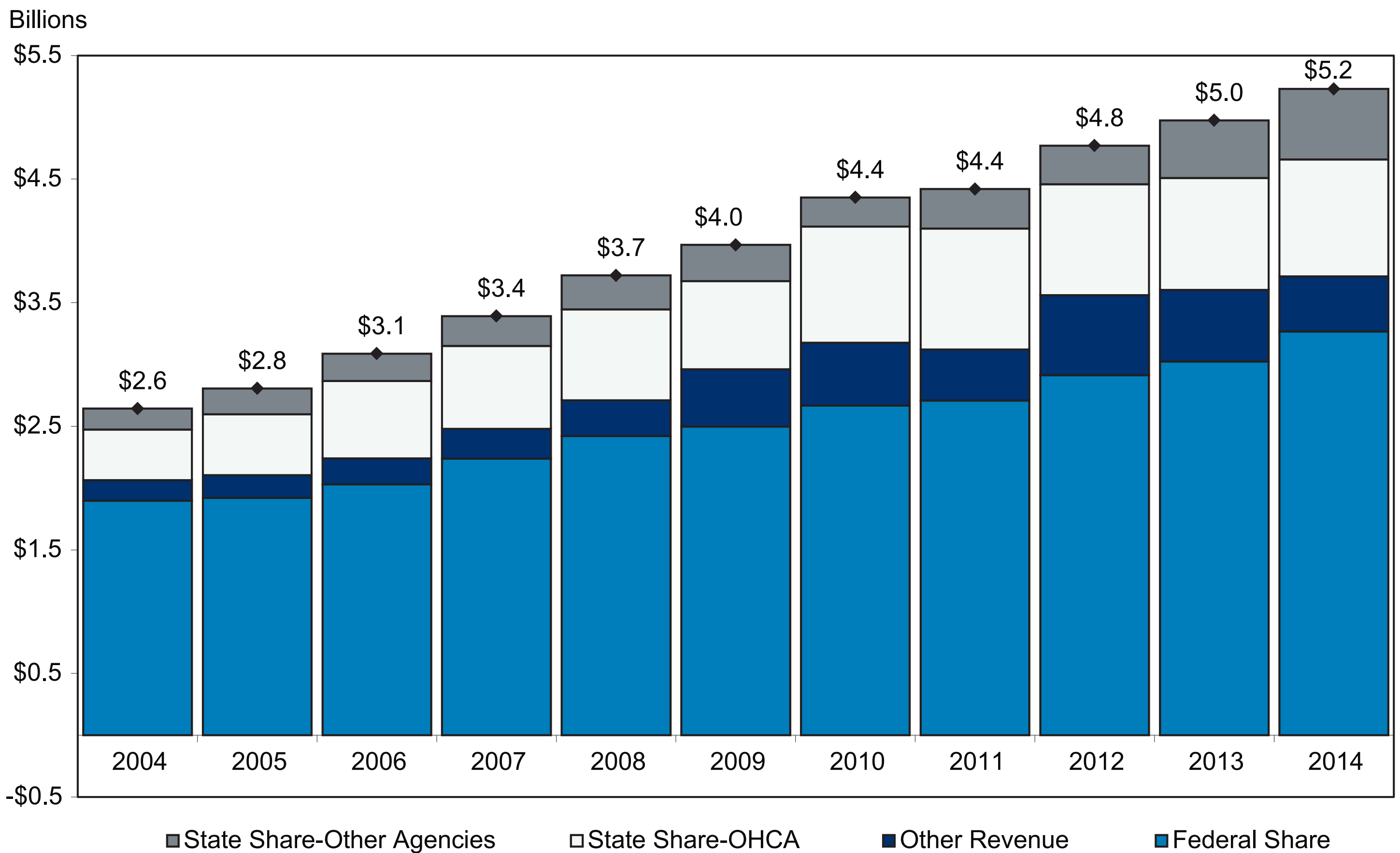
*SoonerCare Choice members will be enrolled/served under SoonerCare Traditional until their SoonerCare Choice becomes effective. Therefore, members may be counted in both categories. **SoonerCare Supplemental and ***Home and Community-Based Services (HCBS) waiver served members may also be included in 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 $406,660,323 in Supplemental Hospital Offset payments; $241,432,073 in Hospital Supplemental payments (includes hospital supplemental payments, DSH, GME and IME); $89,457,402 in GME payments; $32,287,963 in EHR payments and $38,750,454 in Outpatient Behavioral Health Supplemental payments.

Figure 16 SoonerCare Enrollees and Expenditures by Age



Non-age specific payments include $406,660,323 in Supplemental Hospital Offset payments; $241,432,073 in Hospital Supplemental Payments (HSP) (includes HSP, DSH, GME and IME); $38,750,454 in Outpatient Behavioral Health Supplemental payments; $3,204,849 in SoonerExcel payments; $32,287,963 in EHR incentive payments; $89,457,402 in GME payments to Medical schools; and -$38,908 in non-member specific provider adjustments. $124,474,661 in Medicare Part A & B (Buy-In) payments and $76,609,978 in Medicare Part D (clawback) payments are included in Ages 65 and over.

Figure 17 Summary of Expenditures and Revenue Sources — Federal Fiscal Year 2004 - 2014



Federal Fiscal Year	Total Expenditures	Federal Share	Other Revenue	State Share — OHCA	State Share — Other Agencies
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
2014	$5,229,376,869	$3,267,139,805	$444,857,405	$946,812,805	$570,566,854

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 39 of this report.

Figure 18 Historic SoonerCare Enrollees, Served and Expenditures — State Fiscal Year 2010 - 2014

	SFY2010	SFY2011	SFY2012	SFY2013	SFY2014
Expenditures (in Billions)	$4.33	$4.38	$4.78	$4.99	$5.21
Enrollees	885,238	968,296	1,007,356	1,040,332	1,033,114
Served	881,220	929,348	943,695	1,015,939	1,028,097

Community Forums

The community forums provide unique opportunities for community stakeholders to meet face-to-face with key OHCA personnel to ask questions and provide feedback about SoonerCare programs. Sallisaw, Stigler, Altus, Marietta, Antlers, Guymon and Enid hosted community forums and were selected because of their unique challenges and/or limited resources pertaining to SoonerCare members and providers. Key staff has been available to respond to questions and provide feedback. Additionally, discussions at these forums have led to policy changes within the agency and have improved the SoonerCare program delivery.

Medicaid Information Technology Architecture (MITA) State Self-Assessment

MITA 3.0 is a Centers for Medicare & Medicaid Services (CMS) initiative fostering integrated business and information technology (IT) transformation across Medicaid in an effort to improve collaboration of state and federal agencies in Medicaid operations. It has become a required effort for each state to receive continued federal funding in IT development and will be an annual effort going forward. Staff members from all of OHCA's business areas were engaged in conducting the MITA State Self-Assessment from October 2013 through June 2014. Oklahoma's MITA SS-A version 3.0 was submitted to CMS August 2014.

OHCA Adds New Measure to Deter Prescription Drug Abuse

The Pharmacy Lock-in Program has added a new measure to prevent SoonerCare members from receiving controlled substances from more than one prescriber. The measure aims to deter the practice of doctor shopping and reduce the possibility of accidental drug overdose. The new lock-in requirement began in the summer of 2014.

The new requirement limits SoonerCare members who are at risk of misusing prescribed controlled substances to using both a single pharmacy and prescriber (health care provider). Pharmacy claims are blocked from a prescriber who is not the lock-in member's authorized prescriber. This only applies to controlled substance prescriptions.

A redesign to the provider portal was implemented in SFY2014. The portal allows providers, clerks and billing agents access to appropriate provider information, claims, prior authorizations and OHCA messages.

Access to Care Project

The Access to Care project is a collaborative effort between the OHCA, the Oklahoma Commission on Children and Youth and the Texas County community. The project will be highlighted at the Rural HealthCare Association Conference held in September 2014. The project's goals are to increase the number of providers that actively see SoonerCare patients, establish a Federally Qualified Health Center or comparable resource, establish a comprehensive system of health care services to the underserved and reduce the percentage of underserved living in Texas County. The project examines Texas County's current access to care landscape, creating solutions through the development of special committees that are focused on identifying and resolving barriers to care within their community. The project began in December of 2012 and has had many successes, including the foundation of nonprofit status for a counseling center in the area, the addition of buses available in Texas County for SoonerRide services and the pursuit of dental and Federally Qualified Health Center grants. The project was praised at the Guymon community forum. The project is scheduled to continue through 2018.

Claims Resolution Workflow

The new Claims Resolution Workflow (CRW) automatically collects, prioritizes and distributes suspended claims to individual OHCA staff while maintaining a balanced workload. The new system gives OHCA the flexibility to quickly develop and deploy business rules that govern the assignment of suspended claims in the Medicaid Management Information System (MMIS). In addition, new system generated reports empower OHCA's Claims Management team to more efficiently track and monitor user workload and performance. Designed according to the Medicaid Information Technology Architecture (MITA) framework, the new CRW is a great step in OHCA's path to MMIS modernization.

Health Management Program Continues to be a Success

The SoonerCare Health Management Program (HMP) continues to address the health needs of chronically ill SoonerCare members while reducing unnecessary medical costs. Each year the HMP has been evaluated by Pacific Health Policy Group (PHPG) to measure the program's impact on quality of care. PHPG 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.

Findings from the fifth annual analysis were very promising. According to the report, the participant compliance rate exceeded the comparison group rate for 16 of the 21 diagnosis-specific measures. The difference was statistically significant for 11 of the 16, 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 chronic obstructive pulmonary disease, congestive heart failure, diabetes and hypertension. The evaluation articulated a return investment of 562 percent. This equates to more than six dollars in medical savings for every dollar in administrative expenditures.

Beginning in SFY2014, a modification to the Health Management Program was made to rename nurse case managers as health coaches. These health coaches are embedded within primary care practices with a high chronic disease burden. 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 Staff Receive Awards

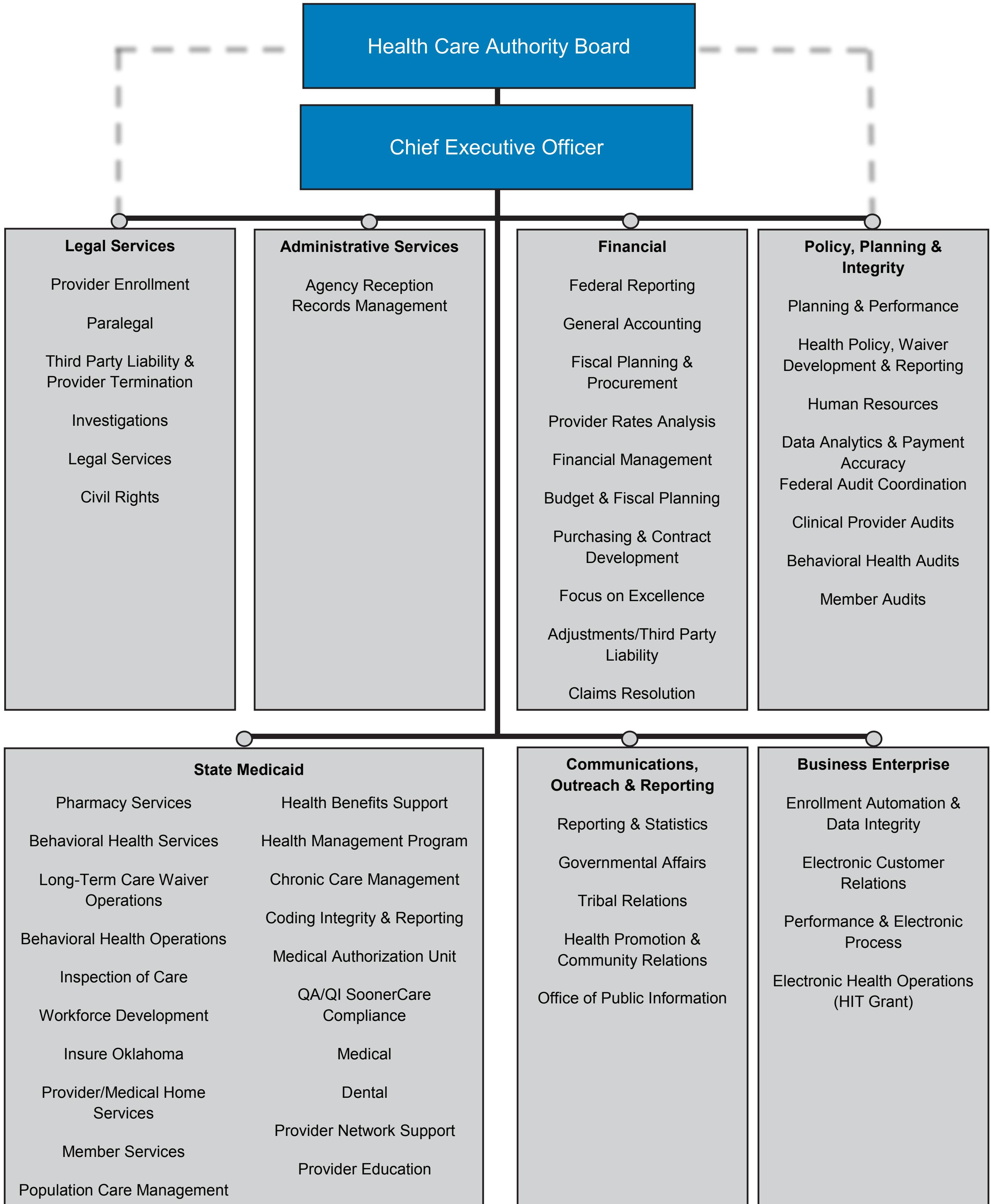
Oklahoma Magazine honored OHCA CEO, Nico Gomez, as an "Oklahoman of the Year". Nico began his public service career as spokesperson for the Oklahoma Department of Transportation in 1995. In 2000, he joined OHCA as public information officer. He was appointed five years later by the Speaker of the House of Representatives to serve on a state Medicaid reform task force. Prior to becoming the CEO in 2013, Gomez had been deputy CEO since 2008. Gomez was one of only six Oklahomans honored with this designation, which recognizes exceptional contributions to community and state.

The Oklahoma Academy of Family Physicians (OAFP) honored SoonerCare Provider Services Director Melody Anthony as the "2014 Patient Advocate of the Year". Ms. Anthony received her award at OAFP's 66th Annual Scientific Assembly in June 2014. As director of Provider Services for OHCA, Ms. Anthony is responsible for provider recruitment, contracting, retention, claims resolution, compliance, policy education and development for the SoonerCare program. Additionally, Ms. Anthony is a key member of OHCA's Medical Home Health Access Network team and serves as an agency lead for the Comprehensive Primary Care initiative through the Innovation Center at the National Centers for Medicare & Medicaid Services.

OHCA 2014 Quality Oklahoma Team Day Award

OHCA highlighted several projects at the 2014 Quality Oklahoma Team Day at the state capitol. The Policy, Planning and Integrity department received a Governor's Commendation for Excellence award for the Medicaid Payment Error Rate Measurement (PERM) program. PERM audits are tri-year, comprehensive audits of state Medicaid programs which include a review of member eligibility, medical necessity of the services rendered and appropriate processing of claims paid. The SoonerCare program has shown consistent improvement in PERM audit results. In the 2012 PERM audit, SoonerCare had the lowest error rate of any of the 17 states in the rotation (0.28 percent in Oklahoma vs. a 5.8 percent national average). The Children's Health Insurance Plan error rate was also one of the lowest in the nation (1.39 percent Oklahoma vs. 6.1 percent national average).

Figure 19 OHCA Organizational Chart



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

Appendix A Summary of Revenue Sources and Recoveries

Table A Revenue Source Summary

Revenue Source	Actual Revenues
State Appropriations	$946,812,805
Federal Funds—OHCA	$2,356,408,053
Federal Funds for Other State Agencies	$910,731,752
Refunds from Other State Agencies	$570,566,854
Tobacco Tax Funds	$92,456,532
Drug Rebate	$233,914,648
Medical Refunds	$55,103,747
Quality of Care Fees	$77,610,030
SHOPP Assessment Fees	$179,037,638
Prior Year Carryover	$41,811,007
Other Revenue	$20,477,852
Total Revenue	**$5,484,930,918**

Source: Oklahoma Health Care Authority (OHCA) Financial Services Division, September 2014. 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.

Table B Post-Payment Review Recoveries

Provider Type	SFY2014
Behavioral Health	$346,878
Dental Services	$603,364
Durable Medical Equipment	$12,198
Electronic Health Record Incentive Payments	$106,250
Hospital	$689,768
Long-Term Care Facilities	$49,430
Non-Emergency Transportation	$105,957
Personal Care	$46,147
Physicians and Other Practitioners	$2,479,956
School-Based Providers	$122,856
Vision	$160,342
Other	$8,676
Total - OHCA Recoveries	**$4,731,822**
MFCU - National Settlements	$20,553,458
MFCU - Other	$615,844
Total SoonerCare Recoveries	**$25,901,123**

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

Table I SoonerCare Expenditures by Payor

Category of Service	Total	Health Care Authority	Other State Agencies
ADvantage Waiver	$183,308,381	$0	$183,308,381
Ambulatory Clinics	$10,260,460	$9,865,921	$0
Behavioral Health - Case Management	$10,421,228	$0	$10,421,228
Behavioral Health - Inpatient	$25,910,229	$12,111,725	$13,317,202
Behavioral Health - Outpatient	$25,710,871	$0	$25,710,871
Behavioral Health - PRTF	$93,137,105	$0	$93,137,105
Behavioral Health - Psychiatrist	$8,469,652	$8,469,652	$0
Behavioral Health Facility- Rehab	$293,768,712	$0	$293,685,418
Clinic Services	$114,644,099	$102,130,011	$11,187,589
CMS Payments	$212,821,326	$212,120,417	$0
Dentists	$143,450,130	$136,555,287	$0
EHR Incentive Payments	$31,836,261	$31,836,261	$0
Family Planning/Family Planning Waiver	$11,023,179	$0	$11,023,179
GME/IME/DME	$138,471,093	$0	$138,471,093
Home and Community-Based Waiver	$172,790,433	$0	$172,790,433
Home Health Care	$20,619,063	$20,589,183	$0
Homeward Bound Waiver	$90,178,069	$0	$90,178,069
ICF/ID Private	$58,724,681	$47,029,857	$0
ICF/ID Public	$36,846,889	$0	$36,846,889
In-Home Support Waiver	$23,896,415	$0	$23,896,415
Inpatient Acute Care	$805,935,343	$589,839,223	$155,054,229
Lab & Radiology	$68,899,981	$65,274,385	$0
Medical Supplies	$46,759,384	$43,477,484	$0
Mid Level Practitioners	$3,520,833	$3,461,365	$0
Miscellaneous Medical Payments	$214,775	$207,190	$0
Money Follows the Person	$11,090,798	$952,877	$10,137,921
Nursing Facilities	$572,855,252	$320,746,680	$0
Other Practitioners	$38,828,013	$37,116,404	$0
Outpatient Acute Care	$288,740,304	$275,914,885	$0
Personal Care Services	$13,291,966	$0	$13,291,966
Physicians	$562,184,234	$431,165,754	$45,652,029
Premium Assistance*	$45,821,868	$0	$0
Prescription Drugs	$467,909,057	$402,810,300	$0
Residential Behavioral Management	$20,833,638	$0	$20,833,638
SHOPP Payments**	$406,660,323	$406,660,323	$0
SoonerCare Choice	$36,682,643	$36,369,100	$0
Targeted Case Management	$66,248,017	$0	$66,248,017
Therapeutic Foster Care	$2,009,305	$2,009,305	$0
Transportation	$64,686,155	$58,791,951	$0
Total SoonerCare Expenditures	**$5,046,151,784**	**$3,255,505,540**	**$1,231,883,291**

July 2013 - June 2014
Appendix B Statewide Figures

Table 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	$377,023	$17,516
Behavioral Health - Case Management	$0	$0	$0	$0
Behavioral Health - Inpatient	$0	$0	$481,302	$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	$83,295
Clinic Services	$0	$0	$1,085,258	$241,241
CMS Payments	$700,909	$0	$0	$0
Dentists	$0	$6,798,911	$63,819	$32,113
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	$1,961	$27,919
Homeward Bound Waiver	$0	$0	$0	$0
ICF/ID Private	$10,839,703	$855,121	$0	$0
ICF/ID Public	$0	$0	$0	$0
In-Home Support Waiver	$0	$0	$0	$0
Inpatient Acute Care	$486,687	$50,741,699	$7,791,148	$2,022,358
Lab & Radiology	$0	$0	$2,940,979	$684,618
Medical Supplies	$2,711,537	$0	$519,667	$50,696
Mid Level Practitioners	$0	$0	$55,670	$3,799
Miscellaneous Medical Payments	$0	$0	$79	$7,506
Money Follows the Person	$0	$0	$0	$0
Nursing Facilities	$211,652,291	$40,447,958	$0	$8,323
Other Practitioners	$446,364	$1,035,806	$220,123	$9,316
Outpatient Acute Care	$41,604	$0	$8,512,239	$4,271,575
Personal Care Services	$0	$0	$0	$0
Physicians	$58,101	$67,901,698	$11,127,931	$6,278,721
Premium Assistance*	$0		$45,821,868	$0
Prescription Drugs	$0	$47,237,047	$16,114,259	$1,747,451
Residential Behavioral Management	$0	$0	$0	$0
SHOPP Payments**	$0	$0	$0	$0
SoonerCare Choice	$0	$0	$296,673	$16,870
Targeted Case Management	$0	$0	$0	$0
Therapeutic Foster Care	$0	$0	$0	$0
Transportation	$2,631,894	$3,205,680	$0	$56,630
Total SoonerCare Expenditures	**$229,569,090**	**$218,223,919**	**$95,409,999**	**$15,559,946**

Source: OHCA Financial Services Division, September 2014. HEEIA includes $45,434,243 paid out of Fund 245 and **$182,116,227 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)

Table II Statewide SoonerCare Figures by County

County	Population Proj. July 2013*	Rank	Unduplicated SoonerCare Enrollees**	Rank	Percent Population Enrolled in SoonerCare	Rank
ADAIR	22,194	39	10,332	29	47%	1
ALFALFA	5,847	69	995	70	17%	72
ATOKA	13,898	48	4,311	50	31%	31
BEAVER	5,566	70	893	73	16%	74
BECKHAM	23,637	38	6,172	41	26%	51
BLAINE	9,720	60	3,210	56	33%	23
BRYAN	44,244	23	14,971	16	34%	19
CADDO	29,594	33	10,205	30	34%	16
CANADIAN	126,123	4	19,693	8	16%	75
CARTER	48,491	16	15,886	12	33%	25
CHEROKEE	48,017	17	14,667	17	31%	34
CHOCTAW	15,045	46	6,342	40	42%	3
CIMARRON	2,335	77	670	75	29%	40
CLEVELAND	269,340	3	44,391	3	16%	73
COAL	5,867	68	2,007	64	34%	18
COMANCHE	124,937	5	30,551	4	24%	53
COTTON	6,152	67	1,700	65	28%	43
CRAIG	14,672	47	4,844	46	33%	24
CREEK	70,470	10	20,786	7	29%	36
CUSTER	29,377	34	6,834	38	23%	57
DELAWARE	41,377	24	12,165	24	29%	37
DEWEY	4,844	71	1,003	69	21%	64
ELLIS	4,170	73	594	77	14%	77
GARFIELD	62,267	12	16,716	11	27%	48
GARVIN	27,334	35	8,447	34	31%	32
GRADY	53,685	13	11,488	27	21%	62
GRANT	4,528	72	961	71	21%	63
GREER	6,171	66	1,699	66	28%	44
HARMON	2,869	76	909	72	32%	30
HARPER	3,813	74	832	74	22%	61
HASKELL	13,052	51	4,879	45	37%	7
HUGHES	13,823	49	4,580	48	33%	22
JACKSON	26,088	36	7,358	36	28%	41
JEFFERSON	6,432	65	2,415	63	38%	6
JOHNSTON	10,990	56	4,031	52	37%	10
KAY	45,633	19	15,766	13	35%	15
KINGFISHER	15,276	45	3,369	55	22%	60
KIOWA	9,341	61	3,196	57	34%	17
LATIMER	10,775	57	3,615	54	34%	21
LEFLORE	49,774	15	17,405	10	35%	13
LINCOLN	34,351	30	8,936	32	26%	52
LOGAN	44,422	22	8,590	33	19%	68

Appendix B Statewide Figures (continued)

Table II Statewide SoonerCare Figures by County (continued)

County	Expenditures	Rank	Annual Per Est. Population	Rank	Monthly Average Per Enrollee	Rank
ADAIR	$36,859,567	32	$1,661	11	$297	60
ALFALFA	$3,756,065	72	$642	70	$315	51
ATOKA	$19,116,940	50	$1,376	24	$370	23
BEAVER	$2,140,813	74	$385	76	$200	74
BECKHAM	$26,686,636	41	$1,129	42	$360	27
BLAINE	$11,021,677	59	$1,134	41	$286	64
BRYAN	$57,466,375	19	$1,299	32	$320	45
CADDO	$32,200,277	36	$1,088	45	$263	70
CANADIAN	$73,862,722	11	$586	72	$313	53
CARTER	$63,093,796	15	$1,301	31	$331	39
CHEROKEE	$64,561,221	14	$1,345	28	$367	25
CHOCTAW	$30,390,153	37	$2,020	2	$399	15
CIMARRON	$1,047,553	76	$449	75	$130	76
CLEVELAND	$163,865,692	3	$608	71	$308	57
COAL	$10,324,420	60	$1,760	6	$429	7
COMANCHE	$93,821,346	6	$751	62	$256	72
COTTON	$6,514,674	67	$1,059	46	$319	47
CRAIG ‡	$27,999,986	38	$1,908	3	$482	3
CREEK	$94,426,883	5	$1,340	30	$379	20
CUSTER	$23,525,692	43	$801	60	$287	63
DELAWARE	$47,972,607	26	$1,159	40	$329	41
DEWEY	$3,957,653	71	$817	59	$329	40
ELLIS	$912,821	77	$219	77	$128	77
GARFIELD ‡	$88,167,039	8	$1,416	22	$440	5
GARVIN ‡	$50,031,441	24	$1,830	4	$494	2
GRADY	$44,822,578	29	$835	57	$325	43
GRANT	$3,971,321	70	$877	54	$344	35
GREER	$8,339,618	64	$1,351	26	$409	12
HARMON	$4,549,909	69	$1,586	15	$417	9
HARPER	$2,782,056	73	$730	67	$279	67
HASKELL	$19,901,175	46	$1,525	18	$340	36
HUGHES	$21,818,668	45	$1,578	16	$397	17
JACKSON	$25,633,561	42	$983	50	$290	61
JEFFERSON	$8,209,194	65	$1,276	33	$283	65
JOHNSTON	$19,729,883	48	$1,795	5	$408	13
KAY	$56,726,008	20	$1,243	35	$300	59
KINGFISHER	$12,617,360	56	$826	58	$312	54
KIOWA	$14,175,045	55	$1,518	19	$370	22
LATIMER	$15,042,485	53	$1,396	23	$347	32
LEFLORE	$74,171,461	10	$1,490	20	$355	29
LINCOLN	$33,323,025	35	$970	51	$311	55
LOGAN	$37,235,071	31	$838	56	$361	26

Appendix B Statewide Figures (continued)

Table II Statewide SoonerCare Figures by County (continued)

County	Population Proj. July 2013*	Rank	Unduplicated SoonerCare Enrollees**	Rank	Percent Population Enrolled in SoonerCare	Rank
LOVE	9,742	59	2,898	59	30%	35
MCCLAIN	36,511	29	8,095	35	22%	59
MCCURTAIN	33,065	31	14,043	19	42%	2
MCINTOSH	20,493	42	6,526	39	32%	29
MAJOR	7,683	64	1,551	68	20%	65
MARSHALL	15,988	44	5,171	43	32%	26
MAYES	40,804	26	13,084	21	32%	28
MURRAY	13,712	50	3,721	53	27%	46
MUSKOGEE	70,303	11	24,512	5	35%	14
NOBLE	11,446	54	2,768	62	24%	54
NOWATA	10,555	58	2,936	58	28%	42
OKFUSKEE	12,377	52	4,478	49	36%	12
OKLAHOMA	755,245	1	207,217	1	27%	45
OKMULGEE	39,438	27	13,239	20	34%	20
OSAGE	47,987	18	7,043	37	15%	76
OTTAWA	32,245	32	12,743	23	40%	4
PAWNEE	16,513	43	5,065	44	31%	33
PAYNE	79,066	7	15,381	15	19%	67
PITTSBURG	44,703	21	13,060	22	29%	39
PONTOTOC	37,992	28	11,166	28	29%	38
POTTAWATOMIE	71,158	9	23,007	6	32%	27
PUSHMATAHA	11,233	55	4,082	51	36%	11
ROGER MILLS	3,743	75	651	76	17%	71
ROGERS	89,044	6	17,880	9	20%	66
SEMINOLE	25,426	37	9,367	31	37%	9
SEQUOYAH	41,218	25	15,711	14	38%	5
STEPHENS	44,919	20	12,066	25	27%	47
TEXAS	22,081	40	5,776	42	26%	50
TILLMAN	7,711	63	2,850	60	37%	8
TULSA	622,409	2	164,327	2	26%	49
WAGONER	75,700	8	14,636	18	19%	69
WASHINGTON	51,577	14	12,021	26	23%	56
WASHITA	11,678	53	2,788	61	24%	55
WOODS	9,041	62	1,587	67	18%	70
WOODWARD	21,221	41	4,756	47	22%	58
OUT OF STATE			4,696			
OTHER ◊			3,802			
TOTAL	**3,850,568**		**1,033,114**		**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)

Table II Statewide SoonerCare Figures by County (continued)

County	Expenditures	Rank	Annual Per Est. Population	Rank	Monthly Average Per Enrollee	Rank
LOVE	$8,902,627	63	$914	52	$256	71
MCCLAIN	$27,878,517	39	$764	61	$287	62
MCCURTAIN	$54,413,007	22	$1,646	13	$323	44
MCINTOSH	$34,400,166	34	$1,679	9	$439	6
MAJOR	$5,764,513	68	$750	63	$310	56
MARSHALL	$19,825,640	47	$1,240	36	$320	46
MAYES	$54,722,983	21	$1,341	29	$349	30
MURRAY	$16,592,675	51	$1,210	38	$372	21
MUSKOGEE	$117,576,191	4	$1,672	10	$400	14
NOBLE	$14,185,428	54	$1,239	37	$427	8
NOWATA	$11,711,991	57	$1,110	43	$332	37
OKFUSKEE ‡	$27,823,412	40	$2,248	1	$518	1
OKLAHOMA	$824,164,113	1	$1,091	44	$331	38
OKMULGEE	$65,032,398	13	$1,649	12	$409	11
OSAGE	$35,013,827	33	$730	66	$414	10
OTTAWA	$47,889,624	27	$1,485	21	$313	52
PAWNEE	$22,389,313	44	$1,356	25	$368	24
PAYNE	$58,807,181	18	$744	64	$319	48
PITTSBURG	$60,183,709	16	$1,346	27	$384	19
PONTOTOC	$59,878,653	17	$1,576	17	$447	4
POTTAWATOMIE	$90,130,466	7	$1,267	34	$326	42
PUSHMATAHA	$19,446,261	49	$1,731	7	$397	16
ROGER MILLS	$1,722,464	75	$460	74	$220	73
ROGERS	$74,693,117	9	$839	55	$348	31
SEMINOLE	$43,430,669	30	$1,708	8	$386	18
SEQUOYAH	$65,372,803	12	$1,586	14	$347	33
STEPHENS	$45,749,556	28	$1,018	47	$316	49
TEXAS	$11,217,089	58	$508	73	$162	75
TILLMAN	$9,105,995	62	$1,181	39	$266	69
TULSA	$621,783,042	2	$999	49	$315	50
WAGONER	$49,063,125	25	$648	69	$279	66
WASHINGTON	$51,749,905	23	$1,003	48	$359	28
WASHITA	$10,262,056	61	$879	53	$307	58
WOODS	$6,579,760	66	$728	68	$346	34
WOODWARD	$15,688,469	52	$739	65	$275	68
OUT OF STATE	$1,509,099					
OTHER ◊	$1,085,052,655					
TOTAL	**$5,206,484,966**		**$1,076**		**$334**	

‡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 $406,660,323 in SHOPP payments; $241,432,073 in Hospital Supplemental payments (includes hospital supplemental payments, DSH, GME and IME); $124,474,661 in Medicare Part A & B (Buy-In) payments; $76,609,978 in Medicare Part D (clawback) payments; $89,457,402 in GME payments to medical schools; $44,708,863 in Insure Oklahoma ESI premiums; $408,189 in Insure Oklahoma ESI Out-Of Pocket payments; $32,287,963 in EHR incentive payments; $38,750,454 in Outpatient Behavioral Health Supplemental payments; $3,204,849 in SoonerExcel payments; $6,551,610 in Health Access Network payments and -$1,455,659 in non-member specific provider adjustments.

Appendix B Statewide Figures (continued)

Table 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	$14,290,320	$36,859,567	39%
ALFALFA	$1,542,974	$3,756,065	41%
ATOKA	$15,527,317	$19,116,940	81%
BEAVER	$1,201,895	$2,140,813	56%
BECKHAM	$17,618,241	$26,686,636	66%
BLAINE	$6,974,341	$11,021,677	63%
BRYAN	$54,980,192	$57,466,375	96%
CADDO	$16,259,326	$32,200,277	50%
CANADIAN	$42,218,722	$73,862,722	57%
CARTER	$65,923,601	$63,093,796	104%
CHEROKEE	$67,065,244	$64,561,221	104%
CHOCTAW	$18,976,578	$30,390,153	62%
CIMARRON	$263,546	$1,047,553	25%
CLEVELAND	$142,807,918	$163,865,692	87%
COAL	$4,207,955	$10,324,420	41%
COMANCHE	$90,569,532	$93,821,346	97%
COTTON	$3,559,148	$6,514,674	55%
CRAIG	$21,235,076	$27,999,986	76%
CREEK	$63,927,187	$94,426,883	68%
CUSTER	$21,657,564	$23,525,692	92%
DELAWARE	$31,665,354	$47,972,607	66%
DEWEY	$1,864,374	$3,957,653	47%
ELLIS	$1,575,218	$912,821	173%
GARFIELD	$76,370,525	$88,167,039	87%
GARVIN	$32,546,496	$50,031,441	65%
GRADY	$28,514,760	$44,822,578	64%
GRANT	$2,135,501	$3,971,321	54%
GREER	$3,813,608	$8,339,618	46%
HARMON	$3,200,424	$4,549,909	70%
HARPER	$1,782,516	$2,782,056	64%
HASKELL	$20,124,806	$19,901,175	101%
HUGHES	$11,864,766	$21,818,668	54%
JACKSON	$19,923,872	$25,633,561	78%
JEFFERSON	$2,656,055	$8,209,194	32%
JOHNSTON	$12,597,272	$19,729,883	64%
KAY	$46,297,097	$56,726,008	82%
KINGFISHER	$6,482,767	$12,617,360	51%
KIOWA	$9,827,150	$14,175,045	69%
LATIMER	$7,885,159	$15,042,485	52%
LEFLORE	$46,815,645	$74,171,461	63%
LINCOLN	$12,022,237	$33,323,025	36%
LOGAN	$18,826,254	$37,235,071	51%

Appendix B Statewide Figures (continued)

Table 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
LOVE	$2,993,483	$8,902,627	34%
MCCLAIN	$12,811,529	$27,878,517	46%
MCCURTAIN	$28,314,757	$54,413,007	52%
MCINTOSH	$32,752,114	$34,400,166	95%
MAJOR	$2,439,371	$5,764,513	42%
MARSHALL	$9,806,678	$19,825,640	49%
MAYES	$20,831,443	$54,722,983	38%
MURRAY	$9,995,133	$16,592,675	60%
MUSKOGEE	$101,074,948	$117,576,191	86%
NOBLE	$7,883,153	$14,185,428	56%
NOWATA	$5,464,308	$11,711,991	47%
OKFUSKEE	$16,687,745	$27,823,412	60%
OKLAHOMA	$1,170,831,745	$824,164,113	142%
OKMULGEE	$33,626,964	$65,032,398	52%
OSAGE	$11,311,575	$35,013,827	32%
OTTAWA	$36,936,681	$47,889,624	77%
PAWNEE	$11,689,832	$22,389,313	52%
PAYNE	$41,361,777	$58,807,181	70%
PITTSBURG	$47,875,148	$60,183,709	80%
PONTOTOC	$68,540,210	$59,878,653	114%
POTTAWATOMIE	$57,241,503	$90,130,466	64%
PUSHMATAHA	$27,900,432	$19,446,261	143%
ROGER MILLS	$209,828	$1,722,464	12%
ROGERS	$46,028,318	$74,693,117	62%
SEMINOLE	$24,207,381	$43,430,669	56%
SEQUOYAH	$43,795,805	$65,372,803	67%
STEPHENS	$37,246,275	$45,749,556	81%
TEXAS	$7,838,938	$11,217,089	70%
TILLMAN	$3,542,311	$9,105,995	39%
TULSA	$873,124,042	$621,783,042	140%
WAGONER	$16,746,358	$49,063,125	34%
WASHINGTON	$34,604,983	$51,749,905	67%
WASHITA	$4,870,015	$10,262,056	47%
WOODS	$3,717,791	$6,579,760	57%
WOODWARD	$11,552,473	$15,688,469	74%
OUT OF STATE	$177,645,731	$1,509,099	
OTHER ◊	$1,093,385,655	$1,085,052,655	
TOTAL	**$5,206,484,966**	**$5,206,484,966**	**Average 67%**

◊Non-member specific payments include $406,660,323 in SHOPP payments; $241,432,073 in Hospital Supplemental payments (includes hospital supplemental payments, DSH, GME and IME); $124,474,661 in Medicare Part A & B (Buy-In) payments; $76,609,978 in Medicare Part D (clawback) payments; $89,457,402 in GME payments to medical schools; $44,708,863 in Insure Oklahoma ESI premiums; $408,189 in Insure Oklahoma Out-Of Pocket payments; $32,287,963 in EHR incentive payments; $38,750,454 in Outpatient Behavioral Health Supplemental payments; $3,204,849 in SoonerExcel payments; $6,551,610 in Health Access Network payments and -$427,977 in non-member specific provider adjustments.

Appendix B Statewide Figures (continued)

Table IV Expenditures by Type of Service Percent of Change

Type of Service	SFY2013			SFY2014			Percent Change		
	Expenditures	Members	Avg Per Member Served	Expenditures	Members	Avg Per Member Served	Expend-itures	Mem-bers	Aver-age
Adult Day Care	$4,452,096	808	$5,510	$4,704,748	837	$5,621	6%	4%	2%
Advanced Practice Nurse	$3,357,358	15,110	$222	$3,025,966	13,785	$220	-10%	-9%	-1%
ADvantage Home Delivered Meals	$15,221,754	13,527	$1,125	$16,190,529	13,933	$1,162	6%	3%	3%
Ambulatory Surgical Services	$10,137,760	18,015	$563	$9,821,589	17,330	$567	-3%	-4%	1%
Architectural Modification	$352,790	152	$2,321	$379,288	180	$2,107	8%	18%	-9%
Audiology Services	$139,404	1,375	$101	$189,125	2,184	$87	36%	59%	-15%
Behavioral Health Services	$247,522,841	105,563	$2,345	$263,408,815	110,050	$2,394	6%	4%	2%
Capitated Services	$36,296,235	726,510	$50	$41,635,927	725,884	$57	15%	0%	15%
Chiropractic Services	$8,039	124	$65	$8,917	111	$80	11%	-10%	24%
Clinic	$86,173,922	138,706	$621	$88,965,913	138,063	$644	3%	0%	4%
Clinics - OSA Services	$11,081,354	103,871	$107	$10,094,390	90,398	$112	-9%	-13%	5%
Community Mental Health	$33,701,277	35,295	$955	$34,120,596	35,461	$962	1%	0%	1%
Dental	$138,731,535	323,313	$429	$136,433,713	321,453	$424	-2%	-1%	-1%
Direct Support	$191,652,574	4,291	$44,664	$209,894,216	4,439	$47,284	10%	3%	6%
Employee Training Specialist	$28,031,755	2,753	$10,182	$29,533,708	2,845	$10,381	5%	3%	2%
End-Stage Renal Disease	$6,628,633	2,171	$3,053	$8,579,256	2,311	$3,712	29%	6%	22%
Eye Care and Exams	$21,712,636	136,558	$159	$24,067,246	138,231	$174	11%	1%	10%
Eyewear	$7,072,915	51,551	$137	$6,837,227	48,328	$141	-3%	-6%	3%
Self-Directed Care	$5,542,651	702	$7,896	$6,085,864	833	$7,306	10%	19%	-7%
Group Home	$21,413,896	640	$33,459	$23,108,526	648	$35,661	8%	1%	7%
Home Health	$20,188,669	6,796	$2,971	$19,504,337	6,345	$3,074	-3%	-7%	3%
Homemaker Services	$1,928,639	394	$4,895	$2,133,973	353	$6,045	11%	-10%	23%
Hospice	$1,101,671	133	$8,283	$554,555	89	$6,231	-50%	-33%	-25%
ICF-ID Services	$111,373,096	1,748	$63,715	$95,458,210	1,703	$56,053	-14%	-3%	-12%
Inpatient Services	$610,325,795	140,884	$4,332	$622,864,627	154,372	$4,035	2%	10%	-7%
Laboratory Services	$48,572,305	264,861	$183	$54,617,978	271,737	$201	12%	3%	10%
Medicare Part A & B (Buy-In) Payments	$131,025,519	-	$0	$124,474,661	-	$0	-5%	0%	0%
Medicare Part D Payments	$77,694,210	-	$0	$76,609,978	-	$0	-1%	0%	0%
Mid-Level Practitioner	$441,524	2,982	$148	$386,606	2,663	$145	-12%	-10%	-2%
Medical Supplies/DMEPOS	$70,600,955	94,173	$750	$67,266,458	92,609	$726	-5%	-2%	-3%
Nursing Facility	$536,153,689	19,703	$27,212	$573,447,949	20,165	$28,438	7%	2%	5%
Nursing Services	$8,462,738	19,342	$438	$8,535,003	18,902	$452	1%	-2%	3%
Nutritionist Services	$947,811	781	$1,214	$997,872	814	$1,226	5%	4%	1%
Insure Oklahoma ESI Out-of-Pocket	$688,863	-	$0	$408,189	-	$0	-41%	0%	0%
Insure Oklahoma ESI Premium	$50,107,558	23,429	$2,139	$44,708,863	21,325	$2,097	-11%	-9%	-2%
Outpatient	$281,943,483	478,968	$589	$290,569,503	475,868	$611	3%	-1%	4%

Appendix B Statewide Figures (continued)

Table IV Expenditures by Type of Service Percent of Change (continued)

Type of Service	SFY2013			SFY2014			Percent Change		
	Expenditures	Members	Avg Per Member Served	Expenditures	Members	Avg Per Member Served	Expend-itures	Mem-bers	Aver-age
Personal Care	$94,684,936	21,728	$4,358	$97,630,357	21,108	$4,625	3%	-3%	6%
Physician	$562,856,420	734,533	$766	$590,457,795	760,400	$777	5%	4%	1%
Podiatry	$3,248,078	14,998	$217	$3,568,799	15,076	$237	10%	1%	9%
Prescribed Drugs	$406,788,858	625,305	$651	$457,228,437	604,847	$756	12%	-3%	16%
Psychiatric Services	$107,745,675	6,945	$15,514	$102,521,146	5,743	$17,851	-5%	-17%	15%
Residential Behavior Mgmt	$22,599,397	2,063	$10,955	$22,840,483	2,039	$11,202	1%	-1%	2%
Respite Care	$476,358	311	$1,532	$499,727	282	$1,772	5%	-9%	16%
Room and Board	$280,953	594	$473	$214,624	502	$428	-24%	-15%	-10%
School-Based Services	$7,007,613	8,201	$854	$6,451,354	8,218	$785	-8%	0%	-8%
Specialized Foster Care/ID Services	$3,675,506	234	$15,707	$3,547,005	225	$15,764	-3%	-4%	0%
Targeted Case Manager	$107,255,067	45,802	$2,342	$106,256,440	46,561	$2,282	-1%	2%	-3%
Therapy Services	$13,348,060	13,166	$1,014	$14,286,396	12,075	$1,183	7%	-8%	17%
Transportation - Emergency	$41,990,407	84,700	$496	$44,199,147	87,998	$502	5%	4%	1%
Transportation - Non-Emergency	$27,099,967	888,251	$31	$28,822,757	885,217	$33	6%	0%	7%
X-Ray Services	$19,875,088	239,078	$83	$19,227,540	237,208	$81	-3%	-1%	-2%
Uncategorized Services	$1,195,214	-	$0	$520,424	-	$0	-56%	-	-
Total	**$4,240,915,548**	**1,015,939**	**$4,174**	**$4,397,896,751**	**1,028,097**	**$4,278**	**4%**	**1%**	**2%**

Non-Member Specific Payments									
HSP - Indirect Medical Education (IME)	$30,449,271	-	-	$31,088,706	-	-	2%	-	-
HSP - Graduate Medical Education (GME)	$20,302,415	-	-	$16,241,932	-	-	-20%	-	-
HSP - Acute DSH	$42,696,630	-	-	$43,348,467	-	-	2%	-	-
HSP - Supplemental Payments	$135,173,587	-	-	$150,752,968	-	-	12%	-	-
HSP - SHOPP	$352,893,974	-	-	$406,660,323	-	-	15%	-	-
Behavioral Health Supplemental Payments	$40,133,334	-	-	$38,750,454	-	-	-3%	-	-
EHR Incentive Payments	$38,517,566	-	-	$32,287,963	-	-	-16%	-	-
Capitated Services - GME to Medical Schools	$93,666,695	-	-	$89,457,402	-	-	-4%	-	-
Total	**$4,994,749,021**	**1,015,939**	**$4,174**	**$5,206,484,966**	**1,028,097**	**$4,278**	**-10%**	**1%**	**2%**

Source: OHCA Financial Service Division, September 2014. 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.

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)

Table V Expenditures by Type of Service by Adult and Child

Type of Service	Adult Totals			Children Totals		
	Expenditures	Members Served	Avg per Adult	Expenditures	Members Served	Avg per Child
Adult Day Care	$4,704,748	837	$5,621	$0	-	$0
Advanced Practice Nurse	$802,874	3,243	$248	$2,223,092	10,542	$211
ADvantage Home Delivered Meals	$16,190,529	13,933	$1,162	$0	-	$0
Ambulatory Surgical Services	$4,481,272	8,320	$539	$5,340,317	9,010	$593
Architectural Modification	$365,121	172	$2,123	$14,167	8	$1,771
Audiology Services	$16,322	325	$50	$172,803	1,859	$93
Behavioral Health Services	$66,342,179	27,552	$2,408	$197,066,636	82,498	$2,389
Capitated Services	$10,456,802	161,307	$65	$31,179,125	564,577	$55
Chiropractic Services	$8,917	111	$80	$0	-	$0
Clinic	$34,333,002	47,760	$719	$54,632,911	90,303	$605
Clinics - OSA Services	$2,363,587	20,727	$114	$7,730,803	69,671	$111
Community Mental Health	$17,928,909	20,335	$882	$16,191,687	15,126	$1,070
Dental	$16,728,181	36,419	$459	$119,705,532	285,034	$420
Direct Support	$197,473,239	3,857	$51,199	$12,420,977	582	$21,342
Employee Training Specialist	$28,820,361	2,731	$10,553	$713,347	114	$6,257
End-Stage Renal Disease	$8,445,888	2,287	$3,693	$133,368	24	$5,557
Eye Care and Exams	$1,688,020	19,253	$88	$22,379,225	118,978	$188
Eyewear	$32,662	267	$122	$6,804,565	48,061	$142
Self-Directed Care	$6,085,864	833	$7,306	$0	-	$0
Group Home	$22,396,910	629	$35,607	$711,616	19	$37,453
Home Health	$4,778,883	4,191	$1,140	$14,725,454	2,154	$6,836
Homemaker Services	$1,904,426	285	$6,682	$229,547	68	$3,376
Hospice	$514,548	84	$6,126	$40,006	5	$8,001
ICF-ID Services	$91,619,738	1,623	$56,451	$3,838,472	80	$47,981
Inpatient Services	$369,363,669	80,016	$4,616	$253,500,958	74,356	$3,409
Laboratory Services	$39,975,183	118,807	$336	$14,642,795	152,930	$96
Medicare Part A & B (Buy-In) Payments	$124,474,661	-	$0	$0	-	$0
Medicare Part D Payments	$76,609,978	-	$0	$0	-	$0
Mid-Level Practitioner	$119,410	527	$227	$267,195	2,136	$125
Medical Supplies/DMEPOS	$48,336,238	57,003	$848	$18,930,220	35,606	$532
Nursing Facility	$573,038,220	20,145	$28,446	$409,729	20	$20,486
Nursing Services	$8,534,625	18,900	$452	$378	2	$189
Nutritionist Services	$982,558	770	$1,276	$15,313	44	$348
Insure Oklahoma ESI Out-of-Pocket	$408,189	-	$0	$0	-	$0
Insure Oklahoma ESI Premium	$44,708,863	21,325	$2,097	$0	-	$0

Appendix B Statewide Figures (continued)

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

Type of Service	Adult Totals			Children Totals		
	Expenditures	Members Served	Avg per Adult	Expenditures	Members Served	Avg per Child
Outpatient	$163,861,353	197,064	$832	$126,708,150	278,804	$454
Personal Care	$96,932,593	20,995	$4,617	$697,764	113	$6,175
Physician	$283,167,788	258,248	$1,096	$307,290,008	502,152	$612
Podiatry	$2,578,024	12,643	$204	$990,775	2,433	$407
Prescribed Drugs	$230,792,148	173,857	$1,327	$226,436,289	430,990	$525
Psychiatric Services	$447,530	369	$1,213	$102,073,616	5,374	$18,994
Residential Behavior Mgmt	$0	-	$0	$22,840,483	2,038	$11,207
Respite Care	$425,677	249	$1,710	$74,050	33	$2,244
Room and Board	$95,427	131	$728	$119,197	371	$321
School-Based Services	$0	-	$0	$6,451,354	8,217	$785
Specialized Foster Care/ID Services	$2,380,745	143	$16,649	$1,166,260	82	$14,223
Targeted Case Manager	$76,174,555	25,749	$2,958	$30,081,885	20,812	$1,445
Therapy Services	$1,573,030	2,698	$583	$12,713,365	9,377	$1,356
Transportation - Emergency	$32,908,354	63,010	$522	$11,290,793	24,988	$452
Transportation - Non-Emergency	$22,712,134	269,428	$84	$6,110,623	615,789	$10
X-Ray Services	$14,679,793	130,212	$113	$4,547,746	106,996	$43
Uncategorized Services	$403,467	-	$0	$116,957	-	$0
Total	**$2,754,167,195**	**378,684**	**$7,273**	**$1,643,729,555**	**659,049**	**$2,494**
Unduplicated Enrollees	$2,754,167,195	414,471	$6,645	$1,643,729,555	618,643	$2,657

Non-Member Specific Payments						
HSP - Indirect Medical Education (IME)	$31,088,706	-	-	$0	-	-
HSP - Graduate Medical Education (GME)	$8,120,966	-	-	$8,120,966	-	-
HSP - Acute DSH	$0	-	-	$43,348,467	-	-
HSP - Supplemental Payments	$0	-	-	$150,752,968	-	-
HSP - SHOPP	$0	-	-	$406,660,323	-	-
Behavioral Health Supplemental Payments	$0	-	-	$38,750,454	-	-
EHR Incentive Payments	$0	-	-	$32,287,963	-	-
Capitated Services - GME to Medical Schools	$0	-	-	$89,457,402	-	-
Total	**$2,793,376,867**	**378,684**	**$7,273**	**$2,413,108,098**	**659,049**	**$2,494**

Source: OHCA Financial Service Division, September 2014. 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)

Table 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	$4,704,748
Advanced Practice Nurse	$205,789	$2,745,509	$41,234	$4,661	$28,773	$0
ADvantage Home Delivered Meals	$0	$0	$0	$0	$0	$16,190,529
Ambulatory Surgical Services	$1,122,033	$7,198,973	$354,175	$29,667	$1,115,594	$1,147
Architectural Modification	$0	$0	$0	$0	$0	$379,288
Audiology Services	$20,619	$163,203	$188	$0	$5,038	$77
Behavioral Health Services	$43,817,828	$186,302,469	$358,581	$0	$26,900,607	$6,029,330
Capitated Services	$3,484,517	$33,865,000	$298,185	$0	$3,988,225	$0
Chiropractic Services	$0	$0	$0	$0	$8,917	$0
Clinic	$17,043,343	$67,647,053	$1,037,024	$617,523	$2,619,915	$1,056
Clinics - OSA Services	$1,460,901	$7,432,533	$12,994	$1,122,089	$65,874	$0
Community Mental Health	$5,330,348	$21,030,594	$116,002	$0	$7,643,304	$347
Dental	$14,238,612	$117,737,550	$56,111	$0	$3,583,560	$817,881
Direct Support	$0	$0	$0	$0	$0	$209,894,216
Employee Training Specialist	$0	$0	$0	$0	$0	$29,533,708
End-Stage Renal Disease	$2,996,716	$2,452,271	$8,043	$0	$3,121,593	$634
Eye Care and Exams	$2,981,813	$20,400,947	$79,999	$0	$604,478	$8
Eyewear	$858,139	$5,945,019	$265	$0	$33,803	$0
Self-Directed Care	$0	$0	$0	$0	$0	$6,085,864
Group Home	$0	$0	$0	$0	$0	$23,108,526
Home Health	$7,889,810	$10,394,889	$1,961	$0	$586,399	$631,279
Homemaker Services	$0	$0	$0	$0	$0	$2,133,973
Hospice	$13,527	$27,111	$0	$0	$0	$513,917
ICF-ID Services	$30,881,399	$78,897	$0	$0	$64,497,915	$0
Inpatient Services	$303,424,323	$279,663,704	$8,440,304	$2,789	$31,326,696	$6,811
Laboratory Services	$10,288,421	$40,586,944	$2,031,646	$907,815	$802,914	$239
Medicare Part A & B (Buy-In) Payments	$0	$0	$0	$0	$124,474,661	$0
Medicare Part D Payments	$0	$0	$0	$0	$76,609,978	$0
Mid-Level Practitioner	$16,478	$343,859	$12,569	$44	$13,655	$0
Medical Supplies/DMEPOS	$10,567,159	$22,262,489	$506,857	$0	$11,434,340	$22,495,613
Nursing Facility	$66,148,882	$600,017	$0	$0	$506,313,853	$385,197
Nursing Services	$0	$0	$0	$0	$0	$8,535,003
Nutritionist Services	$87,123	$3,665	$352	$0	$249,365	$657,366
Insure Oklahoma ESI Out-of-Pocket	$0	$0	$408,189	$0	$0	$0
Insure Oklahoma ESI Premium	$0	$0	$44,708,863	$0	$0	$0
Outpatient	$58,781,224	$207,901,679	$9,005,285	$941,152	$13,937,927	$2,236
Personal Care	$953,054	$2,599,830	$0	$0	$8,444,796	$85,632,677

Appendix B Statewide Figures (continued)

Table 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	$104,578,688	$426,082,904	$11,825,473	$1,464,787	$44,718,900	$1,787,044
Podiatry	$596,563	$1,896,650	$126,158	$0	$949,226	$202
Prescribed Drugs	$96,253,049	$333,016,976	$14,371,267	$2,763,180	$2,721,810	$8,102,156
Psychiatric Services	$86,772,941	$15,408,600	$0	$0	$339,604	$0
Residential Behavior Mgmt	$22,677,567	$162,916	$0	$0	$0	$0
Respite Care	$0	$0	$0	$0	$0	$499,727
Room and Board	$47,684	$130,164	$0	$0	$36,776	$0
School-Based Services	$889,339	$5,555,225	$0	$0	$6,790	$0
Specialized Foster Care/ID Services	$0	$0	$0	$0	$0	$3,547,005
Targeted Case Manager	$33,572,653	$2,040,003	$0	$0	$16,430,879	$54,212,906
Therapy Services	$1,957,435	$10,795,280	$3,117	$63	$297,812	$1,232,689
Transportation - Emergency	$10,049,103	$18,674,593	$0	$0	$7,280,171	$8,195,281
Transportation - Non-Emergency	$0	$13,552,375	$0	$0	$15,270,383	$0
X-Ray Services	$3,848,781	$11,700,570	$804,822	$3,680	$2,869,015	$672
Uncategorized Services	$168,350	$73,425	$0	$15,134	$263,515	$0
Total	**$944,024,213**	**$1,876,473,885**	**$94,609,661**	**$7,872,582**	**$979,597,059**	**$495,319,352**
Unduplicated Members Served	412,262	724,111	37,673	84,022	105,126	27,208
Average Cost Per Member Served	$2,290	$2,591	$2,511	$94	$9,318	$18,205
Unduplicated SoonerCare Enrollees	NA	708,822	40,103	87,838	125,915	26,928
Average Cost Per Enrolled	NA	$2,647	$2,359	$90	$7,780	$18,394

Source: OHCA Financial Service Division, September 2014. *Insure Oklahoma IP and ESI includes $408,189 Insure Oklahoma ESI Out-of-Pocket; $44,708,863 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 $406,660,323 in Supplemental Hospital Offset Payment Program (SHOPP); $241,432,073 in hospital supplemental payments (includes hospital supplemental payments, DSH, GME and IME); $89,457,402 in GME payments; $32,287,963 in EHR payments; and $38,750,454 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
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
SFY2014	$2,290	$2,591	$2,511	$94	$9,318	$18,205

Source: OHCA Financial Service Division, September 2014. *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)

Table VII Expenditures by Type of Service by Aid Category

Type of Service	Aged	Blind / Disabled	TANF/ Children & Parents	Oklahoma Cares	SoonerPlan	TEFRA	Other Total*
Adult Day Care	$1,976,959	$2,727,789	$0	$0	$0	$0	$0
Advanced Practice Nurse	$13,007	$416,745	$2,545,165	$4,108	$4,661	$166	$42,114
ADvantage Home Delivered Meals	$8,468,229	$7,722,300	$0	$0	$0	$0	$0
Ambulatory Surgical Services	$614,204	$2,244,626	$6,548,427	$19,873	$29,667	$4,185	$360,608
Architectural Modification	$70,962	$308,327	$0	$0	$0	$0	$0
Audiology Services	$1,895	$19,961	$166,618	$201	$0	$261	$188
Behavioral Health	$4,940,945	$67,387,285	$190,475,707	$55,970	$0	$80,797	$468,111
Capitated Services	$4,169,346	$2,837,325	$34,263,777	$19,256	$0	$36,091	$310,132
Chiropractic Services	$3,366	$5,551	$0	$0	$0	$0	$0
Clinic	$1,105,239	$15,473,557	$68,868,125	$261,022	$617,523	$13,066	$2,627,381
Clinics - OSA Services	$1,649	$683,379	$8,147,864	$14,152	$1,122,089	$75,528	$49,729
Community Mental Health	$649,494	$16,143,167	$17,156,100	$35,845	$0	$986	$135,004
Dental	$810,638	$10,922,553	$124,481,090	$36,070	$0	$37,619	$145,743
Direct Support	$6,542,357	$203,351,859	$0	$0	$0	$0	$0
Employee Training Specialist	$526,587	$29,007,121	$0	$0	$0	$0	$0
End-Stage Renal Disease	$1,050,765	$7,181,973	$338,476	$0	$0	$0	$8,043
Eye Care and Exams	$359,834	$1,853,215	$21,748,618	$4,576	$0	$9,478	$91,525
Eyewear	$16,203	$470,697	$6,332,569	$0	$0	$13,111	$4,647
Self Directed Care	$2,753,937	$3,331,928	$0	$0	$0	$0	$0
Group Home	$1,142,609	$21,965,917	$0	$0	$0	$0	$0
Home Health	$374,670	$14,318,369	$2,509,160	$31,334	$0	$2,268,134	$2,670
Homemaker Services	$0	$2,133,973	$0	$0	$0	$0	$0
Hospice	$61,478	$463,406	$29,670	$0	$0	$0	$0
ICF-ID Services	$7,671,580	$87,482,797	$303,833	$0	$0	$0	$0
Inpatient Services	$22,816,969	$257,452,293	$330,169,864	$2,199,066	$2,789	$501,259	$9,722,388
Laboratory Services	$463,706	$14,769,016	$35,274,577	$479,065	$907,815	$7,878	$2,715,920
Medicare Part A & B (Buy-In) Payments	$124,474,609	$0	$52	$0	$0	$0	$0
Medicare Part D Payments	$76,609,978	$0	$0	$0	$0	$0	$0
Mid-Level Practitioner	$5,795	$78,115	$289,652	$424	$44	$7	$12,569
Medical Supplies/DMEPOS	$15,276,822	$40,621,175	$10,232,429	$55,558	$0	$557,547	$522,926
Nursing Facility	$428,504,053	$144,263,418	$596,824	$9,417	$0	$0	$74,238
Nursing Services	$1,930,811	$6,604,192	$0	$0	$0	$0	$0
Nutritionist Services	$38,928	$951,725	$6,866	$0	$0	$0	$352
Insure Oklahoma ESI Out-of-Pocket	$0	$0	$0	$0	$0	$0	$408,189
Insure Oklahoma ESI Premium	$0	$0	$0	$0	$0	$0	$44,708,863
Outpatient	$6,577,879	$78,228,124	$190,733,486	$4,294,960	$941,152	$222,256	$9,571,646

Appendix B Statewide Figures (continued)

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

Type of Service	Aged	Blind / Disabled	TANF/ Children & Parents	Oklahoma Cares	SoonerPlan	TEFRA	Other Total*
Personal Care	$52,944,706	$44,621,872	$47,157	$0	$0	$16,622	$0
Physician	$21,590,124	$138,876,782	$406,866,305	$6,163,613	$1,464,787	$872,350	$14,623,834
Podiatry	$585,986	$1,550,148	$1,300,185	$5,797	$0	$0	$126,683
Prescribed Drugs	$4,184,301	$205,293,518	$227,106,457	$1,522,498	$2,763,180	$1,356,142	$15,002,343
Psychiatric Services	$448,894	$22,099,476	$79,843,356	$0	$0	$82,854	$46,567
Residential Behavior Mgmt	$0	$1,063,355	$21,762,236	$0	$0	$0	$14,892
Respite Care	$279,912	$219,815	$0	$0	$0	$0	$0
Room and Board	$1,951	$62,798	$141,782	$7,968	$0	$125	$0
School-Based Services	$0	$2,458,729	$3,780,556	$0	$0	$211,902	$167
Specialized Foster Care/ID Services	$47,450	$3,499,555	$0	$0	$0	$0	$0
Targeted Case Manager	$30,409,219	$48,766,667	$27,058,140	$0	$0	$5,750	$16,664
Therapy Services	$141,896	$4,158,776	$9,635,680	$309	$63	$340,075	$9,598
Transportation - Emergency	$4,167,811	$24,463,265	$15,451,202	$61,833	$0	$26,000	$29,036
Transportation - Non-Emergency	$7,458,740	$17,992,911	$3,273,319	$3,149	$0	$85,986	$8,654
X-Ray Services	$1,616,914	$7,314,305	$9,113,498	$272,380	$3,680	$5,743	$901,021
Uncategorized Services	$31,034	$2,920	$34,070	$1	$15,134	$0	$437,265
Total	**$843,934,439**	**$1,563,866,765**	**$1,856,632,895**	**$15,558,445**	**$7,872,582**	**$6,831,916**	**$103,199,710**
Unduplicated Members Served	59,888	144,477	933,644	1,761	84,022	600	51,208
Average Cost Per Member Served	$14,092	$10,824	$1,989	$8,835	$94	$11,387	$2,015
Unduplicated SoonerCare Enrollees	51,510	126,515	733,370	1,330	87,838	591	NA
Average Cost Per Enrolled	$16,384	$12,361	$2,532	$11,698	$90	$11,560	NA

Source: OHCA Financial Service Division, September 2014. *Other includes $406,660,323 in Supplemental Hospital Offset Payment Program (SHOPP) and $241,432,073 in hospital supplemental payments (includes hospital supplemental payments, DSH, GME and IME); and $38,750,454 in outpatient behavioral health supplemental payments. $89,457,402 in GME payments; $32,287,963 in EHR payments; $408,189 Insure Oklahoma ESI Out-of-Pocket; $50,107,558. 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)

Table 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	$0	$0	$0	$0	$0
Advanced Practice Nurse	$73,452	$71,371	$261,740	$1,813,293	$3,237
Ambulatory Surgical Services	$224,354	$339,996	$682,091	$4,086,660	$7,217
Architectural Modification	$5,845	$8,322	$0	$0	$0
Audiology Services	$11,269	$14,407	$22,023	$124,947	$157
Behavioral Health Services	$19,340,597	$28,445,533	$20,757,388	$128,398,385	$124,732
Capitated Services	$1,053,007	$24,587	$4,167,773	$25,910,947	$22,810
Clinic	$2,147,990	$2,213,121	$8,288,961	$41,656,186	$326,653
Clinics - OSA Services	$615,468	$575,438	$610,597	$5,702,781	$226,518
Community Mental Health	$2,163,614	$1,984,858	$2,036,433	$9,987,247	$19,535
Dental	$4,672,957	$6,762,983	$21,580,162	$86,583,307	$106,123
Direct Support	$6,655,915	$5,765,062	$0	$0	$0
Employee Training Specialist	$573,381	$139,967	$0	$0	$0
End-Stage Renal Disease	$78,140	$0	$2,431	$52,797	$0
Eye Care and Exams	$1,009,472	$1,509,162	$4,168,016	$15,675,899	$16,677
Eyewear	$441,318	$479,471	$1,203,511	$4,675,617	$4,647
Group Home	$513,388	$198,228	$0	$0	$0
Home Health	$11,923,451	$1,268,074	$220,622	$1,312,599	$709
Homemaker Services	$82,580	$146,967	$0	$0	$0
Hospice	$2,081	$8,255	$0	$29,670	$0
ICF-ID Services	$3,183,595	$501,798	$0	$153,079	$0
Inpatient Services	$39,762,827	$21,686,155	$13,123,192	$178,652,076	$276,708
Laboratory Services	$691,114	$531,145	$1,391,029	$11,716,613	$312,894
Mid-Level Practitioner	$7,871	$13,993	$34,376	$210,904	$52
Medical Supplies/DMEPOS	$9,787,225	$1,800,211	$1,400,388	$5,932,053	$10,344
Nursing Facility	$360,267	$34,905	$0	$14,557	$0
Nursing Services	$108	$270	$0	$0	$0
Nutritionist Services	$5,539	$6,550	$836	$2,388	$0
Outpatient	$10,286,953	$6,020,791	$16,488,886	$93,624,411	$287,109
Personal Care	$635,353	$20,731	$2,081	$39,599	$0
Physician	$23,684,592	$18,288,944	$35,134,545	$229,417,633	$764,294
Podiatry	$86,382	$60,998	$218,990	$623,132	$1,273
Prescribed Drugs	$53,022,688	$24,330,066	$27,800,534	$120,533,282	$749,719
Psychiatric Services	$17,771,529	$41,498,583	$7,730,805	$35,026,133	$46,567
Residential Behavior Mgmt	$106,655	$22,417,394	$17,431	$284,252	$14,751

Appendix B Statewide Figures (continued)

Table 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*
Respite Care	$18,288	$55,763	$0	$0	$0
Room and Board	$6,360	$1,651	$19,541	$91,645	$0
School-Based Services	$2,543,140	$653,272	$613,645	$2,641,130	$167
Specialized Foster Care/ID Services	$412,810	$753,450	$0	$0	$0
Targeted Case Manager	$1,730,273	$25,856,806	$309,000	$2,170,262	$15,544
Therapy Services	$2,976,970	$1,256,480	$1,551,388	$6,919,897	$8,631
Transportation - Emergency	$1,504,055	$808,786	$786,638	$8,166,725	$24,590
Transportation - Non-Emergency	$3,149,222	$275,741	$428,879	$2,254,341	$2,440
X-Ray Services	$406,504	$209,849	$649,020	$3,258,396	$23,979
Uncategorized Services	$32,982	$3,496	$10,862	$29,256	$40,361
Grand Total	**$223,761,579**	**$217,043,629**	**$171,713,810**	**$1,027,772,099**	**$3,438,437**
Unduplicated Members Served	25,974	33,860	159,486	574,986	15,237
Average Cost Per Member Served	$8,615	$6,410	$1,077	$1,787	$226

Source: OHCA Financial Service Division, September 2014. 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 $241,432,073 in Supplemental Hospital Offset Payment Program (SHOPP)/GME/DSH and hospital supplemental payments and $38,750,454 in outpatient behavioral health supplemental payments. $89,457,402 in GME payments; $32,287,963 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.

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.

Appendix B Statewide Figures (continued)

Table 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	$4,704,748	$2,737,551	$1,207,890	$2,576	$677,065
ADvantage Home Delivered Meals	$16,190,529	$16,044,008	$0	$0	$0
Ambulatory Surgical Services	$1,147	$1,147	$0	$0	$0
Architectural Modification	$379,288	$126,980	$79,574	$24,064	$30,287
Audiology Services	$77	$0	$77	$0	$0
Behavioral Health	$6,029,330	$740	$4,817,466	$877,465	$164,919
Clinic	$1,056	$1,056	$0	$0	$0
Community Mental Health	$347	$330	$16	$0	$1
Dental	$817,881	$0	$417,432	$311,731	$81,683
Direct Support	$209,894,216	$0	$105,421,282	$78,911,248	$17,996,439
Employee Training Specialist	$29,533,708	$0	$21,331,180	$4,271,969	$3,446,922
End Stage Renal Disease	$634	$634	$0	$0	$0
Eye Care and Exam	$8	$8	$0	$0	$0
Self-Directed Care	$6,085,864	$5,887,975	$0	$0	$0
Group Home	$23,108,526	$0	$22,498,046	$89,834	$0
Home Health Services	$631,279	$0	$0	$0	$1,842
Homemaker Services	$2,133,973	$0	$1,773,501	$213,579	$146,840
Hospice	$513,917	$513,917	$0	$0	$0
Inpatient Services	$6,811	$6,811	$0	$0	$0
Laboratory Services	$239	$239	$0	$0	$0
Medical Supplies/DMEPOS	$22,495,613	$17,551,546	$2,728,313	$811,447	$679,527
Nursing Facility	$385,197	$385,197	$0	$0	$0
Nursing Services	$8,535,003	$3,638,709	$1,611,157	$1,254,909	$2,985
Nutritionist Services	$657,366	$0	$402,349	$203,460	$4,393
Outpatient	$2,236	$1,533	$703	$0	$0
Personal Care	$85,632,677	$84,123,202	$0	$0	$0
Physician	$1,787,044	$6,611	$1,114,271	$502,780	$47,188
Podiatry	$202	$202	$0	$0	$0
Prescribed Drugs	$8,102,156	$6,347,244	$1,045,339	$168,360	$305,524
Respite Care	$499,727	$367,984	$114,195	$0	$4,983
Specialized Foster Care/ID Services	$3,547,005	$0	$3,456,755	$90,250	$0
Targeted Case Manager	$54,212,906	$53,293,980	$0	$0	$0
Therapy Services	$1,232,689	$18,720	$769,865	$278,094	$49,063
Transportation Services	$8,195,281	$447	$5,101,255	$2,310,526	$616,357
X-Ray Services	$672	$650	$22	$0	$0
Total	**$495,319,352**	**$191,057,419**	**$173,890,688**	**$90,322,292**	**$24,256,019**
Unduplicated Members Served	27,208	21,299	2,879	697	1,828
Average Cost Per Member Served	$18,205	$8,970	$60,400	$129,587	$13,269

Source: OHCA Financial Service Division, September 2014. 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)

Table 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	$79,668	$0	$0	$0
ADvantage Home Delivered Meals	$37,693	$11,610	$68,052	$29,168
Ambulatory Surgical Services	$0	$0	$0	$0
Architectural Modification	$112,546	$3,093	$2,745	$0
Audiology Services	$0	$0	$0	$0
Behavioral Health	$168,739	$0	$0	$0
Clinic	$0	$0	$0	$0
Community Mental Health	$0	$0	$0	$0
Dental	$7,034	$0	$0	$0
Direct Support	$7,565,247	$0	$0	$0
Employee Training Specialist	$483,637	$0	$0	$0
End Stage Renal Disease	$0	$0	$0	$0
Eye Care and Exam	$0	$0	$0	$0
Self-Directed Care	$263	$87,082	$69,756	$40,789
Group Home	$520,645	$0	$0	$0
Home Health Services	$0	$629,436	$0	$0
Homemaker Services	$53	$0	$0	$0
Hospice	$0	$0	$0	$0
Inpatient Services	$0	$0	$0	$0
Laboratory Services	$0	$0	$0	$0
Medical Supplies/DMEPOS	$424,439	$194,724	$75,366	$30,250
Nursing Facility	$0	$0	$0	$0
Nursing Services	$372,897	$1,600,056	$38,118	$16,173
Nutritionist Services	$47,165	$0	$0	$0
Outpatient	$0	$0	$0	$0
Personal Care	$344,261	$429,715	$525,296	$210,203
Physician	$116,194	$0	$0	$0
Podiatry	$0	$0	$0	$0
Prescribed Drugs	$66,388	$115,742	$51,210	$2,349
Respite Care	$3,429	$9,137	$0	$0
Specialized Foster Care/ID Services	$0	$0	$0	$0
Targeted Case Manager	$444,644	$155,550	$218,424	$100,309
Therapy Services	$116,947	$0	$0	$0
Transportation Services	$166,697	$0	$0	$0
X-Ray Services	$0	$0	$0	$0
Total	**$11,078,584**	**$3,236,144**	**$1,048,966**	**$429,240**
Unduplicated Members Served	302	57	96	50
Average Cost Per Member Served	$36,684	$56,774	$10,927	$8,585

Source: OHCA Financial Service Division, September 2014. 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)

Table 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)	$3,073,446	1,354	$2,270
Inpatient (Acute - Freestanding)	$10,095,131	2,201	$4,587
Psychiatric Residential Treatment Facility (PRTF)	$93,132,148	4,120	$22,605
Outpatient	$194,569,587	75,998	$2,560
Psychologist	$9,719,013	11,531	$843
Psychiatrist	$3,750,116	9,008	$416
Residential Behavior Management Services (Group)	$8,319,844	1,032	$8,062
Residential Behavior Management Services (TFC)	$14,523,100	1,076	$13,497
Targeted Case Management (TCM)	$4,697,712	16,392	$287
Other Outpatient Behavioral Health Services	$176,945	100	$1,769
Psychotropic Drugs[3]	$79,697,150	67,731	$1,177
Total[4]	**$421,754,191**	**98,107**	**$4,299**

Adults Aged 21 and Older Type of Service	Expenditures[1]	Members Served[2]	Average per Member Served
Inpatient (Acute - General)	$8,766,008	2,633	$3,329
Inpatient (Acute - Freestanding)	$413,069	49	$8,430
Psychiatric Residential Treatment Facility (PRTF)	$0	-	$0
Outpatient	$74,992,798	38,833	$1,931
Psychologist	$1,896,558	1,767	$1,073
Psychiatrist	$4,165,275	12,828	$325
Residential Behavior Management Services (Group)	$0	-	$0
Residential Behavior Management Services (TFC)	$0	-	$0
SMI/SED Case Management	$2,795,524	15,868	$176
Other Outpatient Behavioral Health Services	$2,378,556	1,105	$2,153
Psychotropic Drugs[3]	$43,841,545	69,528	$631
Total[4]	**$139,249,332**	**46,166**	**$3,016**

Total Behavioral Health Services Listed Above[4]	$561,003,524	144,273	$3,888

Source: OHCA Financial Service Division, September 2014. 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	SFY2014
Adult Day Care	51
Advance Practice Nurse	1,898
Advantage Home Delivery Meal	19
Ambulatory Surgical Center	58
Anesthesiology Assistant	8
Audiologist	126
Behavioral Health Provider	10,051
Capitation Provider - IHS (Indian Health Services) Case Manager	88
Capitation Provider - PACE (Program of All-Inclusive Care for the Elderly)	2
Case Manager	66
Certified Registered Nurse Anesthetist	1,151
Chiropractor	31
Clinic - Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	3
Clinic - Family Planning Clinic	4
Clinic - Federally Qualified Health Clinic (FQHC)	71
Clinic - Native American	61
Clinic - Rural Health	13
Clinic - Tuberculosis	2
Community Mental Health Center (CMHC)	96
County/City Health Department	3
DDSD - Architectural Modification	29
DDSD - Community Transition Services	54
DDSD - Employee Training Specialist	82
DDSD - Group Home	44
DDSD - Homemaker Services	80

Provider Network	SFY2014
DDSD - Volunteer Transportation Provider	228
Dentist	1,613
Direct Support Services	248
DME/Medical Supply Dealer	1,350
End-Stage Renal Disease Clinic	100
Extended Care and Skilled Nursing Facilities	268
Extended Care Facility - Facility Based Respite Care	106
Extended Care Facility - ICF/ID	88
Genetic Counselor	10
Home Health Agency	230
Hospital - Acute Care	670
Hospital - Critical Access	87
Hospital - Native American	7
Hospital - Psychiatric	23
Hospital - Resident Treatment Center	45
Laboratory	297
Lactation Consultant	58
Long-Term Care Authority Hospice	77
Maternal/Child Health LCSW	16
Nursing Agency - Non-Skilled	44
Nursing Agency - Skilled	53
Nutritionist	186
Optician	53
Optometrist	611
Outpatient Behavioral Health Agency	523
Personal Care Services	1,289
Pharmacy	1,307

Provider Network	SFY2014
Physician - Allergist	41
Physician - Anesthesiologist	1,057
Physician Assistant	1,326
Physician - Cardiologist	582
Physician - General/Family Medicine	2,675
Physician - General Pediatrician	1,442
Physician - General Surgeon	657
Physician - Internist	1,970
Physician - Obstetrician/ Gynecologist	707
Physician - Other Specialist	5,379
Physician - Pediatric Specialist	1,361
Physician - Radiologist	1,301
Preadmission Screening and Resident Review (PASRR)	6
Program for Assertive Community Treatment (PACT)	12
Psychologist	313
Registered Nurse	9
Residential Behavior Management Services (RBMS)	21
Respite Care	92
Room and Board	19
School Corporation	236
Specialized Foster Care/ID	179
Therapist - Occupational	257
Therapist - Physical	635
Therapist - Speech/Hearing	716
Transportation Provider	341
X-Ray Clinic	54

* 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 SFY2014, 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
6/14/12	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
6/14/12	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
11/1/12	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
12/13/12	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
12/13/12	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
12/13/12	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
12/13/12	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
3/14/13	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
3/14/13	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
3/14/13	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
3/14/13	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
3/14/13	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

Appendix D Board Approved Rules (continued)

Board Approval Date	Rule Description	Estimated Savings/Total Cost/State Share	Effective Date
3/14/13	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
3/14/13	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
3/14/13	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
3/14/13	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
3/14/13	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
3/14/13	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
3/14/13	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
3/14/13	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
3/14/13	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

Appendix D Board Approved Rules (continued)

Board Approval Date	Rule Description	Estimated Savings/Total Cost/State Share	Effective Date
3/14/13	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
3/14/13	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
3/14/13	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
3/14/13	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
3/14/13	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
3/14/13	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
3/14/13	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
3/14/13	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
3/14/13	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
3/14/13	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
3/14/13	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
3/14/13	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

Appendix D Board Approved Rules (continued)

Board Approval Date	Rule Description	Estimated Savings/Total Cost/State Share	Effective Date
3/14/13	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
3/14/13	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
3/14/13	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
3/14/13	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
3/14/13	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
3/14/13	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
3/14/13	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, $173,00 federal share, $270,725 total	Jul-1-2013

Appendix D Board Approved Rules (continued)

Board Approval Date	Rule Description	Estimated Savings/Total Cost/State Share	Effective Date
3/14/13	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/ID 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
8/26/14	Eligibility policy is amended to implement Systems Simplification Implementation rules effective October 1, 2013, instead of January 1, 2014. Rules are also revised to delay periodic renewals that would fall during the period January – March, 2014 until April, 2014, and to delay the effective date of terminations of SoonerCare eligibility for reasons related to changes in household composition or income until April, 2014 when the agency is re-determining eligibility based on changes in circumstances from January to March, 2014. These rule changes allow the state to avoid having to use two sets of eligibility rules for MAGI groups (children, pregnant women, parents and caretaker relatives, Soon-To-Be-Sooners, and the SoonerPlan Family Planning Program) from October 2013 to March 2014. APA WF# 13-08	$20,600,000 Total; $7,400,000 State Share; $13,200,000 Federal Share	Sep-24-2013
8/26/14	Insure Oklahoma (IO) rules are revised to align with the Special Terms and Conditions of the Section 1115 Demonstration Waiver. In accordance with waiver special terms and conditions, the federal government has approved a one year (calendar) extension of the IO program. Rules are revised to remove Individual Plan children (while retaining Employer Sponsored Insurance (ESI) children) and limit adult Individual Plan enrollment to persons with household income at or below 100 percent of FPL. Revisions also include changes to the Individual Plan copayment structure; copayments cannot exceed current federal maximums with the exception of emergency room (ER) visits in which case the existing copay for ER visits will remain at $30.00. APA WF# 13-16	Budget neutral	Oct-15-2013
8/26/14	Rules are revised to limit encounters within Federal Qualified Health Centers (FQHC) and Rural Health Clinic Services (RHC) to one encounter per member per day as well as limit encounters to a total of four visits per member per month. This change in procedure regarding encounters in FQHCs and RHCs is needed in order to reduce overall costs of the Medicaid program. APA WF# 14-02	$218,331 Total Savings and $81,372 State Share	Jul-1-2014
8/26/14	Rules are revoked to eliminate payment for hospital leave to nursing facilities and ICF/IDs. Hospital leave is planned or unplanned leave when the patient is admitted to a licensed hospital. This change in procedure regarding payment to nursing facilities is needed in order to reduce overall costs of the Medicaid program. APA WF# 14-03	$1,615,367 Total Savings and $608,993 State Share	Jul-1-2014
8/26/14	Rules are amended to reduce/deny payment for preventable readmissions that occur within 30 days from discharge. The current policy reviews readmissions occurring within 15 days of prior acute care admissions or a related condition to determine medical necessity and appropriateness of care. If it is determined either or both admissions may be inappropriate, payment for either or both admissions may be denied. This change in policy regarding readmissions is needed in order to reduce overall costs of the Medicaid program. APA WF# 14-04	$18,783,264 Total Savings and $7,000,523 State Share	Oct-1-2014
8/26/14	Agency's cost-sharing rules are revised to permit an increase of copays to the federal maximum. APA WF# 14-05	$8,294,160 Total Savings and $3,091,234 State Share	Jul-1-2014
8/26/14	Dental rules are revised to eliminate the perinatal dental benefit. APA WF# 14-06	$3,951,697 Total Savings and $1,472,797 State Share	Jul-1-2014
8/26/14	Oxygen and oxygen equipment rules are revised to require a prior authorization after the initial three months. In addition, rules are revised to clarify arterial blood gas analysis (ABG) and pulse oximetry testing and Certificate of Medical Necessity requirements. APA WF# 14-07	$2,000,000 Total Savings and $745,400 State Share	Aug-1-2014
8/26/14	Rules are amended to limit the number of payment for glasses to two per year. Any additional glasses beyond this limit must be prior authorized and determined to be medically necessary. These changes are needed in order to reduce the overall costs of the Medicaid program. APA WF# 14-08	$347,055 Total Savings and $129,347 State Share	Jul-1-2014
8/26/14	SoonerCare Choice rules regarding enrollment ineligibility are amended to include making individuals with other forms of creditable health insurance coverage ineligible for SoonerCare Choice. Additionally, members who are currently enrolled in SoonerCare Choice who have or gain other forms of creditable insurance will be disenrolled from SoonerCare Choice. These changes are needed in order to reduce the overall costs of the Medicaid Program. APA WF# 14-09	$3,887,634 Total Savings and $1,448,921 State Share	Jul-1-2014

Appendix D Board Approved Rules (continued)

Board Approval Date	Rule Description	Estimated Savings/Total Cost/State Share	Effective Date
8/26/14	Outpatient behavioral health rules are amended to add additional eligibility criteria required in order to receive psychosocial rehabilitation (PSR) services. Adult PSR services will be limited to members with a history of psychiatric hospitalization or admissions to crisis centers; have been determined disabled by the Social Security Administration for mental health reasons; are residing in residential care facilities; or are receiving services through a specialty court program. Children's PSR services will be limited to members with a history of psychiatric hospitalization or admissions to crisis centers; have been determined disabled by the Social Security Administration for mental health reasons; have a current Individual Education Plan (IEP) or 504 Plan for emotional disturbance; or have been evaluated by a school psychologist, licensed psychologist, or psychiatrist and determined to be "at risk". Narrowing the eligibility criteria for PSR services comports with the Federal definition of rehabilitative services found in 42 CFR 440.130(d) which defines them as "any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts…for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level." APA WF# 14-10	$54,322,344 Total Savings $20,479,524 State Share $33,842,820 Federal Share	Jul-1-2014
8/26/14	Dental rules are revised to eliminate the perinatal dental benefit. APA WF# 14-11	$3,951,697 Total Savings and $1,472,797 State Share	Sep-12-2014
8/26/14	Rules are revoked to eliminate payment for hospital leave to nursing facilities and ICF/IIDs. Hospital leave is planned or unplanned leave when the patient is admitted to a licensed hospital. This change in procedure regarding payment to nursing facilities is needed in order to reduce overall costs of the Medicaid program. APA WF# 14-12	$1,615,367 Total Savings and $608,993 State Share	Sep-12-2014
8/26/14	Outpatient behavioral health rules are amended to add additional eligibility criteria required in order to receive psychosocial rehabilitation (PSR) services. Adult PSR services will be limited to members with a history of psychiatric hospitalization or admissions to crisis centers; have been determined disabled by the Social Security Administration for mental health reasons; are residing in residential care facilities; or are receiving services through a specialty court program. Children's PSR services will be limited to members with a history of psychiatric hospitalization or admissions to crisis centers; have been determined disabled by the Social Security Administration for mental health reasons; have a current Individual Education Plan (IEP) or 504 Plan for emotional disturbance; or have been evaluated by a school psychologist, licensed psychologist, or psychiatrist and determined to be "at risk". Narrowing the eligibility criteria for PSR services comports with the Federal definition of rehabilitative services found in 42 CFR 440.130(d) which defines them as "any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts…for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level." APA WF# 14-13	$54,322,344 Total Savings $20,479,524 State Share $33,842,820 Federal Share	Sep-12-2014
8/26/14	Insure Oklahoma (IO) rules are revised to align with the Special Terms and Conditions of the Section 1115 Demonstration Waiver. In accordance with waiver special terms and conditions, the federal government has approved a one year (calendar) extension of the IO program. Rules are revised to remove Individual Plan children (while retaining Employer Sponsored Insurance (ESI) children) and limit adult Individual Plan enrollment to persons with household income at or below 100 percent of FPL. Revisions also include changes to the Individual Plan copayment structure; copayments cannot exceed current federal maximums with the exception of emergency room (ER) visits in which case the existing copay for ER visits will remain at $30.00. Additionally, rules are revised to remove references to eligibility income determinations. APA WF# 13-16	Budget neutral	Sep-12-2014
8/26/14	Eligibility policy is amended to implement Systems Simplification Implementation rules effective October 1, 2013, instead of January 1, 2014. Rules are also revised to delay periodic renewals that would fall during the period January – March, 2014 until April, 2014, and to delay the effective date of terminations of SoonerCare eligibility for reasons related to changes in household composition or income until April, 2014 when the agency is re-determining eligibility based on changes in circumstances from January to March, 2014. APA WF# 13-08	$20,600,000 Total; $7,400,000 State Share; $13,200,000 Federal Share	Sep-12-2014
8/26/14	Policy is being revised to give providers greater flexibility in the populations with complex health care needs that can receive care management services through HANs. Policy is also amended to remove the HMP care management component as a responsibility of the HAN and to allow HMP to provide health coaching services to “high risk” or “at risk” members that are in the HAN but not receiving care management services through the HAN. These changes streamline policy in the waiver, contract, and OHCA rules. APA WF# 13-04	Budget neutral	Sep-12-2014
8/26/14	Policy is revised to clarify diabetic supplies are covered items when medically necessary according to the member's diabetic classification (e.g., Type 1 insulin and non-insulin dependent and type 2 insulin and non-insulin dependent and gestational diabetes). APA WF# 13-07	Budget neutral	Sep-12-2014

Appendix D Board Approved Rules (continued)

Board Approval Date	Rule Description	Estimated Savings/Total Cost/State Share	Effective Date
8/26/14	Policy is revised to remove reference to OKDHS form Adm 41, a form used to claim therapeutic and hospital leave. The form has not been utilized in over 7 years and the agency now tracks leave through its claims system; therefore, the process to claim leave in the rules is obsolete and must be amended to reflect current practice. APA WF# 13-10	Budget neutral	Sep-12-2014
8/26/14	The proposed 340B Drug Discount program rules are implemented to comply with a Federal Mandate. The 340B mandate requires states to include their 340B Drug Discount program rules in their State Plan and Medicaid policy. APA WF# 13-11	Budget neutral	Sep-12-2014
8/26/14	Policy is revised to clarify the use of options for manually pricing durable medical equipment items. Policy will be modified to reflect that OHCA will calculate and compare prices based on different methodologies, then use the lesser of the two for reimbursement. One method will use Manufacturer Suggested Retail Price (MSRP) minus 30%. The other option for manually-priced DME items will be invoice cost plus 30%. APA WF# 13-12	Budget neutral	Sep-12-2014
8/26/14	Policy is amended to allow reimbursement for Long Acting Reversible Contraceptive (LARC) devices to hospitals outside of the Diagnosis Related Group (DRG) methodology. APA WF#13-13	Budget neutral	Sep-12-2014
8/26/14	Tobacco cessation counseling policy is revised to include Maternal/Child Health Licensed Clinical Social Workers (LCSWs) with certification as a tobacco treatment specialist as a qualified provider for cessation counseling services. APA WF# 13-17	$30,015.00 Total; $10,523.26 State Share; $19,491.74 Federal Share	Sep-12-2014
8/26/14	Rules are revised to update references to other areas of policy within the text. The policy that is referenced in the tuberculosis rules is outdated and it has been revoked. Additionally, correct policy references are inserted to replace the revoked policy. APA WF# 13-18	Budget neutral	Sep-12-2014
8/26/14	Policy is revised to provide clarification that ADvantage program residential units are deemed to be rental units and that members in the program are to be provided with a lockable compartment within each member's rental unit for valuables. Additionally, minor grammatical changes will be made through the policy. APA WF# 13-19A	Budget neutral	Sep-12-2014
8/26/14	Policy will be revised to provide clarification regarding interdisciplinary team (IDT) meetings for case management services in the ADvantage Assisted Living waiver as well as other minor changes. Policy changes specify that IDT meetings, except for extraordinary circumstances, are to be held in the member's home. APA WF# 13-19B	Budget neutral	Sep-12-2014
8/26/14	PACE policy is revised to replace ADvantage policy references with a more precise ADvantage policy that defines the PACE eligibility criteria and the PACE eligibility determination for the PACE program. The proposed rule change to the PACE program will align rules to reflect the PACE model and PACE CFR Part 460. APA WF# 13-20	Budget neutral	Sep-12-2014
8/26/14	Pharmacy rules are revised to update and make general clean up changes and to comply with Federal Law on claims for covered over-the counter (OTC) products, which must be prescribed by a health care professional with prescriptive authority. Additional revisions include removing hard coded dates that no longer apply, removing the "Upper limit" reference from brand necessary certification product policy, and clarifying the product-based prior authorization for tier one and tier two products. APA WF# 13-21	Budget neutral	Sep-12-2014
8/26/14	Policy is added to include information on the Address Confidentiality Program (ACP). The ACP provides victims of domestic violence, sexual assault, or stalking with a substitute address and mail forwarding service that can be utilized when victims interact with state and local agencies. APA WF# 13-24	Budget neutral	Sep-12-2014
8/26/14	Policy is amended to include information on rounding of billable time as per the Interactive Voice Response Authentication (IVRA) system. This change in policy will enforce compliance, clarify information for providers, and reflect practices already taking place. Additionally, minor policy revisions are made to the policy. APA WF# 13-25	Budget neutral	Sep-12-2014
8/26/14	Policy is being revised to add language that sets boundaries as to what is deemed approved genetic testing methods. Problems have recently arisen which call for more stringent policy, particularly issues regarding lab billing for expensive methods that lack sufficient evidence for their use. APA WF# 13-26	Budget neutral	Sep-13-2014
8/26/14	Policy is added to include language that explicitly addresses proper billing in regard to nucleic acid testing of single/multiple infectious organisms in a specimen. APA WF# 13-27	$2,900,000 Total Savings; $1,080,000 State Share; $1,820,000 Federal Share	Sep-12-2014
8/26/14	Policy is revised to comply with Federal Law, 42 CFR 440.185, for ventilator-dependent individuals and clarify Nursing Home admission for ventilator-dependent and tracheostomy care services for residents in a nursing home facility. APA WF# 13-29	Budget neutral	Sep-12-2014
8/26/14	Policy is amended to more accurately reflect each party's responsibilities in an audit and clarify other audit procedures in order to streamline the process. The proposed changes define responsibilities of providers, who can represent a provider in her/his absence, and the duties of the docket clerk and the Administrative Law Judge during an audit. Further, the rule clarifies timeframes for document submission and prehearings. APA WF# 13-30	Budget neutral	Sep-12-2014

Appendix D Board Approved Rules (continued)

Board Approval Date	Rule Description	Estimated Savings/Total Cost/State Share	Effective Date
8/26/14	Policy is amended to remove language regarding the Level of Care Evaluation Unit (LOCEU) and to state that only categorical relationship to age is necessary per SSA guidelines for Sooner Senior Waiver Services only. In addition, policy is amended to change the scope of waiver services regarding Pharmacological Evaluations for Sooner Seniors and My Life, My Choice Waivers. This service will be redefined as Pharmacological Therapy Management, and its scope of work will be changed to include a case management approach to reviewing medication profiles of qualified members who meet medication utilization criterion or if they are referred for this service by a care manager. APA WF# 13-32	Budget neutral	Sep-12-2014
8/26/14	Policy is amended to specify that providers enroll in Electronic Fund Transfers for Medicaid reimbursement via the electronic enrollment process. Language referencing the Provider Relations unit will be removed as this unit no longer exists. APA WF# 13-35	Budget neutral	Sep-12-2014
8/26/14	Policy is revised to clarify documentation and prior authorization requirements for dental services and to clarify coverage for adult extractions, radiographs (x-rays) and endodontics procedures, among other services. Rules are further revised to remove the two tier orthodontic services and clarify treatment year is determined by the date of banding and clarify that reimbursement for orthodontic services is limited to authorized general dentist or orthodontist. Finally, rules are revised to align ambulatory surgical center (ASC) policy with Oklahoma Statute Title 63 § 2657. This law allows certified dental facilities to be recognized as ambulatory surgical centers. APA WF# 13-39	Budget neutral	Sep-12-2014
8/26/14	Policy is updated to further clarify the definition of inpatient and outpatient status for hospitals. Specifically, how hospitals may bill in the event a member is admitted as an inpatient but later determined by OHCA not to meet criteria for inpatient status; current policy is silent to the appropriate claim filing for these instances. The proposed revisions would clarify that hospitals may submit an outpatient claim for the ancillary services provided to the member while they were on inpatient status; this change will align policy with current practice. APA WF# 13-40	Budget neutral	Sep-12-2014
8/26/14	The Agency's inpatient psychiatric hospital rules are revised to establish medical necessity criteria specific for admission and continued stays in community based transitional (CBT) programs as these facilities are a lower level of care than psychiatric residential treatment facilities (PRTF) and acute residential treatment facilities. Changes are also being proposed to the rules regarding "active treatment" requirements for children under the age of 18. The change will allow providers flexibility to better tailor treatment to the individual needs of the child. Additional proposed changes include: revisions to Inspection of Care (IOC) rules, clarifying which types of facilities will be still receive on-site inspections, allowing psychosocial evaluations or admission assessments to substituted for the first therapy session, and allowing the use of mechanical restraints for children 18-20 since they are treated on the adult care unit. Other revisions are also made to make minor "cleanup" changes to terminology, which include changes mandated by the Diagnostic and Statistical Manual (DSM) V. APA WF# 13-45	Budget neutral	Sep-12-2014
8/26/14	The Agency's outpatient behavioral health (OBH) rules are revised to remove the behavioral health rehabilitation specialist (BHRS) designation from policy since, effective July 1, 2014, these services will only be reimbursed if provided by an LBHP, CADC or Case Manager II (CM II). Changes are also made to the rules to clarify that OBH services cannot be separately billable to individuals residing in nursing facilities. Reimbursements for these services are included within the nursing facility rate, as required by federal regulation. Additionally, clarification is made that individual and group psychotherapy services cannot be provided to children ages 0-3 unless medical necessity criteria is met, and partial hospitalization (PHP) and day treatment language is amended to clarify psychosocial rehabilitation is not allowed for children ages 0-3 and prior authorization is required for children ages 4-6. Additional changes include: additional supervision requirements for paraprofessionals by licensed, master level staff that render services to members outside of an agency setting, revising peer recovery support specialist services to include youth ages 16-18 that are transitioning into adulthood, revise behavioral health rehabilitation service documentation requirements, and clarifying when services may be rendered without a treatment plan. Other revisions are also made to make minor "cleanup" changes to terminology, which include changes mandated by the Diagnostic and Statistical Manual (DSM) V. APA WF# 13-46	Budget neutral	Sep-12-2014
8/26/14	The Agency's psychologists and licensed behavioral health provider rules are revised to add coverage for bio-psychosocial assessments for adults when required by OCHA as part of a preoperative prior authorization protocol for organ transplant or bariatric surgical procedures. Revisions are also made to clarify that payment for behavioral health services are not separately reimbursable for members residing in a nursing facility. APA WF# 13-47	Budget neutral	Sep-12-2014

Appendix D Board Approved Rules (continued)

Board Approval Date	Rule Description	Estimated Savings/Total Cost/State Share	Effective Date
8/26/14	The Agency's licensed behavioral health provider rules are revised to eliminate reimbursement for services provided by behavioral health professionals under supervision for licensure if they work under the direction of an individually contracted LBHP, outside of an agency setting. The additional oversight requirements imposed upon agencies provide a better training ground for individuals under supervision and afford OHCA and the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) better opportunity to ensure the quality of services being provided to SoonerCare members. APA WF# 13-48	Budget neutral	Sep-12-2014
8/26/14	The Agency's behavioral health case management rules are revised to ensure consistency with changes in case manager provider requirements made in Title 450 of the Oklahoma Administrative Code, by the certifying agency, the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS). Provider qualifications are being revised in order to reflect the legislature's intent, as expressed during the 2013 legislative session. Case management reimbursement rules are also being revised in order to allow reimbursement for transitional case management provided during the last 30 days of an inpatient stay. This change will ensure successful integration back into the community upon discharge from the inpatient facility. APA WF# 13-49	Budget neutral	Sep-12-2014
8/26/14	The Agency's therapeutic foster care (TFC) rules are being revised to allow for the completion of assessments and treatment plans from 14 days to 30 days. This change aligns with current practice that mandates when provisional diagnosis documentation must be submitted. All documentation will now be due to the OHCA within 30 days of admission to a TFC facility. The Agency is also proposing rule revisions to disallow coverage of Psychosocial Rehabilitation (PSR) services for children below age 6 unless services are medically necessary and required pursuant to Federal Early and Periodic Screening Diagnosis and Treatment (EPSDT) laws. Additionally, the agency is proposing to add detail language requirements for developing and rendering assessments, service plans, and PSR services. Other revisions are also made to make minor "cleanup" changes to terminology, which include changes mandated by the Diagnostic and Statistical Manual (DSM) V. APA WF# 13-50	Budget neutral	Sep-12-2014
8/26/14	Policy is revised to expand the age for which application of fluoride varnish during course of a well child screening is covered, from ages 12 months to 42 months to ages 6 months to 60 months. APA WF# 13-51	$22,485.85 Total; $8,467 State Share; $14,018.85 Federal Share	Sep-12-2014
8/26/14	OHCA rules related to IDEA and School Based services are revised for clarity and consistency. Revisions include removing references to outdated terms and/or policy, and adding guidelines for school-based services and evaluations as it relates to the Individual Education Plan/ Individual Family Service Plan (IEP/IFSP) for clarity and consistency. APA WF# 13-52	Budget neutral	Sep-12-2014
8/26/14	Policy is revised to clarify clinical laboratory services will be reimbursed in accordance with methodology approved under the State Plan. APA WF# 13-53	Budget neutral	Sep-12-2014
	Agency staff has estimated that the revisions would provide a total budget savings of $21,345,007.15 for the remainder of State Fiscal Year 2014, with a state share of $8,239,596.74.	Total budget savings of $75,667,351.15 for SFY2014; State Share of $28,719,120.74	

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 — BCC/SoonerPlan	5 — PIN Reset for SoonerCare
2 — Claim Status	6 — OKDHS
3 — SoonerCare Enrollment	9 — Repeat Options
4 — Pharmacy Inquiries	

Provider Services	405-522-6205 or 800-522-0114
1 — Policy Questions	5 — Provider Contracts
2 — PIN Reset/EDI/SoonerCare Secure Site Assistance	6 — Prior Authorizations
3 — Third Party Liability or Adjustments	9 — Repeat Options
4 — Pharmacy Help Desk	

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.ok.gov/oag
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