oklahoma health care authority

Building Bridges to Health Care for Oklahomans

SFY2006 Annual Report

July 2005 through June 2006

HCA


oklahoma
health care
authority

Our Mission Statement

To purchase state and federally funded health care in the most efficient and comprehensive manner possible and to study and recommend strategies for optimizing the accessibility and quality of health care.

Our Vision

Our vision at the Oklahoma Health Care Authority (OHCA) is for Oklahomans to enjoy optimal health status through having access to quality health care regardless of their ability to pay.

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.**

Our offices are located at:

4545 North Lincoln, Suite 124
Oklahoma City, Oklahoma 73105
405-522-7300

www.okhca.org

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State of Oklahoma

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Lieutenant Governor

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50th Legislature (2005-2006)

Mike Morgan
State Senate President Pro Tempore

Todd Hiett
House of Representatives Speaker

OHCA Chief Executive Officer and Board Members

Top (left to right):
Sandra Langenkamp; George Miller; *Vice Chairman* Wayne Hoffman; Chickasaw Governor Bill Anoatubby; *CEO* Mike Fogarty, JD, MSW

Bottom (left to right):
Lyle Roggow; Anne M. Roberts; *Board Secretary* Sue Branstetter; *Chairman* Charles (Ed) McFall, DPH

Message from the Chief Executive Officer

Bridges to a Healthy Oklahoma

Throughout our history, Oklahomans have overcome many obstacles to get us from where we are to where we want to be. From the simplicity of a fallen tree across a stream to a feat of modern engineering that spans miles of impassable terrain, bridges have provided access to our desired destination.

The VISION of the Oklahoma Health Care Authority describes our objective as a place and time when "Oklahomans . . . enjoy optimal health status through having access to quality health care regardless of the ability to pay." Since 1994, the OHCA has been designing and building bridges of all shapes and sizes over which Oklahomans are gaining access to health care.

Several of the newest bridges reach across traditional "categorical" barriers that excluded people from Medicaid coverage. There is a bridge that offers financial assistance to employers and individuals to make health insurance affordable for working Oklahomans and their families. One newly constructed bridge educates Oklahomans on the importance of preventive services and appropriate sources of care for themselves and their children and one provides care management to help members navigate the health care system. There is also a new bridge to quality nursing facility care built upon improved direct care staffing. Several other bridges encourage more health care providers to make their services available to Oklahomans through the SoonerCare (Oklahoma Medicaid) network.

In this Annual Report you will find that over these new bridges many thousands of Oklahomans are now gaining access to health care. The OHCA staff is grateful for the opportunity to have participated in this great effort. We also acknowledge and thank the Oklahoma taxpayers, the Governor and Legislature, and the OHCA Board of Directors for the resources and leadership to make this progress possible.

We are also pleased to introduce the new OHCA logo. It symbolizes our continuing efforts to bridge the gap between Oklahomans and health care services.

oklahoma health care authority

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SFY2006 Highlights

Enrollees

- There were 742,152 unduplicated members enrolled in either SoonerCare (Oklahoma Medicaid) or O-EPIC during SFY2006 (July 2005 through June 2006).
- 727,224 Oklahoma SoonerCare members received services during SFY2006.
- Overall SoonerCare enrollees increased by 6.5 percent and the number served increased 5.9 percent from SFY2005 (July 2004 through June 2005).
- Children age 18 and under are the majority of Oklahoma SoonerCare enrollees at 65 percent.
- SoonerCare covers more than 50 percent of the births in Oklahoma.
- During SFY2006, OHCA provided coverage to 29,997 Family Planning (SoonerPlan) enrollees and 6,343 women needing further diagnosis or treatment for breast and/or cervical cancer under Oklahoma Cares.

Expenditures

- The bulk of SoonerCare expenditures were made on behalf of the elderly and disabled. 59 percent of expenditures are made for services provided to the aged, blind and disabled, who made up an average of 19 percent of SoonerCare members for SFY2006.
- SoonerCare funded 73 percent of Oklahoma's total long-term care actual bed days.
- OHCA expended $19 million on behalf of the Breast and Cervical Cancer enrollees and more than $3.8 million on SoonerPlan enrollees.
- Quality of Care revenues totaled $54,277,601.
- Dollars recovered by OHCA through post payment reviews totaled $8,969,963.
- Drug Rebate collections increased by 31 percent to $128,759,931.
- By limiting the amount paid for generic drugs, OHCA saved more than $66 million through the State Maximum Allowable Cost (SMAC) program.

Administration

- The OHCA processed 28 emergency rules and 20 permanent rules and 23 State Plan amendments.
- There were 177 group provider training/seminars attended by more than 8,200 providers. OHCA and EDS held 5,404 individual provider training sessions during SFY2006.
- OHCA received and investigated 5,538 SoonerCare member complaints. This represents less than one percent of the entire 742,152 SoonerCare enrollees.
- There were 41 provider and 42 member formal appeals filed. This is less than one quarter of one percent of both populations.
- OHCA administrative costs comprised 1.96 percent of the total SoonerCare expenditures. OHCA operating costs represent 49 percent of OHCA administrative costs and the other 51 percent are contract costs.

SFY2006 Year in Review

TEFRA Implemented

In October 2005, OHCA began enrollment for the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) as a means to further address the needs of disabled Oklahoma children who would not otherwise qualify for SoonerCare benefits. TEFRA provides health insurance coverage for home-based children who meet an institutional level of care. Financial qualifications for TEFRA consider only the child's income, so the parent's income does not create an obstacle to enrollment.

First Phase of O-EPIC Begins; Expansion Anticipated

The Oklahoma Employer/employee Partnership for Insurance Coverage (O-EPIC) program is making affordable health coverage available to adults throughout the state who are either uninsured or at risk of losing their coverage due to high premium costs. O-EPIC Premium Assistance, implemented in November 2005, is the first phase of a statewide initiative to use public and private partnerships to insure Oklahoma. The Premium Assistance Program is designed to assist Oklahoma small business owners (with 25 or fewer employees) in purchasing health insurance on the private market for their income eligible employees (at or below 185 percent of Federal Poverty Level). On June 9, 2006, Governor Henry signed a bill into law that raises the number of employees a qualifying small business can have from 25 to 50. Enrollment for the expanded employers is expected to begin in fall 2006.

The second phase of the plan, the O-EPIC Individual Plan, is slated for implementation during the next fiscal year. This plan will extend coverage to those additional qualified individuals and groups including uninsured self-employed individuals, workers whose employers do not provide health plans or who are not qualified to participate in their employer's health plan, sole proprietors not qualified for small group health plans and the unemployed who are currently seeking work. This program will allow qualified Oklahomans to buy a health plan directly through the state.

Oklahoma Enrollment Expansion Successful

During SFY2006, OHCA extended enrollment to 29,997 Family Planning (SoonerPlan) enrollees, 6,343 women needing further diagnosis or treatment for breast and/or cervical cancer under Oklahoma Cares and 80 disabled children through TEFRA. OHCA also provided premium subsidies on behalf of approximately 1,058 employees of more than 465 small employers through the Oklahoma Employer/employee Partnership for Insurance Coverage (O-EPIC).

Medicare Part D Task Force Successful

OHCA formed a task force with the Oklahoma Department of Human Services employees, to coordinate the transition of dual enrollees (Medicare and Medicaid) to the new Medicare prescription drug benefit. The group met for more than a year and focused on various issues such as, policy changes, communications to members, Web site development, community outreach, and training. We successfully transitioned 85,000 dual eligible members from SoonerCare pharmaceutical benefits to Medicare Part D prescription drug coverage. Oklahoma is one of only 20 states that were able to transition smoothly. Thirty states had to "recall" their dually enrolled population and expend state funds to the tune of several million dollars to cover the costs of medications that Medicare Part D should have paid.

SFY2006 Year in Review (continued)

OHCA Raises Reimbursement Rates for Providers

With the cooperation of the Oklahoma Legislature and changes in policy, OHCA was able to increase provider payments to various provider types. Rates for physicians, inpatient and outpatient hospital services were raised. OHCA also increased per diem payments to freestanding rehabilitation and behavioral health facilities, as well as long term care sub-acute children's facilities. In addition, hospital crossover payments for dually qualified Medicaid and Medicare members were also restored to 100 percent of Medicare. For more information, refer to the SoonerCare and Our Providers section on page 40 of this report.

Services and Benefits to Assist Members in Smoking Cessation Expanded

It is estimated that one in four Oklahomans uses tobacco products. In order to assist our members in their efforts to quit, the OHCA has worked with the Tobacco Settlement Endowment Trust to increase the use of the Oklahoma Tobacco Helpline services (a phone-based support and coaching program) by the SoonerCare population. A direct mailing to adults was successful in increasing utilization; nearly 2,000 members called the Helpline as a result of this mailing.

SoonerCare benefits have been expanded to include physician and other primary practitioners' provision of evidence-based smoking cessation counseling in the outpatient office setting.

OHCA Projects Receive Recognition

OHCA highlighted nine projects at the 2006 *Quality Oklahoma* Team Day held at the state capitol. Projects included: Random Moment/Time Sheet, an internal system that simplified the tracking of OHCA staff time for payroll and federal reporting; the Oklahoma Employer/employee Partnership for Insurance Coverage (O-EPIC) implementation project; Certified Nurse Aide (CNA) Pilot, which provides free training for individuals to obtain CNA certification in exchange for working at a SoonerCare contracted long-term care facility; Computer Telephony Integration (CTI), which increased the effectiveness of OHCA's telephone computer system; Medicare Part D Task Force; OHCA's Web site redesign; SoonerCare ER Project which identified potential over-utilizers of emergency room services for education and care management; Provider Super Contracting, a project that enhanced the efficiency of provider contracting; and The Big Three, OHCA's Service Efforts and Accomplishments, Strategic Planning and Annual Reports.

OHCA staff were at the podium many times to collect awards. Specialty award nominations went to Computer Telephony Integration (CTI) for Red Tape Reduction Award, SoonerCare ER Project for Quality Crown Award, and Medicare Part D Task Force for both the Extra Mile Award and Motivating the Masses Award. The Governor's Commendation for Excellence awards went to O-EPIC, the Medicare Part D Task Force, OHCA's Web site redesign and the SoonerCare ER Project. The Red Tape Reduction Award went to OHCA's Medicare Part D Task Force.

OHCA Receives Second Performance Reporting Award

OHCA's Service Efforts and Accomplishments (SEA) SFY2005 report received the Certificate of Excellence from the Association of Government Accountants. This is the second consecutive year OHCA has received the award. The SEA report details the goals and objectives of the agency and outlines the progress toward achieving them using key performance measures, trends and benchmarks. The SEA report is available at OHCA's Web site at: www.okhca.org/Research/Reports.

SFY2006 Year in Review (continued)

SoonerCare Member Outreach

One main goal of the OHCA is to educate and empower SoonerCare members about their SoonerCare benefits and all resources available to them. Each month, OHCA staff attempt to contact various members in SoonerCare.

SoonerCare Choice members are surveyed to find out how much they know about the program, how to access their primary care provider and what resources are available to them. Members are encouraged to read their Member Handbook so they will know their rights and responsibilities.

Oklahoma Cares members upon certification are assigned a care manager to assist in coordinating diagnostic services related to the abnormal breast or cervical cancer screening. The Care Manager follows the woman's progress through her diagnostic services and the course of her cancer treatment or until confirmation is received that the diagnostic results were negative. Member Services staff provide education and outreach, including individualized enrollment with a primary care provider/case manager. Member Services also attempts to reach each member on an OKDHS list of members who have not returned their recertification paperwork. Staff offer any assistance necessary to complete the member paperwork in a timely manner and inform them they will lose their eligibility if the paperwork is not returned.

TEFRA members are contacted by Member Services to assist in the selection of a primary care provider. Care Management staff then contacts the parent or guardian of the enrolled disabled child to familiarize them with SoonerCare benefits and help coordinate services.

SoonerPlan members receive assistance from OHCA staff with questions they may have regarding their medical care. Primary care services are not covered under SoonerPlan; however, OHCA maintains a resource referral list to assist SoonerPlan members. Members are given a contact number for a clinic or facility from the list based on availability, services offered, hours of operations and a confirmed phone number. The OHCA mails SoonerPlan outreach letters to all post-partum women as well as men and women turning 19 who traditionally lose Medicaid coverage based on age.

Additionally, OHCA staff educate SoonerCare members identified as potential over-utiliziers of emergency room (ER) services. Staff call members with four or more visits to the ER in one given quarter. Members are informed about the proper use of the ER and encouraged to call their primary care provider during office hours to determine if they have a true emergency. If it is after hours, members are advised to call the Patient Advice Line from 5 p.m. to 8 a.m. and 24 hours on state holidays and weekends. For those members unable to be contacted by telephone, a letter is mailed.

OHCA staff also conduct home visits to all children receiving skilled nursing care. Upon receipt of a new skilled nursing request, an OHCA exceptional needs coordinator (ENC) nurse visits the child and conducts a scoring assessment to determine if the child meets medical criteria for private duty nursing. Once care is established, the ENC does a home visit quarterly to recertify the authorized care.

SFY2006 Year in Review (continued)

SoonerCare Member Outreach (continued)

In an effort to increase participation of members in the use of preventive care services, OHCA staff initiated a calling campaign to members with newborn babies. The 300 calls per month offered information on the availability of child health services (EPSDT) and the recommended schedule for child health screens. In addition, members were given the opportunity to change their primary care provider and to discuss any concerns they had. The members also received information on the availability of SoonerRide and SoonerPlan.

Non-custody SoonerCare members under the age of 21 identified as being within the top 50 users of inpatient behavioral health days have been contacted to gather clinical information and to provide care coordination services. The goal is to help the individual and family obtain the appropriate outpatient behavioral health services in order to maintain the identified child in their home.

Improving the Health Care of Children in the Custody of OKDHS

The OHCA and the Oklahoma Department of Human Services (OKDHS) have developed and piloted a process whereby information for children in custody of the state is exchanged on a daily basis. Initially, when children are taken into state custody due to abuse or neglect concerns, there is little or no background health care information available to OKDHS. Due to a lack of information, children may not have received needed care and treatments. Now SoonerCare claims history for each child is researched and information returned to OKDHS within one business day. This information is shared by OKDHS with the child welfare worker, emergency foster parents and medical professionals, resulting in improved health care for this vulnerable population. Due to the clear success of this pilot, the service is being expanded to include all children entering OKDHS custody statewide.

OHCA Communication Improved

Computer Telephony Integration (CTI) was implemented with two contractors this fiscal year: OU College of Pharmacy (Pharmacy Help Desk) and Life Care (SoonerCare Help Line). The CTI application allows agents to receive an inbound phone call from the OHCA lines with pop-up information on the caller retrieved from the medical management information system (MMIS) and displayed on the computer screen at the same time the voice connection is made. CTI also allows call agents from different units to transfer the caller along with the information screen, cutting down on repetitive questions and reducing the time of a call.

Another innovation, Elite Routing, enables OHCA and contractor call agents to take calls of more than one type. For example, if a Spanish-speaking agent is not occupied with a Spanish call, then that agent is able to take an English call instead of sitting idle. Since the implementation, all answer rates have increased due to better use of personnel.

SFY2006 Year in Review (continued)

MRI Prior Authorization Guideline Revisions

The Oklahoma Health Care Authority revised the prior authorization requirements for Magnetic Resonance Imaging (MRI) procedures, effective October 1, 2005. These guidelines are listed online at the agency's Web site (www.okhca.org) to allow providers to identify if the MRI procedure they are requesting will require a prior authorization. The procedure code and the member's diagnosis code are all that is needed to confirm the authorization status. The OHCA is hopeful that this revision will help to alleviate claims issues for the facilities and radiologists performing MRI procedures for our members.

Agency Initiatives

In order to provide the most comprehensive benefits possible to our members, OHCA constantly develops new plans and strategies.

Disease Management is being developed at OHCA. Chronic disease management programs include self-monitoring and patient education as ways to increase member involvement in and responsibility for their health status. Diabetes, asthma, smoking cessation and hypertension are all disease states that can be improved through patient education.

SoonerPSYCH (Prescription Solutions for Your Cognitive Health) is a partnership between OHCA, the Department of Mental Health and Substance Abuse and drug manufacturer Eli Lilly. The program is working toward educating physicians about drugs used to treat behavioral health issues and to providing information about their patient's total prescription utilization. SoonerPSYCH is contracted to Comprehensive NeuroScience Inc. and funded entirely by Eli Lilly.

The Real Choice Systems Change Grant Mental Health System Transformation represents a collaborative effort between the Oklahoma Health Care Authority and the Oklahoma Department of Mental Health and Substance Abuse Services. One of the goals of the grant is to help participants gain information and skills to cope with mental illness, set meaningful individual goals, and make progress toward personal recovery. Another goal is to help families better understand mental illness, recognize the important role of the family in recovery, and promote improved outcomes for the members and their families. Training will be offered to providers interested in learning about the programs throughout the remainder of the grant.

Perinatal Advisory Task Force Launched

For the past several years, more than 50 percent of the women who give birth in Oklahoma are SoonerCare members. OHCA has partnered with the Oklahoma State Department of Health to create the OHCA-OSDH Perinatal Advisory Task Force. This task force functions to assist both agencies in their missions to provide quality prenatal care and delivery services, improving the health of our tiniest citizens and their mothers. Task force members represent over 20 associations and organizations. In addition to the bi-monthly meetings, six perinatal 'Asking Conferences' were held in various locations across the state. Physicians, nurses, midwives, advocates and other interested parties attended these sessions where the task force received helpful input on ways to improve perinatal care and services.

SFY2006 Year in Review (continued)

Provider Training Successful

OHCA and Electronic Data Systems (EDS) staff made more than 5,000 on-site provider visits this year. Along with this one-on-one educational opportunity, providers were offered workshops, seminars and regional trainings throughout the year. More than 800 attended these informational sessions. Class sessions were based on provider requests along with changes in agency programs and policies. The providers' participation adds value to our program and shows the provider's commitment to the members we serve. Additional regional training including specific training for our Indian Health Providers is in development for SFY2007.

The Oklahoma Employer/employee Partnership for Insurance Coverage (O-EPIC) also had many training efforts. A targeted mailing to 3,000 producers (insurance providers) invited them to seminars to learn how to insure Oklahomans through the O-EPIC program. Approximately 47,000 small businesses were mailed an informational packet about O-EPIC's premium assistance program. Chambers of Commerce and numerous other organizations were contacted to present information regarding O-EPIC. Additionally, O-EPIC newsletters are published and distributed quarterly. For more details go to www.oepic.ok.gov.

OHCA and OSU-OKC Certified Nurse's Aide (CNA) Training Continues

The OHCA, in partnership with the Oklahoma State University-Oklahoma City (OSU-OKC) and other state agencies, continued the Certified Nurse Aide (CNA) pilot program in Oklahoma and Logan counties that began in May 2005. One goal of the program is to improve the quality of life for long-term care members by providing standardized training and curriculum in an educational setting. Another goal for the program is to decrease turnover rates. According to a 2003 American Health Care Association survey, Oklahoma had a 135 percent turnover rate for CNAs. Classes are free for students who earn certification and subsequently gain and hold employment at a SoonerCare contracted long-term care facility for at least 12 out of 24 months.

Initiation of a Medical Services Review Committee

The Oklahoma Health Care Authority implemented the Medical Services Review Committee in October 2005 to review and evaluate potential Medicaid/SoonerCare policy changes or revisions relevant to current and advancing medical practices and to support continued maintenance of the most current and cost-effective practices for our membership.

Issues considered during SFY2006 include newly developed medical practices and/or equipment for consideration for coverage, medical review guidelines for services requiring prior authorization and interpretation of the SoonerCare rules.

Understanding SoonerCare

What is Medicaid?

Who Qualifies for Medicaid?

What is SoonerCare?

Who are the Members of SoonerCare?

How is SoonerCare Financed?

Where are the SoonerCare Dollars Going?

Oklahoma's Uninsured

Oklahoma's Response to the Working Uninsured

SoonerCare and the Economy

What is Medicaid?

Medicaid:

- was created as Title XIX (19) of the Social Security Act in 1965;
- is a federal and state partnership program that provides medical benefits to low-income individuals who have little or no health insurance coverage;
- makes coverage available for basic health and long-term care services based upon income and/or resources;
- is overseen at the federal level by the Centers for Medicare & Medicaid Services (CMS) within the Department of Health and Human Services (HHS);
- has requirements concerning funding, qualification guidelines as well as quality and extent of medical services that are set and monitored by CMS;
- Oklahoma Medicaid is called SoonerCare.

Who Qualifies for Medicaid?

Medicaid serves as the nation's primary source of health insurance coverage for vulnerable populations. To get federal financial participation, states agree to cover certain groups of individuals (referred to as "mandatory groups") and offer a minimum set of services (referred to as "mandatory benefits"). States also can receive federal matching payments to cover additional ("optional") groups of individuals and provide additional ("optional") services.

Figure 1 2006 Federal Poverty Level Guidelines

Family Size	Annual (Monthly) Income			
	100%	133%	185%	200%
1	9,800 ($817)	13,034 ($1,086)	18,130 ($1,511)	19,600 ($1,633)
2	13,200 ($1,100)	17,556 ($1,463)	24,420 ($2,035)	26,400 ($2,200)
3	16,600 ($1,383)	22,078 ($1,840)	30,710 ($2,559)	33,200 ($2,767)
4	20,000 ($1,667)	26,600 ($2,217)	37,000 ($3,083)	40,000 ($3,333)
5	23,400 ($1,950)	31,122 ($2,594)	43,290 ($3,608)	46,800 ($3,900)
6	26,800 ($2,233)	35,644 ($2,970)	49,580 ($4,132)	53,600 ($4,467)
7	30,200 ($2,517)	40,166 ($3,347)	55,870 ($4,656)	60,400 ($5,033)
8	33,600 ($2,800)	44,688 ($3,724)	62,160 ($5,180)	67,200 ($5,600)

**For family units with more than eight members, add $3,400 for each additional member. Based on Federal Income Guidelines printed in the Federal Register: January 24, 2006, Volume 71, Number 15, Page 3848-3849.*

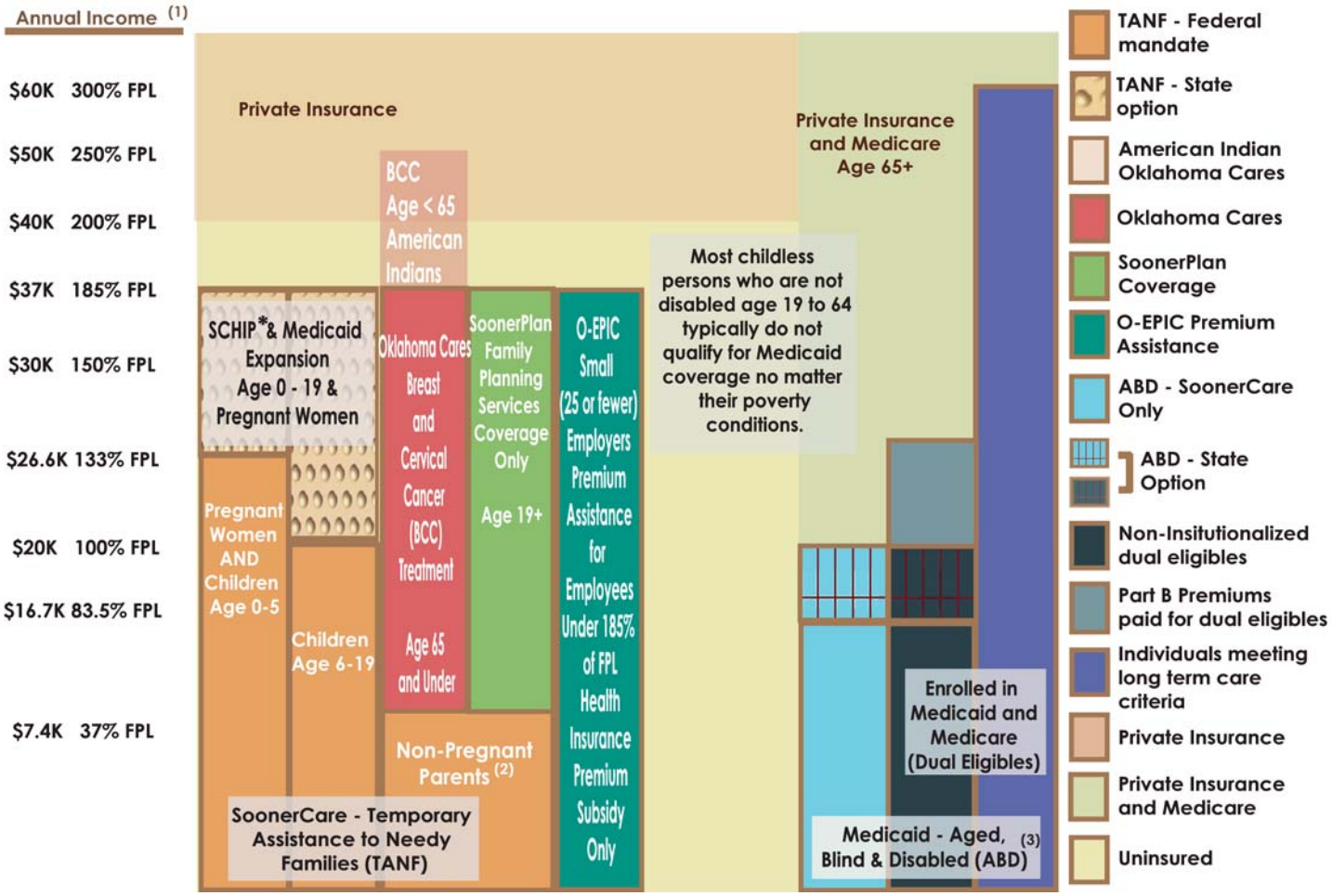
The designation of some groups as mandatory and others as optional is an artifact of Medicaid's origins as a health care provider for traditional welfare populations. Through laws enacted over the past 40 years, eligibility has been extended to include not only the people who are receiving cash-assistance programs but also the individuals who are not. Although welfare reform has severed the link between Medicaid and cash assistance, income criteria relative to the federal poverty level (FPL) is still being used to qualify members for Medicaid. As Medicaid across the nation continues to expand and disconnect from its welfare roots, determining how to categorize enrollees becomes increasingly difficult.

Who Qualifies for Medicaid? (continued)

Oklahoma Department of Human Services' Role in Eligibility

In accordance with Oklahoma State Statutes Title 63 Sec. 5009, the OHCA contracts with the Oklahoma Department of Human Services (OKDHS) for the determination of SoonerCare eligibility. This means that applications for Oklahoma SoonerCare enrollment (except O-EPIC) are processed and approved or denied by OKDHS. Applications and renewals are reviewed by each county OKDHS office for financial and/or medical qualifications. After an individual meets the qualifications and completes the enrollment process, their records are sent to OHCA to coordinate medical benefits and make payments for services. Each state sets an income limit within federal guidelines for Medicaid eligibility groups and determines what income counts toward that limit. Part of financial qualification for SoonerCare is based upon the family size and relation of monthly income to the federal poverty level (FPL) guidelines.

Figure 2 2006 Federal Poverty Levels (FPL) and Coverage



(1) 2006 Federal Poverty Guidelines, U.S. Department of Health and Human Services. Based on a family of four.
(2) 37 percent federal poverty level (FPL) based on single parent family.
(3) Incomes shown are for single individuals.
** SCHIP is the State Children's Health Insurance Program, for more information go to page 20.*
Oklahoma Cares Breast and Cervical Cancer treatment qualification guidelines are expanded to 250% of federal poverty level for American Indians only.

What is SoonerCare?

SoonerCare is Oklahoma's Medicaid program. The Oklahoma Health Care Authority has the task of providing government assisted health insurance coverage to qualifying Oklahomans. There are varying health benefit packages under SoonerCare, and each has a different name.

SoonerCare Choice is a Primary Care Case Management (PCCM) program in which each member has a medical home that provides basic health care services. Members enrolled in SoonerCare Choice can change their primary care providers up to four times per year. The SoonerCare Choice program is partially capitated, in that providers are paid a monthly capitated rate for a fixed set of services with noncapitated services remaining compensable on a fee-for-service basis.

SoonerCare Traditional is a comprehensive medical benefit plan that purchases benefits for members as they receive a service. SoonerCare Traditional provides coverage for members who qualify for Medicaid and are institutionalized, in state or tribal custody or enrolled under a Home and Community-Based Waiver. The member accesses services from contracted providers, and the OHCA pays the provider on a fee-for-service basis.

The ***Opportunities for Living Life*** program offers additional benefits to certain members who are enrolled in SoonerCare Traditional or SoonerCare Supplemental plans. These benefits could include long-term care facility services, in-home personal care services and/or home and community-based services. The home and community-based benefit provides medical and other supportive services as an alternative to a member entering a long-term care facility.

Some enrollees are not included in the SoonerCare Choice benefit package: members who are institutionalized, dual eligibles enrolled in both Medicare and Medicaid, in state or tribal custody, have coverage under a health maintenance organization (HMO) or enrolled under one of the Home and Community-Based waiver programs.

SoonerCare Supplemental is a plan that pays the coinsurance and deductible and provides medical benefits that supplement those services covered by Medicare.

SoonerPlan is a benefit plan covering limited services related to family planning. In an effort to reduce unwanted pregnancies, Oklahoma received a waiver from the federal Centers for Medicare & Medicaid Services (CMS) to extend coverage to a larger segment of the population. SoonerPlan provides family planning services and contraceptive products to women and men over age 18 who do not traditionally qualify for full SoonerCare benefits.

Who are the Members of SoonerCare?

Main Qualifying Groups

To be eligible for federal funds, states are required to provide Medicaid coverage for certain individuals who receive federally assisted income-maintenance payments (cash assistance), as well as for related groups not receiving cash payments.

Parents and children. Most SoonerCare enrollees are qualified under the Temporary Assistance for Needy Families (TANF) guidelines regardless of whether they were still eligible to receive the TANF cash assistance or not. In SFY2006, SoonerCare covered a total of 489,375 children under age 21; of these, 427,138 were low-income and state-custody children; that is 87 percent of the total children. The other 13 percent qualified under other qualifying groups such as SCHIP, SoonerPlan or Blind and Disabled. Only 10 percent of the children enrolled in SoonerCare under TANF guidelines were in state-custody or received cash assistance. Additionally, nearly 50,000 low-income adults in families with children, mostly were enrolled under TANF guidelines. The majority of these members receive the SoonerCare Choice benefit package.

Aged. More than 61,000 adults age 65 and over, excluding persons who are blind or disabled, were covered by SoonerCare in SFY2006. Twenty-nine percent were enrolled because they were receiving cash assistance through the Supplemental Security Income (SSI) program. Others had too much income or assets to qualify for SSI but were able to "spend down" to SoonerCare eligibility by incurring high medical or long-term care expenses. Most of these members are included in the Aged, Blind and Disabled (ABD) category and receive SoonerCare Traditional benefits.

Blind and Disabled. In SFY2006, more than 84,500 Oklahomans who are blind or have chronic conditions and disabilities were enrolled in SoonerCare. Seventy-one percent qualified because they received cash assistance through the SSI program. The remainder generally qualified by incurring high medical expenses to meet their "spend down" obligation. These members qualify under the Aged, Blind and Disabled (ABD) category and more than half receive the SoonerCare Traditional benefit package.

Dual Eligibles. Some individuals are qualified for Medicaid and Medicare. Medicare has two basic coverage components: Part A, which pays for hospitalization costs, and Part B, which pays for physician services, laboratory and X-ray services, durable medical equipment, outpatient and other services. Dual eligibles are individuals who are entitled to Medicare Part A and/or Part B and qualify for some form of SoonerCare benefit. Oklahoma SoonerCare covered more than 90,000* dually eligible enrollees at some point during SFY2006. These members receive SoonerCare Supplemental or SoonerCare Traditional benefits and are reported under the Aged, Blind and Disabled (ABD) or Other categories.

**Dual enrollees may be accounted for in other qualifying groups.*

Who are the Members of SoonerCare? (continued)

Additional Qualifying Groups

State Children's Health Insurance Program (SCHIP). Implemented in 1997, SCHIP or Title XXI, is designed to help states cover additional uninsured low-income children. SCHIP offers enrollment for children age 18 and under with income below 185 percent of federal poverty level who are not eligible under criteria in effect prior to November 1997 or another federal insurance program. As a federal incentive, Oklahoma receives a higher rate of federal matching dollars for members qualified under SCHIP. (See Figure 5 Historical Federal Medical Assistance Percentage, Page 21) During SFY2006, 78,798 of the 464,553 children age 18 and under were enrolled under SCHIP. A majority of the children who qualify under SCHIP receive the SoonerCare Choice benefit package. These members are categorized under Parents/Children in this report.

SoonerCare expansion. Also in 1997, legislation raised the optional SoonerCare eligibility level to 185 percent of the federal poverty level for children 18 and under as well as pregnant women regardless of their age. The SoonerCare expansion also includes these qualifying individuals even if they have other types of insurance coverage (third party liabilities). Of the 464,553 children enrolled age 18 and under more than 6,000 qualified through this expansion. These enrollees receive SoonerCare Choice benefits and are categorized under Parents/Children.

Since the implementation of the SoonerCare eligibility expansion programs in 1997, the number of children enrolled in Oklahoma SoonerCare has increased 195 percent.

TEFRA. The Tax Equity and Fiscal Responsibility Act (TEFRA) gives Oklahoma the option to make SoonerCare benefits available to children under age 19 with physical or mental disabilities who would not ordinarily be eligible for Supplemental Security Income (SSI) benefits because of their parents' income or resources. Oklahoma instituted this option in October of 2005. TEFRA allows children who qualify for institutional services to be cared for in their homes. The majority are receiving SoonerCare Choice benefits. For this report these enrollees are categorized under Aged, Blind and Disabled (ABD).

There were 80 children who qualified through the TEFRA program since its inception in October of 2005.

Oklahoma Cares. Implemented in January 2005, OHCA's Breast and Cervical Cancer treatment program, Oklahoma Cares, provides SoonerCare health care benefits to women under age 65 found to be in need of further diagnostics or treatment for either breast or cervical abnormal findings, pre-cancerous conditions or cancer. Oklahoma Cares members are covered under either the SoonerCare Choice or SoonerCare Traditional benefit package until they no longer require treatment or qualify financially. Unless it is listed separately, Oklahoma Cares will be grouped under the Parents/Children category in this report.

There were 6,343 women qualified through Oklahoma Cares in SFY2006.

Who are the Members of SoonerCare? (continued)

Additional Qualifying Programs (continued)

SoonerPlan. SoonerPlan is Oklahoma's family planning program for women and men who do not qualify for other SoonerCare services. Implemented under a waiver in April 2005, SoonerPlan offers enrollment to Oklahoma residents who are over age 19 with income below 185 percent of Federal Poverty Level and who do not have family coverage from any other source. SoonerPlan member benefits are limited to family planning services from any SoonerCare provider who offers family planning.

During SFY2006, 29,997 members were enrolled under SoonerPlan.

Home and Community-Based Services (HCBS) Waivers. Medicaid Home and Community-Based Services (HCBS) waivers afford states the flexibility to develop and implement creative alternatives to placing SoonerCare-qualified individuals in either a nursing facility or intermediate care facility for the mentally retarded (ICF/MR).

The Oklahoma Department of Human Services is responsible for and administers the five following Home and Community-Based Services waivers (HCBS):

- *Community Waiver*: Serves approximately 2,500 members with mental retardation (MR) and "related conditions" qualified for placement in an intermediate care facility for the mentally retarded (ICF/MR). This waiver covers children and adults, with the minimum age being 3 years old.

What is a Waiver?

States' Medicaid waivers are granted by the federal Centers for Medicare & Medicaid Services (CMS). The federal government allows states to request waivers to specifically "waive" certain federal requirements of the program. Waivers generally must be "budget neutral" to the federal government (that is, federal spending under a waiver cannot exceed what federal spending would have been without a waiver).

- *ADvantage Waiver*: Serves the "frail elderly" (age 65 years and older) and adults over age 21 with physical disabilities that qualify for placement in a nursing facility. Approximately 18,850 members receive services through this waiver program.
- *Homeward Bound Waiver*: Designed to serve the needs of individuals with MR or "related conditions" who are also members of the Plaintiff Class in *Homeward Bound et al. v. The Hissom Memorial Center, et al.* who would otherwise qualify for placement in an ICF/MR. This waiver covers just over 800 individuals.
- *In-Home Supports Waiver for Adults*: Designed to assist the state in removing adult individuals (ages 18 years of age and older) with mental retardation from a waiting list for waiver services. This waiver serves more than 1,175 adults who would otherwise qualify for placement in an ICF/MR.
- *In-Home Supports Waiver for Children*: Designed to assist the state in removing children ages 3 through 17 years with mental retardation from a waiting list for waiver services. During SFY2006 this waiver served 487 children who qualified for placement in an ICF/MR.

Who are the Members of SoonerCare? (continued)

Approximately 1 in 5 Oklahomans Enrolled in SoonerCare

The SoonerCare program enrolled 742,152 unduplicated members during SFY2006. On average, 568,278 members were enrolled each month of the state fiscal year.

Figure 3 Age of SoonerCare Enrollees

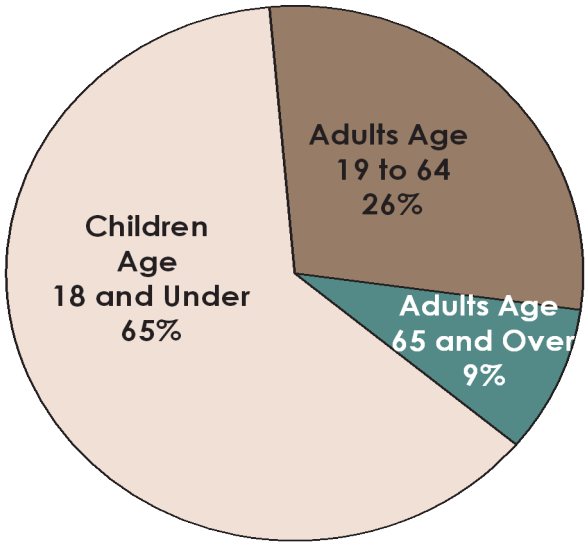
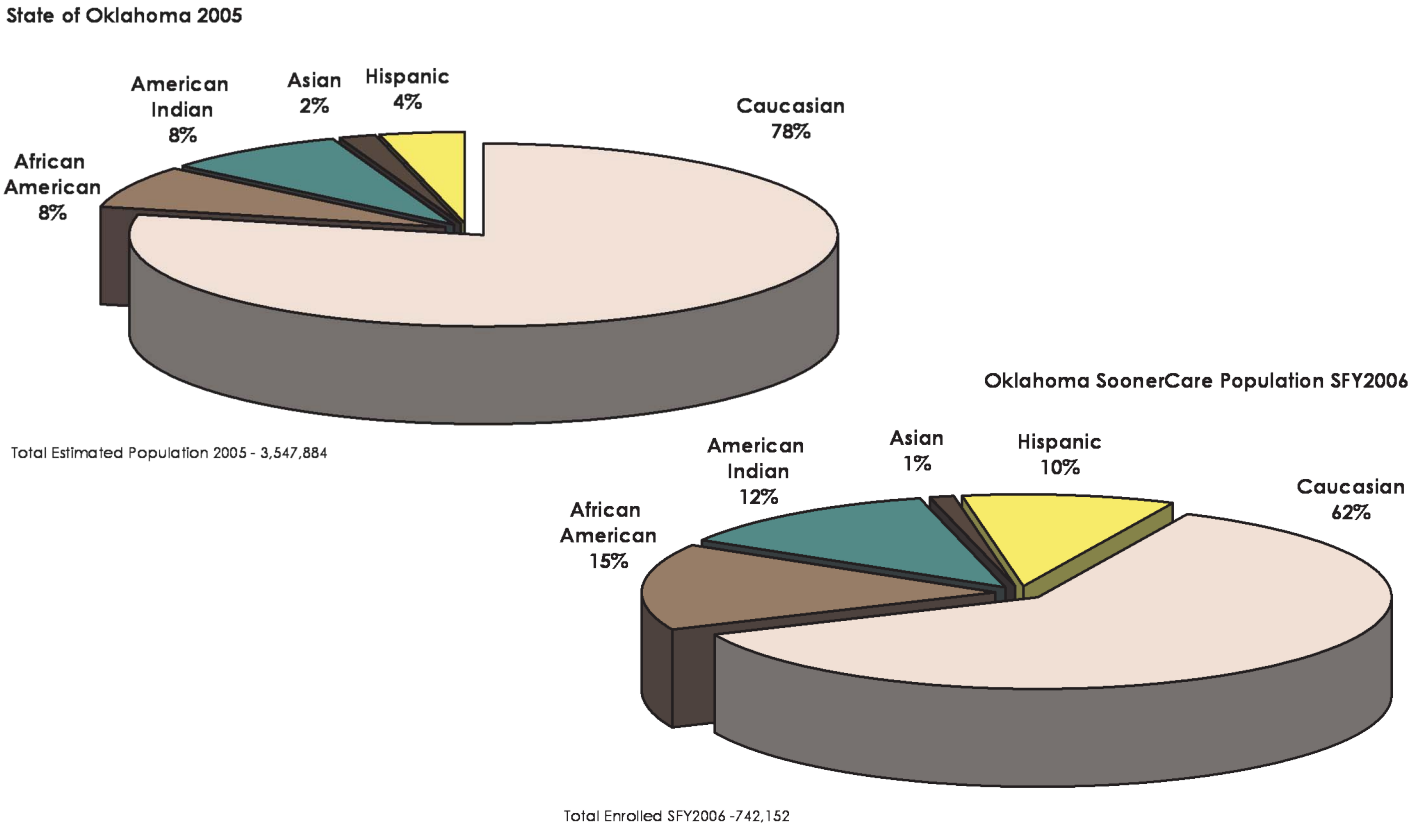


Figure 4 State and SoonerCare Population by Race



Oklahoma state totals based upon US Bureau of the Census Oklahoma State Data Center 2005 Population. Oklahoma SoonerCare unduplicated counts based upon data extracted from member eligibility files on July 17, 2006. Race is self-reported by members at the time of enrollment.

How is SoonerCare Financed?

The federal and state governments share Medicaid costs. In the federal budget, Medicaid is an "open-ended entitlement" program. This means that the federal government is required by law to pay its share of state Medicaid costs regardless of the total amount. 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. During federal fiscal year 2006, Oklahoma SoonerCare's federal matching rate (67.91 percent) was the lowest it has been in more than 12 years. Oklahoma must use our own state or local tax dollars (called state "matching dollars") to meet our share of SoonerCare costs. In order to expand SoonerCare enrollees and/or benefits, Oklahoma must provide more tax dollars to get more money from the federal government.

Figure 5 Historical Federal Medical Assistance Percentage (FMAP)

Federal Fiscal Year	FMAP Rate	SCHIP‡
FFY94	70.39%	
FFY95	70.05%	
FFY96	69.89%	
FFY97	70.01%	
FFY98	70.51%	79.36%
FFY99	70.84%	79.59%
FFY00	71.09%	79.76%
FFY01	71.20%	79.87%
FFY02	70.43%	79.30%
FFY03—Qtr. 1 & 2	70.56%	79.39%
FFY03—Qtr. 3 & 4*	73.51%	79.39%
FFY04—Qtr. 1-3*	73.51%	79.17%
FFY04—Qtr. 4	70.24%	79.17%
FFY05	70.18%	79.13%
FFY06	67.91%	77.54%
FFY07	68.14%	71.76%

‡ *SCHIP: State Children's Health Insurance Program, see additional information on page 18. The Federal Fiscal Year is from October through September.*

**Oklahoma received a temporary increase in the Medicaid matching funds received from the federal government for five calendar quarters from April 1, 2003, through June 30, 2004. The increase for all eligible expenditures was 2.95 percentage points over the normal federal share amount. The funds were part of the Jobs and Growth Tax Relief Reconciliation Act of 2003.*

SoonerCare (Oklahoma Medicaid) is the largest source of federal financial assistance in Oklahoma, accounting for an estimated 40 percent of all federal funds flowing into Oklahoma. Federal Medicaid dollars received for SFY2006 totaled over $2.08 billion.

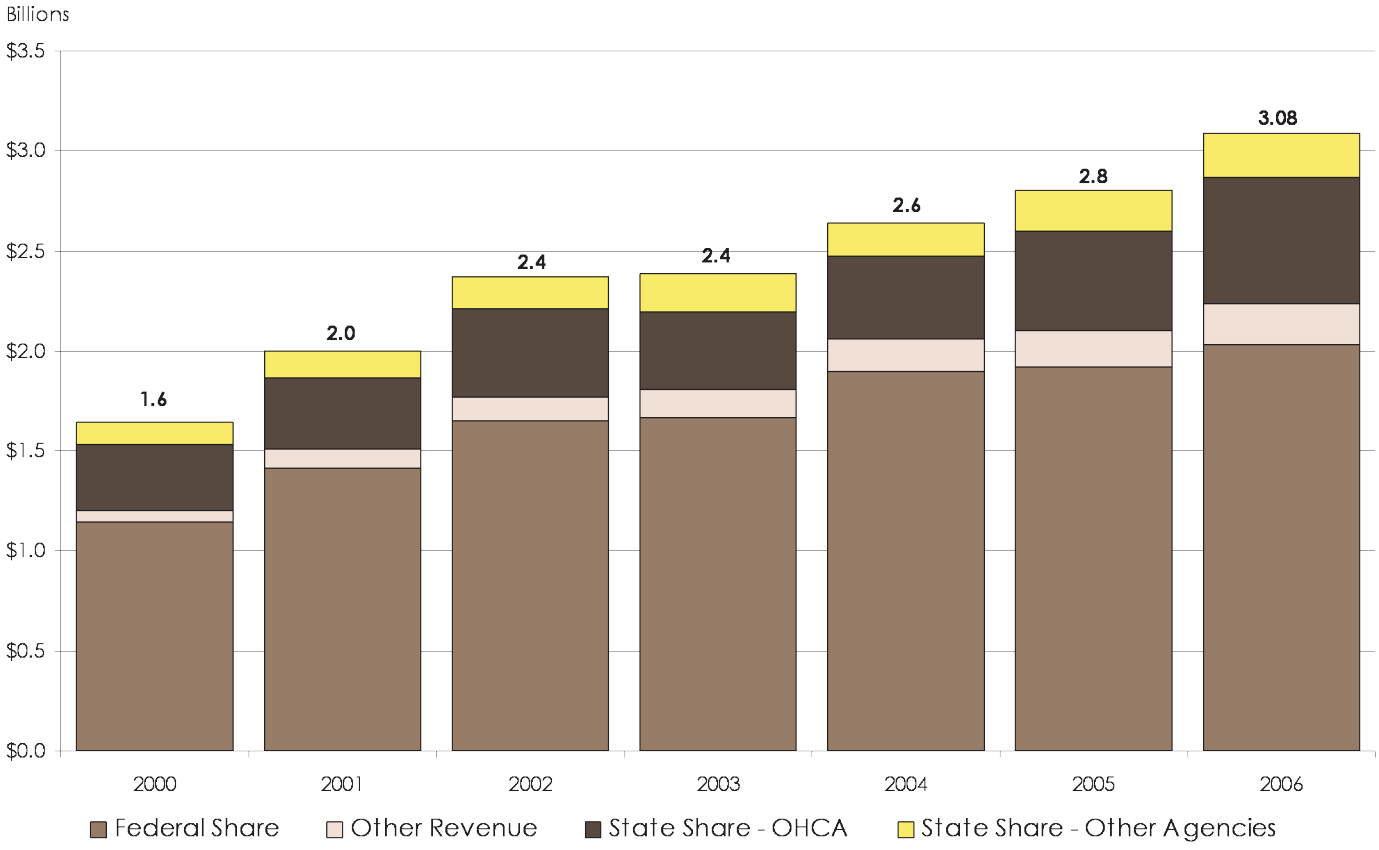
Figure 6 Condensed Summary of OHCA Revenues

Revenue Source	Actual Revenues
State Appropriations	$634,869,807
Federal Funds—OHCA	$1,604,337,435
Federal Funds for Other State Agencies	$480,964,389
Refunds from Other State Agencies	$237,164,823
Tobacco Tax Funds	$79,529,022
Drug Rebate	$128,759,931
Medical Refunds	$18,768,306
Quality of Care Fees	$54,277,601
Prior Year Carryover	$40,958,536
Other Revenue	$263,604
Total Revenue	**$3,279,893,454**

Source: OHCA Financial Services Division (August 2006). 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.

How is SoonerCare Financed? (continued)

Figure 7 Summary of Expenditures and Revenue Sources, Oklahoma SoonerCare 2000—2006



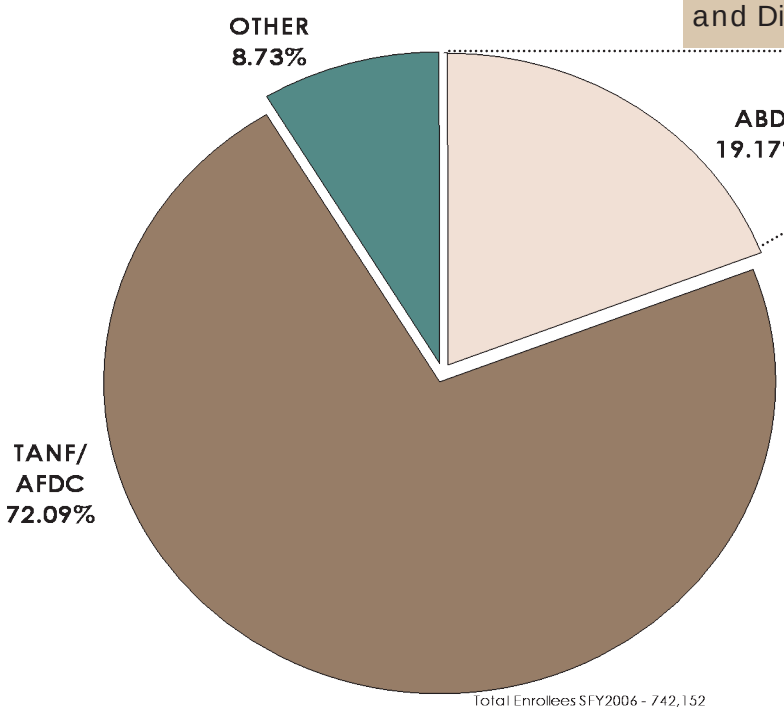
Federal Fiscal Year	Total Expenditures	Federal Share	Other Revenue	State Share—OHCA	State Share—Other Agencies
2000	**$1,639,609,394**	$1,139,128,825	$54,550,198	$342,925,722	$103,004,649
2001	**$1,996,145,200**	$1,401,720,019	$93,226,087	$352,780,424	$148,418,670
2002	**$2,364,757,733**	$1,649,015,855	$116,710,620	$420,623,539	$178,407,719
2003	**$2,372,429,612**	$1,664,286,690	$164,790,753	$347,837,074	$195,515,095
2004	**$2,630,005,465**	$1,898,324,894	$125,246,091	$432,013,624	$174,420,856
2005	**$2,805,599,500**	$1,925,312,737	$191,739,370	$477,858,455	$210,688,938
2006	**$3,086,916,991**	$2,029,524,772	$210,005,646	$626,418,336	$220,968,237

Source: Annual National Association of State Budget Officers (NASBO) Survey as prepared by OHCA Financial Services Division. 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.

Where are the SoonerCare Dollars Going?

Figure 8 SoonerCare Enrollees and Expenditures by Aid Category Percentages

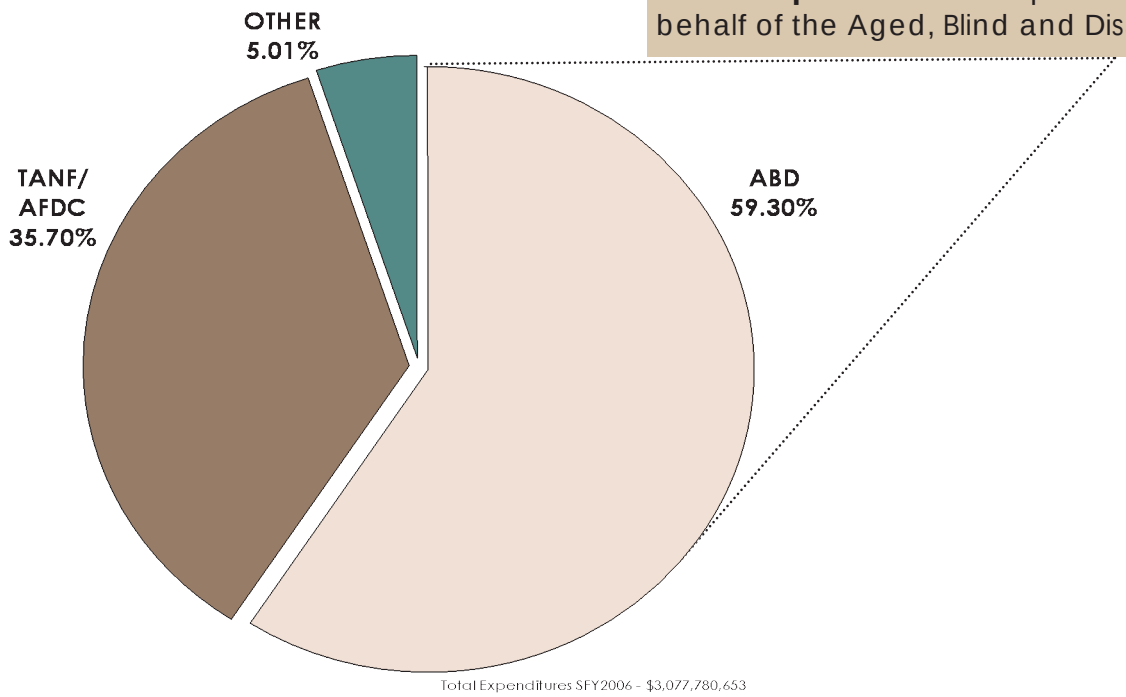
Enrollees



Only 19% of enrollees were Aged, Blind and Disabled.

Approximately 6 of every 10 SoonerCare dollar paid for services rendered to the Aged, Blind and Disabled (ABD) population. This group includes dual eligibles, persons with chronic medical conditions or residents of long-term care facilities.

Expenditures

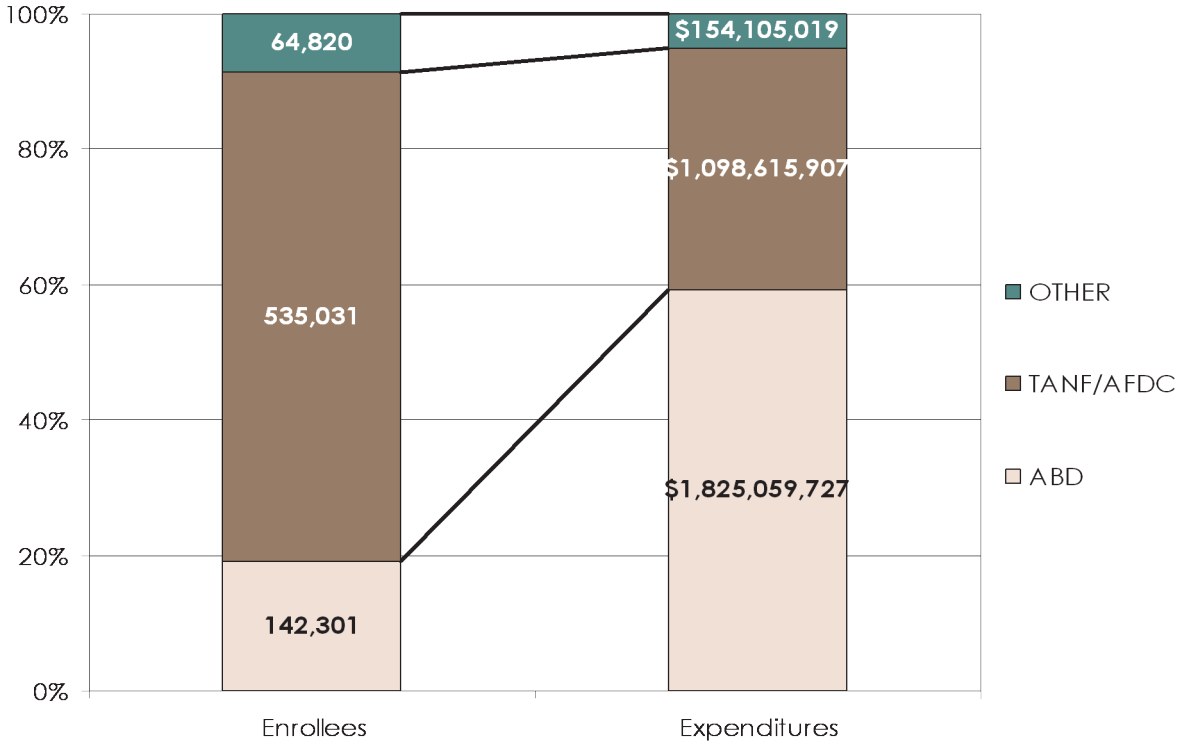


59% of expenditures were paid on behalf of the Aged, Blind and Disabled.

NOTE categories have changed from previous years. ABD no longer includes $140M in IME/GME/DSH and UPL payments as they have now been moved to OTHER. OTHER also includes—SoonerPlan (family planning), O-EPIC, Child Custody, Refuge, SLMB, DDSD Supported Living and TB member enrollees and expenditures. ABD includes TEFRA enrollees and expenditures.

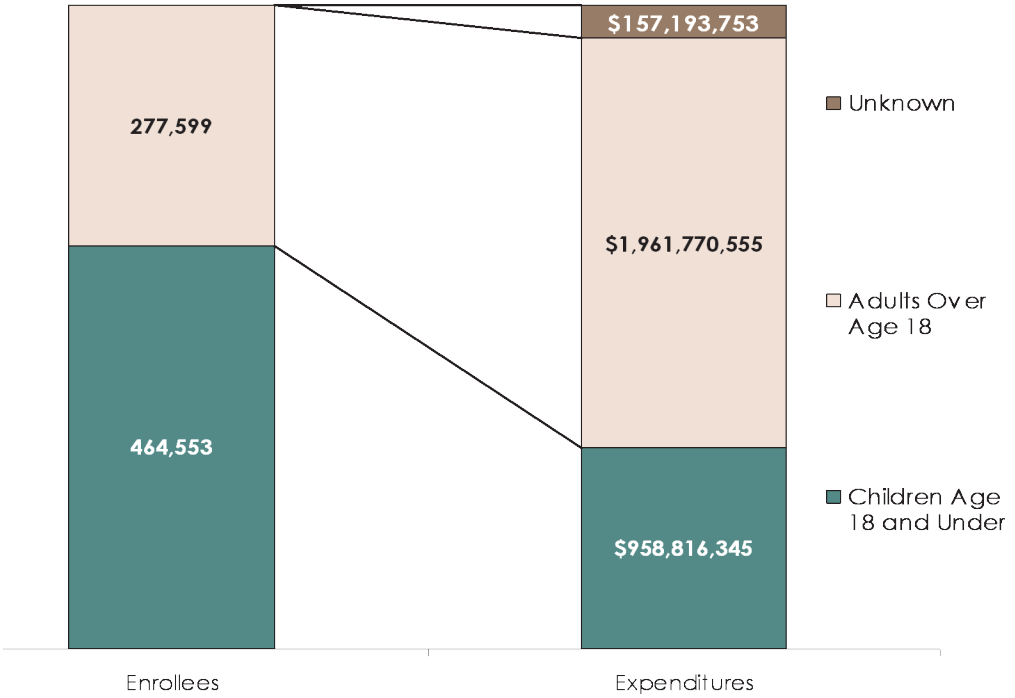
Where are the SoonerCare Dollars Going? (continued)

Figure 9 Oklahoma SoonerCare Enrollees and Expenditures by Aid Category—SFY2006



** OTHER includes—SoonerPlan (family planning), O-EPIC, Child Custody, Refuge, SLMB, DDSD Supported Living and TB members and expenditures. OTHER expenditures also include GME/IME/DSH and UPL hospital payments (were under ABD last year).*

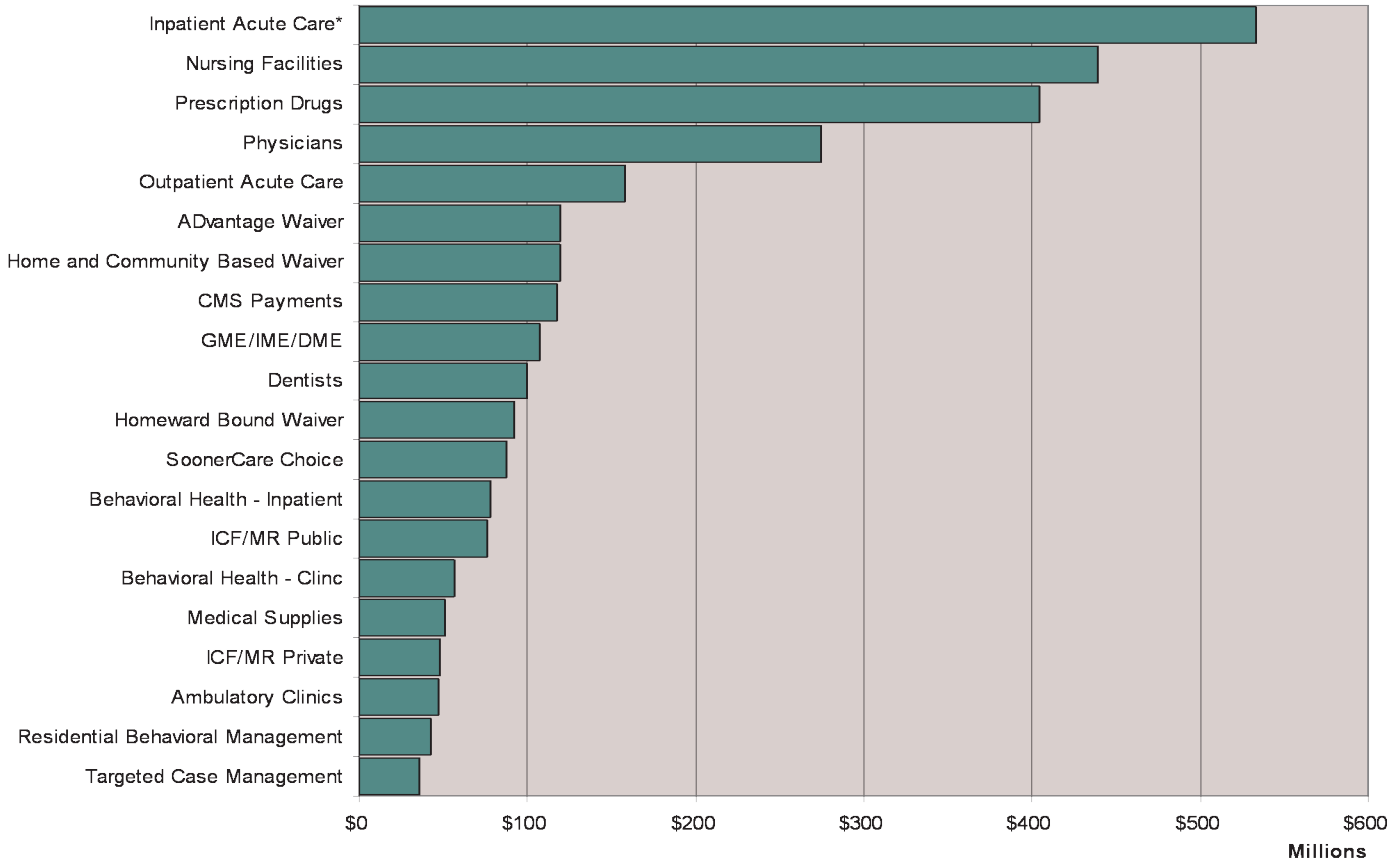
Figure 10 Oklahoma SoonerCare Enrollees and Expenditures by Age–SFY2006



Non-age specific payments include $92,990,352 in Hospital Supplemental payments; $55,717,767 in GME payments to Medical schools; $6,623,270 in Public ICF/MR cost settlements; $1,213,800 in FQHC wrap-around payments; $610,180 for O-EPIC premiums, and $38,420 in non-member specific provider adjustments. $96,692,889 in Medicare Part A & B (Buy-In) payments and $20,493,119 in Medicare Part D (clawback) payments are included in Adults Over Age 18 group. 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.

Where are the SoonerCare Dollars Going? (continued)

Figure 11 Top 20 SoonerCare Expenditures—SFY2006



For detailed expenditure figures go to Appendix B on page 70.

Figure 12 SoonerCare Choice Capitation Payments—SFY2006

Aged, Blind and Disabled (ABD)	Member Months	Capitation Payments
ABD Adults	325,451	$8,602,893
ABD Children	133,750	$3,090,912
IHS ABD Adults	6,432	$19,296
IHS ABD Children	2,675	$8,025
TOTAL	**468,308**	**$11,721,126**

Temporary Assistance to Needy Families (TANF)	Member Months	Capitation Payments
TANF / Poverty Related Adults	395,432	$11,839,856
TANF / Poverty Related Children	3,451,921	$63,333,129
IHS TANF / Poverty Related Adults	6,320	$12,640
IHS TANF / Poverty Related Children	60,309	$128,073
TOTAL	**3,913,982**	**$75,313,699**

Oklahoma's Uninsured

Based on a report from the State Health Access Data Assistance Center (SHADAC), 17.3 percent of Oklahomans were uninsured during the 2004 survey; the national uninsured rate was 15.6 percent. Further broken down, 12.7 percent of children under the age of 18 and 23.1 percent of Oklahomans between the ages of 18 and 63 ha no medical insurance during the 2004 survey period.

Uninsured children are by and large caught in an unforgiving gap. Surprisingly, many are not children of Oklahoma's poorest families. In most cases, their parents earn too much for the children to qualify for traditional SoonerCare, but too little to make the purchase of private insurance possible.

Children without health care coverage have substantially less access to health care services, including preventive care that ensures childhood immunizations are up to date and that vision and hearing screening and routine dental care have been provided. Care for uninsured children is far more likely to be delayed due to cost. Unmet health care needs reduce children's ability to learn and to grow into healthy and productive adults.

For adults, being uninsured even on a temporary basis can have serious implications for state economies. Uninsured workers are less likely to receive adequate and timely health care and, as a result, suffer more serious illnesses that often threaten their work productivity and job retention. Findings published from the Commonwealth Fund Biennial Health Insurance Survey show that:

- More than half (51 percent) of the surveyed uninsured adults reported medical debt or bill problems. Of those, 49 percent used all their savings to pay their bills. Two of five were unable to pay for basic necessities like food, heat, or rent because of medical bills.

- An alarmingly high proportion — 59 percent — of surveyed uninsured adults who had a chronic illness, such as diabetes or asthma, did not fill a prescription or skipped their medications because they could not afford them.

- More than one-third (35 percent) of the surveyed uninsured adults who had a chronic condition went to an emergency room or stayed overnight in the hospital in the past year because of their condition — about two times the rate of people with chronic health problems who were insured all year.

Source: S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, and A. L. Holmgren, Gaps in Health Insurance: An All-American Problem, The Commonwealth Fund, April 2006

Oklahoma's Response to the Working Uninsured

In spite of access problems and other barriers the uninsured Oklahomans face in getting health care, they still do get *some* health care. Studies indicate that, on average, these individuals do not pay for more than half of their health care costs. Obviously, others are stepping in to pick up the tab.

Oklahoma should to be concerned about how health care is financed for the uninsured for two major reasons. One is that the burden is distributed very unevenly throughout the health care delivery system. Some providers serve very few uninsured people, while others face great cost pressures because they serve very large uninsured populations. The second is a concern that health care resources be spent as wisely and efficiently as possible. If people who have access problems could get proper care at a clinic or doctor's office, they would be less likely to go to the emergency room. This would free up emergency rooms to do what they are set up to do and reduce costs.

Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC)

The OHCA submitted a proposal to provide premium assistance to Oklahoma's low-income working uninsured and small businesses to the Centers for Medicare & Medicaid Services under the Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative. On November 1, 2005, the OHCA received approval to help insure Oklahoma. Since implementation, the OHCA has enrolled more than 1,050 employees.

O-EPIC is open to small businesses with 25 or fewer workers, including those that currently offer health insurance coverage. Premium assistance is available for workers and spouses with household incomes at or below 185 percent of the federal poverty level who are not qualified for standard SoonerCare. Participating employers, as well as employees, are required to pay a portion of the premiums. Employees are also responsible for any applicable deductibles and co-payments.

OHCA will expand premium assistance to businesses with up to 50 workers in SFY2007.

OHCA is also working on an O-EPIC Individual Plan that will be offered to people (including self-employed and unemployed) who cannot access private coverage through an employer.

Basic requirements for participation in the O-EPIC program are:

Employers:

- Be located in Oklahoma;
- Have 25 or fewer employees;
- Contribute at least 25 percent of enrolled employees' premium costs; and
- Offer an O-EPIC qualified health plan.

Employees:

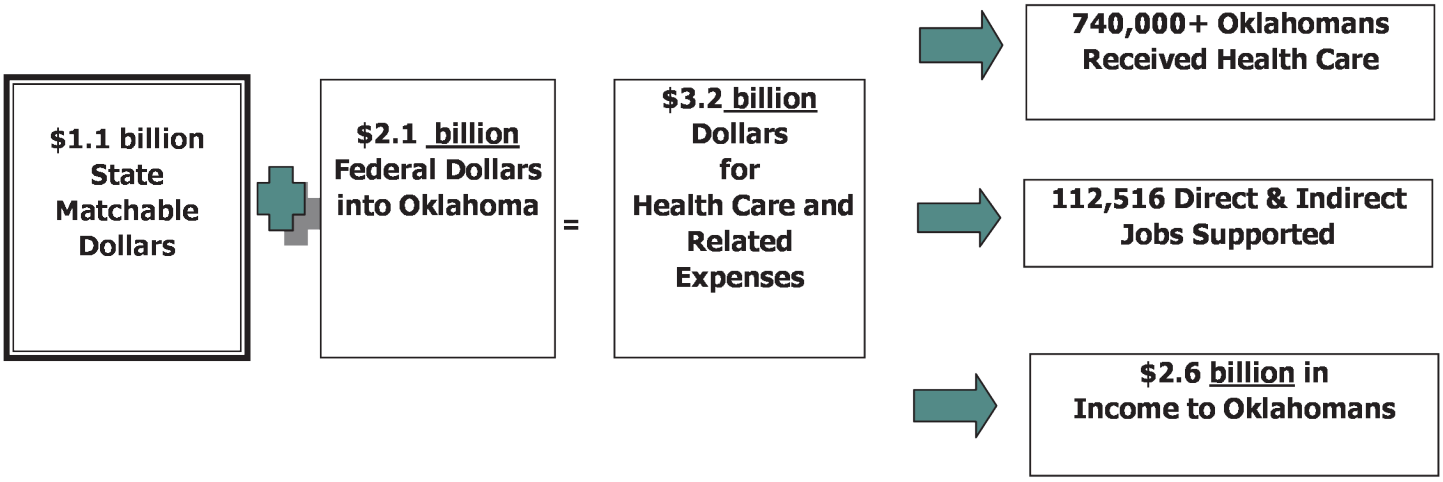
- Oklahoma resident;
- U.S. citizen or legal alien;
- Age 19 to 64;
- Income below 185 percent of federal poverty level;
- Ineligible for SoonerCare or Medicare;
- Contribute up to 15 percent of premium costs; and
- Enroll in an O-EPIC qualified health plan offered by their employer.

For more information on O-EPIC, go to the Web site, www.oepic.ok.gov.

SoonerCare and the Economy

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 underserved Oklahomans. The health care sector affects the economy in much the same way a manufacturing plant does by bringing in money, providing jobs and wages to residents and providing an opportunity to keep health care dollars circulating within the state economy. Health care businesses, in turn, have an additional impact through the purchases 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 the rest of the Oklahoma economy.

Figure 13 Estimated Direct and Indirect Impact of SoonerCare Dollars



State matchable dollars consisted of dollars appropriated to OHCA and other various state agencies, drug rebates, quality of care fees, other fees and refunds.

Estimated Economic Impacts based on Families USA, Medicaid: Good Medicine for State Economies, January 2003; and SFY2000 Input / Output Model developed by the Oklahoma Department of Commerce.

Oklahoma SoonerCare

What Benefits Does SoonerCare Cover?

Oklahoma SoonerCare Benefits

SoonerCare and Native Americans

SoonerCare and Our Providers

What Benefits Does SoonerCare Cover?

Title XIX of the Social Security Act requires that in order for states to receive federal matching funds, certain basic services must be offered to the categorically needy population. States may also receive federal funding if they elect to provide other optional services. Within broad federal guidelines, states determine the amount and duration of services offered under their Medicaid programs. The amount, duration and scope of each service must be sufficient to reasonably achieve its purpose. States may place appropriate limits on a Medicaid service based on such criteria as medical necessity or utilization control. For example, SoonerCare has placed a reasonable limit on the number of covered physician visits or may require prior authorization to be obtained before a service is delivered. Each state spells out what is available under its Medicaid program in a document called the "state plan." The state plan describes the qualifying groups of individuals who can receive Medicaid services and the services available. A state can amend its plan to change its program as needs are identified. State plan amendments are subject to federal review and approval. With certain exceptions, a state's Medicaid plan must allow members freedom of choice among health care providers participating in Medicaid. In general, states are required to provide comparable services to all categorically needy qualifying people.

A general overview of benefits provided under optimum qualifying circumstances is included in Appendix E of this report.

Cost Sharing

States are permitted to require certain members to share some of the costs of Medicaid by imposing enrollment fees, premiums, deductibles, co-insurance, co-payments, or similar cost sharing charges. A co-payment is a charge which must be paid by the member to the service provider when the service is covered by SoonerCare. The OHCA requires a co-payment of some SoonerCare members for certain medical services. A provider participating in SoonerCare may not deny allowable care or services to members based on their inability to pay the co-payment.

Some members are exempt from paying co-pays. Members not required to pay co-pays are children under age 21, members in long-term care facilities, pregnant women and members enrolled under the Home and Community-Based Waivers (except for their prescription drugs). Additionally, some services do not require co-pays, such as family planning and emergency services.

Figure 14 Schedule of Co-Pays (see exemptions above)

$3 Co-pay	**Prescription Co-Pays**	**$1 Co-pay**
Inpatient Hospital Outpatient Hospital Ambulatory Surgical Services	$1 for each prescription under $30 $2 for each prescription $30 and over.	Physicians (not PCP/CM) Certified Registered Nurse Anesthetists Home Health Agencies Rural Health Clinics Federally Qualified Health Centers Optometrists

Oklahoma SoonerCare Benefits

Behavioral Health Services

SoonerCare is the behavioral health treatment lifeline for many Oklahomans with serious mental illness, an emotional disturbance and/or alcohol and other drug disorders. Many people with these conditions either lose or are unable to obtain or afford private coverage. Mental health, alcohol and other drug disorder treatment benefits for those enrolled in Oklahoma SoonerCare include:

- Adult and children's acute psychiatric inpatient care;
- Facility-based crisis stabilization and intervention;
- Emergency care;
- Alcohol or other drug medical detoxification;
- Psychiatric residential treatment (children only);
- Outpatient services (including pharmacological services) such as:
  - Mental health and substance abuse assessments,
  - Mental health and substance abuse treatment planning,
  - Individual psychotherapy,
  - Family psychotherapy,
  - Group psychotherapy,
  - Rehabilitative and life skills redevelopment,
  - Case management,
  - Medication training and support,
  - Pharmacological management,
  - Program for assertive community treatment, and
  - Behavioral health aide.

SFY2006 Specific Information

- Children under age 21 accounted for 73 percent of the members receiving behavioral health services and 66 percent of the expenditures.

Dental Services

Oral health is a key component of an overall healthy and happy lifestyle. The earlier in life that children are put on the "right dental track," the better their chances of keeping their teeth for the rest of their lives.

The greatest challenge is prevention—teaching parents to focus early on dental intervention and treatment is crucial. Currently, adults age 21 and over are covered for emergency extractions only. Dental services are federally mandated for children under 21 years of age through Child Health Screens (Early and Periodic Screening, Diagnosis and Treatment - EPSDT). This program covers all areas of dentistry for children, including orthodontia, based on medical necessity. Dental care includes emergency and preventive services and therapeutic services for dental disease which, if left untreated, may become acute dental problems or may cause irreversible damage to the teeth or supporting structures.

SFY2006 Specific Information

- 178,274 children received dental services and accounted for 95 percent of the dental expenditures.
- Oklahoma SoonerCare contracted with 602 dental providers in SFY2006.

Oklahoma SoonerCare Benefits (continued)

Child Health Screens (Early and Periodic Screening, Diagnosis and Treatment - EPSDT)

Children are the largest number of enrollees in the SoonerCare program with nearly 490,000 in SFY2006. That means 49 percent of Oklahoma's children under age 21 (989,779 according to 2005 US Census estimates) have been enrolled in SoonerCare at some point during the year. All children need basic preventive and early intervention health care in order to make sure we optimize their capacity to grow, learn and develop.

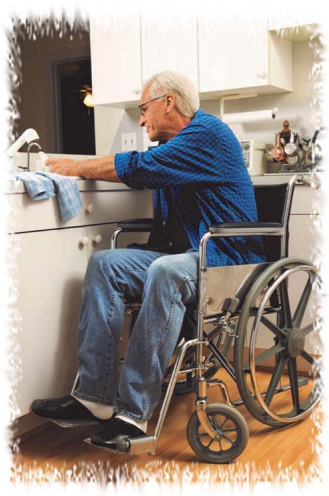
Early and Periodic Screening, Diagnosis and Treatment - EPSDT (called Child Health Screens in Oklahoma) is a federally mandated set of comprehensive health services for children up to age 21. Child Health Screens are designed to ensure all SoonerCare children receive regular health screenings in order to check for early signs of disorders or disease and obtain necessary follow up treatments or services. Child Health Screens provide immunizations and educate parents on safety, nutrition, and child development.

Child Health Screens (EPSDT) include:

- physicals;
- eye and hearing exams;
- dental exams;
- immunizations;
- nutritional review;
- lab tests;
- anticipatory guidance;
- referral for follow-up treatment if necessary; and
- coverage for referred services.

Oklahoma SoonerCare Benefits (continued)

Home and Community-Based Waiver (HCBW) Services



The Home and Community-Based Waivers give Oklahoma the flexibility to offer SoonerCare-qualified individuals alternatives to being placed in long-term care facilities. Services through these waiver programs are available for qualified members that can be served safely in a community-based setting, when the cost of providing waiver services is less than the cost of providing services in the comparable institutional setting and when there are waiver slots available. Individual waiver documents specify member eligibility criteria, any post-eligibility criteria, as applicable, as well as the waiver-specific services available.

Depending on each person's needs as identified in their individual Plan of Care or Individual Habilitation Plan and the specific waiver they are qualified under, benefits could include:

- case management;
- skilled nursing;
- prescription drugs;
- advanced/supportive restorative care;
- adult day care/day health services;
- specialized equipment and supplies;
- home-delivered meals;
- comprehensive home health care;
- personal care;
- respite care;
- habilitation services;
- adaptive equipment;
- architectural (environmental) modifications;
- pre-vocational and vocational services;
- supported employment;
- dental;
- transportation; and
- various therapies.

SFY2006 Specific Information

Waiver Expenditure Totals:

- ADvantage — $133,794,196
- Community — $120,212,909
- Homeward Bound — $93,375,933
- In-Home Supports — $17,251,261

For more waiver expenditure details go to Appendix B on page 88.

Hospital Services

Hospitals are part of the health care environment of the communities they serve, without them, many people would go without essential medical services and programs. Hospitals provide inpatient acute care, newborn delivery services, life-saving emergency services as well as outpatient services such as minor surgeries and dialysis. Local hospitals serve as the cornerstone for a network of care providers that include such economic staples as primary care physicians, specialists, and many allied health services.

SFY2006 Specific Information

- Hospital expenditures accounted for 22 percent of the total SoonerCare expenditures.

Oklahoma SoonerCare Benefits (continued)

Long-Term Care Services

With long-term care coverage largely unavailable through Medicare or traditional private health insurance plans, Medicaid is the nation's de facto financing system. In Oklahoma, SoonerCare funds approximately 73 percent of all of all long-term care (both nursing facilities and intermediate care facilities for the mentally retarded). SoonerCare provides coverage for low-income persons and many middle-income individuals who have become nearly impoverished by "spending down" their assets to cover the high costs of their long-term care.

Quality of Care The Quality of Care program is intended to improve the quality of care received by long-term care residents. A fee per patient day is collected from long-term care facilities and placed in a revolving fund. Monies from this fund are used to pay for expanded SoonerCare benefits that include non-emergency transportation (*SoonerRide*) and attendants; eyeglasses and dentures; and personal needs allowance increases for long-term care SoonerCare members. The fund also provides for coverage of expanded durable medical equipment and supplies services for adults and SoonerCare services for qualified Medicare members. Additionally, funds are used by other state agencies, such as the Oklahoma State Department of Health, to maintain staff dedicated to investigations and on-site surveys of long-term care facilities as well as the Oklahoma Department of Human Services for 10 regional ombudsmen.

Statewide, Oklahoma nursing facilities have a 69 percent occupancy rate.

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

Level of Care Evaluations–Long-Term Care Members In order to ensure that those individuals applying for nursing home care are appropriately placed, the federal Pre-Admission Screening and Resident Review (PASRR) Program provides a Level I screening for possible developmental disability or mental retardation (MR) and/or mental illness (MI) to all people, private pay and SoonerCare, entering a long-term care facility. Furthermore, federal regulations also include a higher level evaluation (Level II) be performed for those applicants who appear to be either mentally ill or developmentally disabled. The Level II assessment ensures that the member requires a long-term care facility and receives proper treatment for their MI and/or MR diagnosis.

SFY2006 Specific Information

- SoonerCare funded 5,269,707 nursing facility bed days for SFY2006; this represents 70 percent of the total actual nursing facility occupied bed days in the state.
- Total Quality of Care Program revenues were $54,277,601 and the state share of the total $178,681,981 Quality of Care expenditures was $56,645,262.

Facility Type	Unduplicated Members	Bed Days	Reimbursement	Yearly Average Per Person*	Average Per Day
Nursing Facilities	22,239	5,269,707	$438,553,027	$19,720	$83.22
ICFs/MR (Private)	1,414	471,937	$47,896,364	$33,873	$101.49
ICFs/MR (Public)	427	146,263	$76,074,247	$178,160	$520.12

*ICFs/MR = Intermediate Care Facilities for the Mentally Retarded. *Average Per Person figures do not include the patient liability that the member pays to the facility (average $20/day). ICFs/MR public facilities per day rate includes ancillary services not included in ICFs/MR private facility rate.*

Oklahoma SoonerCare Benefits (continued)

Medicare "Buy-In" Program

Medicare is made up of two parts, hospital insurance (Part A) and supplementary medical insurance (Part B). For hospital insurance expenses, SoonerCare Supplemental pays the co-insurance and deductible fees for hospital services and skilled nursing services for Medicare and Medicaid (dual eligibles) qualified persons. The deductible and co-insurance fees are also paid for supplementary medical insurance expenses that are primarily physician services.

There are several "buy-in" programs available to assist low-income members with potentially high out-of-pocket health care costs:

Qualified Medicare Beneficiaries (QMB)

- For Medicare beneficiaries with incomes below 100 percent of the federal poverty level who have limited financial resources.
- Pays for Medicare beneficiaries' share of Medicare Part A.

Specified Low-income Medicare Beneficiary (SLMB)

- For Medicare beneficiaries whose incomes are at least 100 percent but less than 120 percent of the federal poverty level who have limited financial resources.
- Pays for beneficiaries' share of Medicare Part B premiums.

Qualifying Individuals (QI)

- For Medicare beneficiaries whose incomes are at least 120 percent but less than 135 percent of the federal poverty level who have limited financial resources.
- Pays the Medicare Part B premiums for Medicare beneficiaries who are not otherwise qualified for SoonerCare.

SFY2006 Specific Information

- "Buy-In" expenditures totaled $96,692,889.
- An average of 2,934 Part A premiums and 77,051 Part B premiums were paid each month.
- Medicare Part D now covers prescription drugs for these members. Go to page 38 for more prescription information.

Oklahoma SoonerCare Benefits (continued)

Pharmacy Services

The pharmacy benefit is accessed by more than 60 percent of SoonerCare's members, making it one of the most commonly used benefits in SoonerCare. The value of prescription medications in modern health care is well documented. Because of its value, prescription medications are covered by every state's Medicaid program in spite of the fact that it is an optional benefit under federal law. It is almost impossible to imagine a health care benefit system in which medication therapies did not play a significant role.

SoonerCare Choice members qualify for prescription drug products that have been approved by the Food and Drug Administration (FDA) and are included in the Federal Drug Rebate program. In general, children up to the age of 21 years may receive prescriptions without monthly limitations and are not subject to a co-pay. Adults are limited to six prescriptions per month. Up to three of those can be for brand name products, and the remainder must be generic products. Adults are subject to a co-pay of $1 or $2 per prescription based on the cost of the drug. There are restrictions such as medical necessity, step therapy, prior authorization and quantity limits that may be applied to covered drugs.

SoonerCare Traditional members have the same pharmacy coverage as SoonerCare Choice for non-Medicare eligible members.

SoonerCare Supplemental dual (Medicare and Medicaid) eligible members receive their primary prescription coverage through Medicare Part D. A few of the drugs not covered by Part D can be covered by this benefit for members also enrolled under SoonerCare Traditional.

Opportunities for Living Life members residing in nursing facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) receive prescriptions as shown for SoonerCare Choice, but do not have a limitation on the number of prescriptions covered each month. A few drugs not covered by Part D for dual eligibles are covered by this benefit plan.

Home and Community-Based Services enrollees receive a pharmacy benefit which is equal to the SoonerCare Choice, plus members who are not Medicare eligible also receive up to an additional seven generic prescriptions per month. For members who are enrolled in Medicare, their primary prescription coverage is through the Medicare Part D plan with limited additional coverage.

SoonerPlan provides prescription coverage for family planning products only.

The federal Medicare prescription plan (Part D) now pays for a majority of Medicare beneficiary's prescriptions. The federal government requires states to pay back an estimated prescription cost savings amount. This amount is referred to as a "clawback".

SFY2006 Specific Information

- The average cost per prescription funded by SoonerCare was $66.54 and the average monthly prescription cost per patient funded by SoonerCare was $191.55.
- $128.76 million dollars were collected through the Drug Rebate programs and $66 million with the State Maximum Allowable Cost (SMAC) program. For more pharmacy related cost savings information see page 39.
- OHCA paid $20,493,119 in Medicare Part D "clawback" payments.

Oklahoma SoonerCare Benefits (continued)

Physicians and Other Practitioners

Physicians and other practitioners are a crucial component in the delivery of health care to Oklahoma's SoonerCare members. The SoonerCare program would not be possible without the dedication of providers who are committed to care for all individuals who are insured with SoonerCare. Oklahoma Primary Care Physicians (PCPs) act as SoonerCare's "front line." Physician services may be limited for adults based upon the benefit package they are receiving. Physicians provide patients education and coordinate their health care needs. Physician and other primary practitioners' benefits have also been expanded to include providing evidence-based smoking cessation counseling in an outpatient office setting.

Crucial services provided by physicians and other practitioners may include, but are not limited to:

- Child Health screens;
- Preventive care;
- Family planning;
- Routine check ups;
- Prenatal care;
- Delivery;
- Postpartum care; and
- Diagnostic services.

SFY2006 Specific Information

- In addition to various other provider types, OHCA contracts with more than 2,450 general/family practitioners and just over 1,675 general pediatricians.

School-Based Services

Health care is a vital foundation for families wanting to ensure their children are ready to learn at school. Studies show children without health insurance are absent more frequently than their classmates. They suffer more from asthma, ear infections and vision problems and are more medically at risk. Treatment of these conditions can improve classroom attendance and participation.

Schools may receive reimbursement for SoonerCare enrolled children who have chronic conditions such as asthma and diabetes and for those who are qualified to receive health related services under the Individuals with Disabilities Education Act (IDEA). The Individual Education Program (IEP) is a treatment plan for a successful education for students with disabilities. The schools outline the treatment plan, and OHCA funds any SoonerCare compensable health related services recommended in the plan for SoonerCare enrolled children.

The OHCA is also involved in the Early Intervention (EI/SoonerStart) program. The EI/SoonerStart program is focused on the early medical intervention and treatment of children age birth to 3 years that are developmentally delayed. Services for the EI program such as targeted case management, speech and physical therapy are provided by the State Department of Education and the Oklahoma State Department of Health. The OHCA offers provider training and reimbursement for this program as well.

SFY2006 Specific Information

- OHCA contracted with 236 school-based providers in 62 counties.
- School-based providers were reimbursed $5,695,341 for SFY2006.

Oklahoma SoonerCare Benefits (continued)

SoonerPlan—Family Planning Services

SoonerPlan is a limited benefit plan covering services related to family planning. In an effort to reduce unwanted pregnancies, SoonerPlan provides family planning services and contraceptive products to women and men over age 18 that do not traditionally qualify for full benefits under SoonerCare.

SoonerPlan benefits may be obtained from any SoonerCare provider who offers family planning including:

- Birth control information and supplies;
- Laboratory tests related to family planning services, including pap smears and screening for sexually transmitted infections;
- Office visits and physical exams related to family planning;
- Pregnancy tests for women;
- Tubal ligations for women age 21 and older;
- Vasectomies for men age 21 and older.

Family planning services are also available to other qualifying members under SoonerCare Choice and SoonerCare Traditional.

SoonerRide (Non-Emergency Transportation) Services

Non-emergency transportation has been part of the Medicaid program since 1969 when federal regulations mandated that states ensure the service for all Medicaid members. The purpose was clear; without transportation, many of the very people SoonerCare was designed to help would not be able to receive medically necessary services.

States are given a considerable amount of flexibility in this area of Medicaid regulations, including setting reimbursement rates and transportation modes. To provide budget predictability and increased accountability of the non-emergency transportation program, OHCA uses a transportation brokerage system to provide the most cost effective and appropriate form of transportation to members. Similar to a managed care health care delivery system, the contracted transportation broker is reimbursed on a per-member-per-month (PM/PM) basis.

If a SoonerCare member does not have transportation to a medically necessary, non-emergency service, SoonerRide can provide transportation.

SFY2006 Specific Information

- An average 8,881 members per month used the SoonerRide services for a total of more than 576,600 transports.
- The non-emergency transportation program costs were $17,054,758.

SoonerCare and Native Americans

Oklahoma is home to 39 tribal governments and, according to the 2005 Census estimates, more than 413,000 Native Americans live here. During SFY2006, there were more than 92,350 Native Americans enrolled in SoonerCare.

In addition to the providers who participate in SoonerCare, Native Americans may receive culturally sensitive health care services from three types of health care systems: Indian Health Services, Tribal health facilities, or Urban Clinics (I/T/U). There are more than 40 I/T/U facilities in Oklahoma, most of which are contracted SoonerCare providers. SoonerCare services provided in any of the contracted Native American health care facilities receive a 100 percent federal medical assistance percentage (FMAP).

SoonerCare Choice and Native Americans

Native American SoonerCare Choice members can select a SoonerCare provider or self-refer to any I/T/U facility. Most providers in I/T/U facilities are SoonerCare Choice providers and may serve as primary care providers (PCPs). As PCPs, I/T/U providers can provide culturally sensitive case management to Native American SoonerCare Choice members, make referrals and coordinate additional services such as specialty care and hospitalization when patients access care at facilities not operated by tribes or the IHS.

Native Americans and Oklahoma Cares Services

In order to become enrolled for SoonerCare benefits under Oklahoma Cares, the Breast and Cervical Cancer treatment program, women must be screened under the Breast and Cervical Cancer Early Detection Program (BCCEDP) and found to be in need of treatment for either breast or cervical cancer. Native Americans have higher qualifying income guidelines of up to 250 percent of the Federal Poverty Level (FPL) for Oklahoma Cares. SoonerCare is working in partnership with the Oklahoma State Department of Health, the Cherokee Nation and the Kaw Nation to provide Breast and Cervical Cancer Early Detection Program screening locations.

SFY2006 Specific Information

- SoonerCare covers more than 54,000 Native American children under the age of 21.
- During SFY2006, OHCA had more than 3,100 pregnant Native American women enrolled.

SoonerCare and Our Providers

One of OHCA's primary goals is to purchase the best value health care for members by paying appropriate rates and exploring all available valid options for program financing to ensure access to medical services by our members. We believe achieving this goal will help members obtain improved access to health care, will contribute to a reduction in the amount of uncompensated care incurred by providers and will help to avoid cost shifting by providers.

What Is Cost Shifting? Cost shifting occurs when health care providers raise their prices and thereby shift the burden of cost to private payers in an effort to make up for losses from patients who do not or cannot pay for their health care services in full. Cost shifting places undue pressure on the health care industry, causing the costs for both services and health insurance to rise at rates greater than normal inflation. Various studies have found that people often lose their health insurance coverage when providers' prices rise and public payer payments do not follow suit.

Many public policy issues came together during 2005 that allowed the OHCA to address one of it long standing goals related to physician and hospital reimbursements and rates during fiscal year 2006.

Physicians

In Oklahoma, a prearranged fee (capitation payment) based on the number of members in the provider's panel is paid to the SoonerCare Choice primary care provider/case manager (PCP/CM) monthly. The capitation payment is for primary and preventive care. Other services not included in the capitation payment are paid under the fee-for-service program, SoonerCare Traditional. Payments are made directly to the providers once an allowable service has been provided and billed. Providers participating in SoonerCare must accept the Medicaid reimbursement level as payment in full.

Since 2002, OHCA has requested funding to increase physician rates so that those rates can be equal to 100 percent of Medicare rates—which are considered national benchmark rates. During the 2005 legislative session, as the budget request was being discussed, OHCA was ordered by the United States District Court for the Northern District of Oklahoma to increase reimbursement rates for certain physicians.

The Oklahoma Legislature, in consultation with the agency and our budget request as well as supported by the court order, appropriated an additional $18 million of state funds to increase provider reimbursements for SoonerCare services and restore Medicare co-insurance and deductible payments to 100 percent of Medicare rates for state fiscal year 2006.

The increase in appropriated funds allowed the agency to match $39.2 million in new federal funds, which resulted in an additional $57.2 million in funds available for physician rate increases.

The subsequent appropriation allowed the agency to increase rates to an estimated 8,700 providers. All relative value unit (RVU) based procedure codes as well as the actuarial value of primary care and case management capitation rates were increased to 100 percent of Medicare rates effective August 1, 2005.

SoonerCare and Our Providers (continued)

Hospitals

By the end of SFY2005 SoonerCare hospital payments covered only 80 percent of cost (excluding DSH, see page 42). Nationally, average Medicaid payments covered 96 percent of hospital costs. Specifically, SoonerCare outpatient payments for services were substantially below costs, and in some cases only 46 percent of costs! The low outpatient cost coverage created a lack of incentive for treating patients in the most cost-efficient setting. The payment gap created additional financial pressures on hospitals during a time when the current trend has been to move more patients to the outpatient setting.

The OHCA teamed up with the Oklahoma Hospital Association and a private consulting firm to create a joint solution to a complicated problem. By the end of the 2005 legislative session OHCA received an additional $50.3 million in state appropriations (#190 million total dollars) to address hospital reimbursements.

Using the state appropriation OHCA not only converted its hospital reimbursement system to a Medicare reimbursement model based on Diagnostic Related Groups (DRG), but also increased per day payments to freestanding rehabilitation and behavioral health facilities, as well as long-term care sub-acute children's facilities. In addition, hospital crossover payments for dually qualified Medicaid and Medicare members were also restored to 100 percent of Medicare reimbursement rates. The combination of changes allowed the agency to redirect funds and increase reimbursements as illustrated by the following chart.

Types of Hospital Payments	Prior Annual Payments	New Projected Annual Payments**	Increase/ Decrease	% Change
Inpatient—Acute	$296,223,467	$416,235,745	$120,012,278	40.51%
Direct Medical Education (DME)	$54,928,184	$16,268,418	$38,659,766	-70.38%
NSGO Retained CPE/IGT *	$10,891,712	$36,449,530	$25,557,818	234.65%
Indirect Medical Education (IME)	$24,136,084	$25,053,255	$917,171	3.80%
Inpatient Rehabilitation	$5,981,821	$6,580,003	$598,182	10.00%
Inpatient Behavior Health—Freestanding	$9,875,247	$10,862,772	$987,525	10.00%
Inpatient—LTAC Children's	$11,176,196	$11,623,244	$447,048	4.00%
Medicare Crossovers	$29,915,718	$47,180,402	$17,264,684	57.71%
Outpatient	$64,178,573	$127,034,317	$62,855,744	97.94%
Total Payments	**$507,307,002**	**$697,287,686**	**$189,980,684**	**37.45%**

**Certified public expenditures (CPE) and intergovernmental transfers (IGT) made by non-state government owned (NSGO) hospitals for their share of the state match. A portion of the increased appropriation was provided to these hospitals to relieve them of their state match requirements.*

***Based on timing of payments, projected payments may not equal actual payments made in SFY2006.*

SoonerCare and Our Providers (continued)

Hospitals (continued)

Disproportionate Share Hospital (DSH) Payments

Hospitals provide health care to the poor and uninsured in the form of uncompensated care, defined as the sum of charity care and bad debt charges. Uncompensated care has always been unevenly distributed. Urban safety net hospitals have had to assume a larger burden of care for the under- and un-insured.

The Medicaid Disproportionate Share Hospital (DSH) payment adjustment was born in a clause in the Omnibus Budget Reconciliation Act of 1981 (OBRA '81) that required Oklahoma SoonerCare to make allowances when determining reimbursement rates for hospitals that served a disproportionate number of SoonerCare members or low-income patients.

The federal disproportionate share payments are made to each state annually. The eligible hospitals are identified and the total funds are allocated on a "weighted" basis. The weighting is based on each hospital's share of Medicaid plus charity care revenues.

According to federal law, Oklahoma is deemed to be a Low Disproportionate Share Hospital (DSH) program state. As such, the state is receiving 16 percent annual increases in DSH funds each year through 2008. Including the increase for 2006, the agency will distribute over $37 million of DSH funds to Oklahoma hospitals to help offset a portion of their uncompensated care.

Additionally, as a Low Disproportionate Share Hospital (DSH) program state, OHCA embarked on the creation of a new DSH formula to allow the state to distribute DSH funds to more Oklahoma hospitals. Through the new formula OHCA added 64 hospitals to the DSH program, providing each hospital with a reimbursement amount based upon the hospital's cost of uncompensated care within its own peer group of hospitals as determined by licensed beds. During 2006, these 64 hospitals will receive $5.9 million in DSH funds. For detailed DSH payments go to Appendix F.

Indirect Medical Education (IME)

Acute care hospitals that qualify as major teaching hospitals receive an indirect medical education (IME) payment adjustment that covers the increased operating or patient care costs associated with approved intern or resident programs. Currently, the only qualifying hospitals are the OU Medical Center in Oklahoma City and the Hillcrest Health System hospitals in Tulsa.

In order to qualify as a teaching hospital and be deemed eligible for IME supplemental incentive payment adjustments, the hospital must:

- be licensed in the state of Oklahoma;
- have 150 or more full-time equivalent residents enrolled in approved teaching programs using the 1996 annual cost report; and
- belong to the Council of Teaching Hospitals or show proof of affiliation with an approved medical education program.

SFY2006 Specific Information

Payments made to IME qualified hospitals:

Oklahoma Medical Center–OKC	$12,538,696
Hillcrest Health Systems–Tulsa	$12,538,696

SoonerCare and Our Providers (continued)

Hospitals (continued)

Direct Medical Education (DME)

In-state hospitals that qualify as teaching hospitals receive a supplemental payment adjustment for direct medical education (DME) expenses based on resident-months.

In order to qualify as a teaching hospital and be deemed eligible for DME supplemental incentive payment adjustments, the hospital must:

- be licensed in Oklahoma;
- have a medical residency program;
- apply for certification by the OHCA prior to receiving payments for any quarter;
- have a contract with OHCA to provide SoonerCare services; and
- belong to the Council of Teaching Hospitals or show proof of affiliation with an approved medical education program.

These payments are made by allocating a pool of funds by the share of residents per month to total residents per month in all qualifying hospitals. The state matching funds are transferred to OHCA from the University Hospital Authority.

DME Qualified Hospitals	SFY2006
Baptist Medical Center	$2,143,223
Bone and Joint Hospital—OKC	$3,188
Comanche County Memorial Hospital	$27,685
Deaconess Hospital	$50,185
Hillcrest Medical Center—Tulsa	$2,932,759
Jane Phillips Hospital	$7,558
Laureate Psych Hospital	$3,273
Medical Center of Southeastern Oklahoma	$48,718
Saint Francis—Tulsa	$1,632,781
Shadow Mountain/Brown Schools Hospital	$8,340
Southwest Medical Center	$189,386
St. Anthony	$1,442,535
St. John—Tulsa	$997,481
Tulsa Regional Medical	$2,499,839
University Health Partners	$14,069,610
TOTAL	**$26,056,561**

Graduate Medical Education (GME)

Graduate medical education refers to the residency training that doctors receive after completing medical school. Most residency programs are set up in teaching hospitals across the United States. GME derives funding from a variety of sources. Funding sources include patient care dollars and university funding, but the bulk of the money for GME comes from public, tax-supported sources, such as Medicare, Medicaid, the Department of Defense and Veterans' Affairs.

Payments are made to the major colleges of medicine based on the number of SoonerCare Choice members where Primary Care Physicians (PCP) are qualified participants. The state matching funds are transferred to OHCA from the University Hospital Authority.

SFY2006 Specific Information

Payments made to GME qualified colleges of medicine:

University of Oklahoma–OKC	$41,192,177
Oklahoma State University College of Osteopathic Medicine–Tulsa	$14,525,590

SoonerCare and Our Providers (continued)

Pharmacies

In an effort to improve services to our pharmacy providers, the OHCA has streamlined the Pharmacy Help Desk with Computer Telephony Integration (CTI). The CTI application allows Help Desk agents to receive an inbound phone call with caller specific information appearing at the same time the voice connection is made. If necessary the information screen transfers with a call, cutting down on repetitive questions. During SFY 2006, the Pharmacy Help Desk handled 141,666 combined calls from both providers and members.

SoonerPSYCH (Prescription Solutions for Your Cognitive Health) is a partnership between OHCA, the Department of Mental Health and Substance Abuse and drug manufacturer Eli Lilly. The program is working toward educating physicians about drugs used to treat behavioral health issues and providing information about their patients' total prescription utilization. SoonerPSYCH is contracted to Comprehensive NeuroScience Inc. and funded entirely by Eli Lilly.

Since 2004, OHCA has contracted with EPOCRATES®, Inc. to provide pharmacy benefit information to prescribers and pharmacists using their desktop or personal digital assistant (PDA). The service allows users to verify drug coverage status, preferred alternatives, drug interactions, prior authorization requirements, quantity limits and other drug-specific messages programmed by OHCA. This results in reduced medication errors and quicker transactions.

Other SoonerCare Providers

In general, OHCA continues to strive to increase provider participation by streamlining processes and keeping our contracted providers as informed as possible. Payment rates are constantly being evaluated within the constraints of available state and federal funds. Ongoing provider outreach and training is being performed on a daily basis. OHCA also provides a secure Web site as a "one stop shop" for providers to submit claims, check member enrollment and qualification for services, and receive specific information related to their provider type. Additionally, OHCA's Web site has changed recently to present provider information by "provider type." Pertinent information such as manuals, forms, policy cites and program information can be found by each provider in their applicable areas.

Oklahoma specifies a target EPSDT screen compliance rate each year. The calendar year 2005 target was 65 percent. Providers who exceeded the target within their own patient panel were eligible for a bonus up to 20 percent of their annual capitation revenue. Out of 842 providers evaluated, 212 received a bonus for a total payout of $680,184.

Understanding OHCA

OHCA and SoonerCare

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Core Function Summary

OHCA and SoonerCare

From 1988 to 1992, the number of Oklahomans receiving Medicaid assistance increased by 47 percent, from 245,000 to 360,000. This escalating growth came with an associated cost increase from $580 million to slightly more than $1 billion.

As a result of recommendations from broad-based citizens committees, the Oklahoma Health Care Authority was established by the Legislature in 1993 through House Bill 1573. The Health Care Authority Act can be found in Oklahoma Statutes Title 63, Sec. 5004.

As we complete our 11th year managing the now $3.1 billion SoonerCare program, it is a long way from 1993 when the task force projected SoonerCare would, if left unchecked, approach $4 billion by the year 2000. One-third of the $3.1 billion pays for nursing home quality initiatives, medical education and medical-related programs administered by other state agencies.

The Oklahoma Health Care Authority has also led the effort to supplement state dollars with available and appropriate federal dollars. OHCA's revenue maximization initiatives have supported programs at the Oklahoma Department of Human Services, Department of Mental Health and Substance Abuse Services, Oklahoma State Department of Health, Office of Juvenile Affairs, and the Department of Education, as well as Oklahoma University and Oklahoma State University medical schools and teaching hospitals.

OHCA does not want to miss an opportunity to maximize federal revenues; however, we must be vigilant. OHCA has an obligation, as a sound fiscal manager, to ensure that all plans to maximize federal revenues are compliant with applicable laws and regulations and will not put the state in jeopardy of a future disallowance.

OHCA staff perform an array of critical functions necessary for program administration, such as developing SoonerCare payment policies; managing programs to fight waste, fraud and abuse; maintaining the operating systems that support SoonerCare payments; developing cost-effective health care purchasing approaches; monitoring contractor and provider performance; promoting and preserving member rights and protections; and disseminating information to the Oklahoma Legislature, congressional delegation, members and the general public.

A board of directors meets monthly to direct and oversee the operations of OHCA. Board members are appointed by the governor, president pro tempore of the Senate and the speaker of the House. OHCA also has a Drug Utilization Review (DUR) board, a Medical Advisory Committee (MAC) and a joint legislative oversight committee. These groups of health professionals, providers, advocates and elected officials all serve to ensure that decisions are made to best serve the members' needs while maintaining the fiscal integrity of the agency.

Operating Principles

The Oklahoma Health Care Authority has a set of goals and objectives that map what we strive to achieve as an agency. Our operating principles state how we will work together to get there. These principles affirm that OHCA is committed to a culture that will support its mission.

Our Member Focus

- We will act based on the knowledge that members are our primary customers and that OHCA's "reason for being" is to understand and respond to members' needs for health care, program-related information and prompt, courteous service.
- We will use our market presence to actively seek high value health care for members and encourage other purchasers of care to do the same.
- We will work toward the highest standards of service to members, their families and the public, providing clear information, prompt and accurate processing of claims, appeals and correspondence.
- We will act, with appropriate partners, to help assure that members receive equitable and nondiscriminatory services.

How We Work with Others in the Health Care System

- We will strive to be an even-handed and reliable business partner with providers, states, contractors and other stakeholders in our programs.
- We will work collaboratively with our colleagues throughout the Oklahoma and federal governments and territories, tribes, accrediting bodies, member and provider advocacy groups and elsewhere to achieve mutual goals.
- We will demonstrate leadership in the public interest, consistent with our position as one of the largest public purchasers of health care in Oklahoma, including the effective use of our administrative and clinical data resources to improve health outcomes and services to the public.
- We will build on our record of successful implementation of legislated program changes to become more flexible and responsive to other changes in the health care environment.

We Want to be Recognized by Our Customers, Partners and the Public

- as the champion of OHCA program members;
- as an effective and efficient administrator of programs and a good steward of the funds entrusted to us by the taxpayers;
- as a leader in the health care system, working toward access to high quality, high value health care for all.

How We Operate Within OHCA

- OHCA staff will operate as members of the same team, with a common mission and each with a unique contribution to make to our success.
- We will be open to new ways of working together, including creating project teams within and across agency divisions and units.
- We will be consistent in our use of qualitative and quantitative data to guide and evaluate our actions and improve our performance in a purposeful way over time.

Administering the SoonerCare Program

Administering a Medicaid program is as challenging a task as there is to be found in public service. What distinguishes the program in degree of difficulty from Medicare and private insurers, however, is its varied and vulnerable member groups; its means-tested qualifying rules; the scope of its benefits package (spanning more than 30 different categories of acute and long-term care services); its interactions with other payers; its financial, regulatory and political transactions with a wide range of provider groups; and its joint federal and state financing.

According to the Kaiser Family Foundation, there are 63 separate federal statutory requirements that state Medicaid plans must meet. About a third (19) of these relate directly to administration.

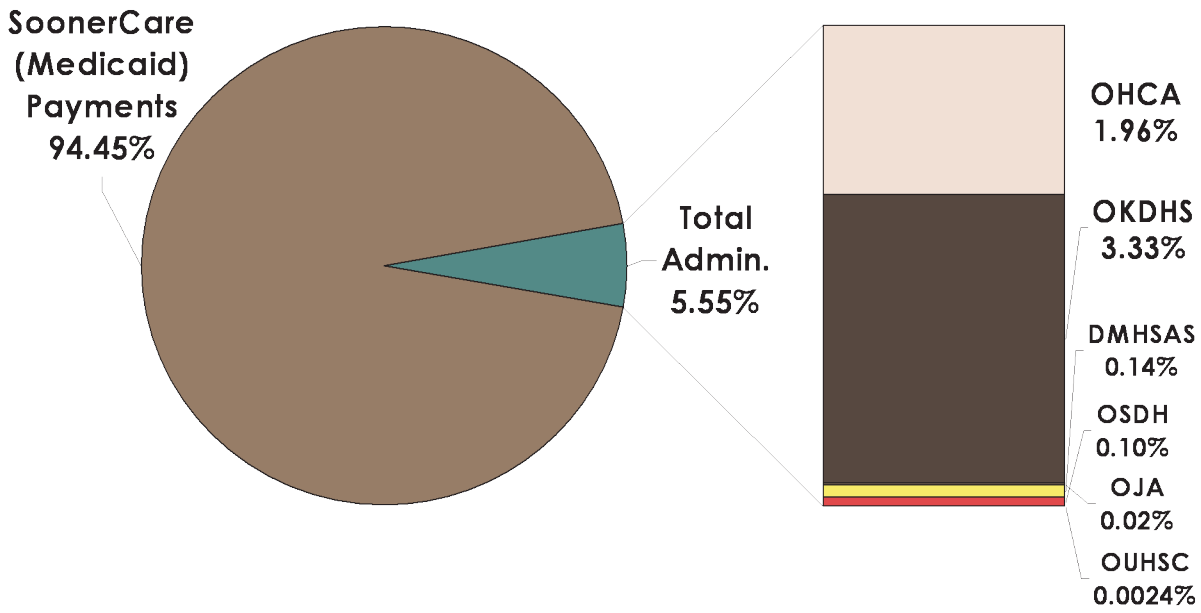
From an administrative perspective, SoonerCare can be viewed as a complex health insurance program: It purchases a broad range of acute and long-term care services on behalf of enrolled low-income individuals. Like private insurers, OHCA has to accomplish nine critical tasks. It must:

- inform individuals who are potentially eligible and enroll those who are qualified;
- determine what benefits it will cover in what settings;
- determine how much it will pay for the benefits it covers and from whom it will buy those services;
- establish standards for the providers from which it will purchase covered benefits and enroll (or contract with) those which meet the standards;
- process and pay claims from fee-for-service providers and make capitation payments to primary care providers;
- monitor the quality of the services it purchases to ensure that members are protected from, and that tax payers are not subsidizing, substandard care;
- ensure that state and federal health care funds are not spent improperly or diverted by fraudulent activities;
- have a process in place for resolving grievances by applicants, members and providers; and
- collect and report information necessary for effective administration and program accountability.

Administering the SoonerCare Program (continued)

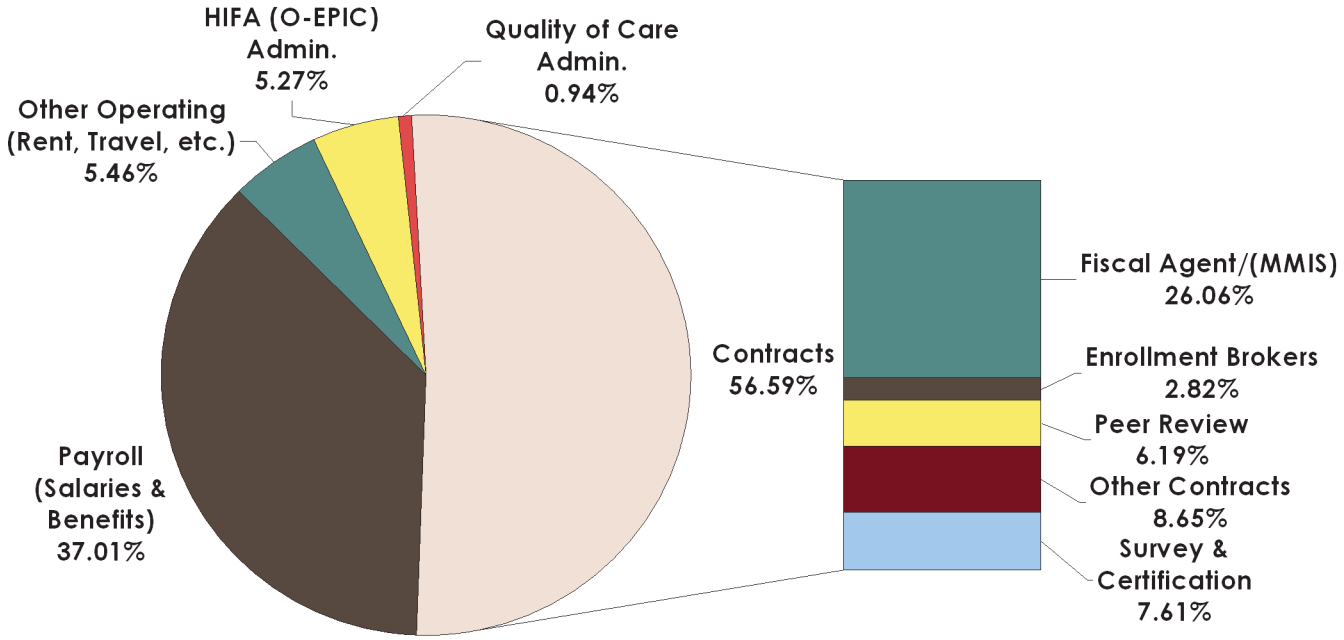
The administration of the SoonerCare program is divided among six different state agencies: the Oklahoma Health Care Authority (OHCA), the Oklahoma Department of Human Services (OKDHS), the Oklahoma State Health Department (OSDH), the Office of Juvenile Affairs (OJA), the Department of Mental Health and Substance Abuse Services (DMHSAS) and the Oklahoma University Health Science Center (OUHSC).

Figure 15 OHCA SoonerCare Expenditure Percentages—SFY2006



Finally, OHCA's administrative expenses are divided between direct operating expenses and vendor contracts. Of the $60 million spent by OHCA in SFY2006 on administration, 43 percent went to direct operation expenses while 57 percent went toward vendor contracts.

Figure 16 OHCA Administrative Expenses—SFY2006



Strategic Planning

It is difficult to over-estimate the importance and impact of SoonerCare, because the program is so large, it serves so many people in so many different population groups, and it plays a role to finance virtually every state program that relates to health. By any measure, SoonerCare makes a positive difference, even a critical difference, in the lives of hundreds of thousands of low-income Oklahomans.

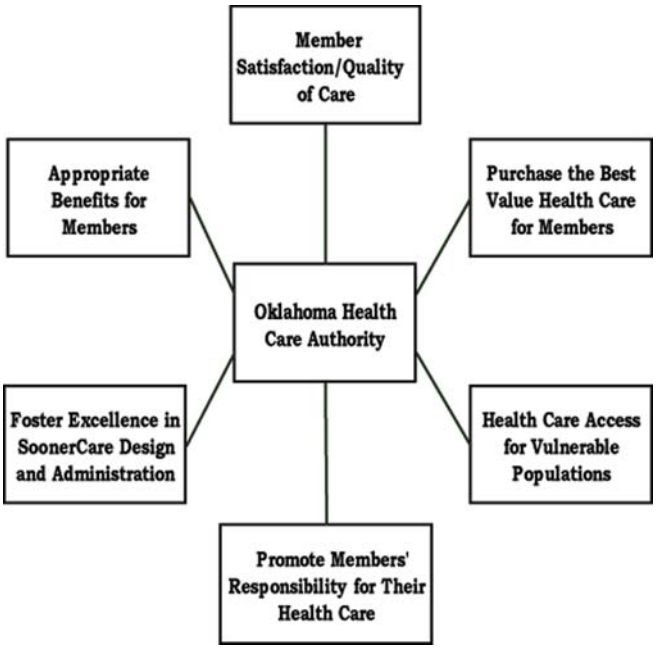
Success of the planning process is determined by:

- how seriously we take our responsibilities;
- how willing we are to come together as a state to make difficult choices regarding direction and priorities, and;
- how committed we are to work together to support those choices in our future actions.

Broadly Stated Goals

The heart of our Strategic Plan is the statement of our primary strategic goals—a short list of our major emphases over the next several years. These goals represent not only our understanding of the agency's statutory responsibilities, but our broader sense of purpose and direction informed by a common set of agency values, they are:

- Improve health care access for the underserved and vulnerable populations of Oklahoma. (SoonerCare Members)
- Protect and improve member health and satisfaction, as well as ensure quality, with programs, services and care. (Member Satisfaction/Quality of Care)
- Promote members' personal responsibility for their health services utilization, behaviors and outcomes. (Member Responsibility)
- Ensure that programs and services respond to the needs of members by providing necessary medical benefits to our members. (Benefits)
- Purchase the best value health care for members by paying appropriate rates and exploring all available valid options for program financing. (Purchasing Issues/ Provider Relations)
- Foster excellence in the design and administration of the SoonerCare program.



Program and Payment Integrity Activities

The demand and costs for social and health care services continues to grow, while available federal and state funding continues to diminish. In addition, public demand for economy and accountability in government spending is increasing. Improper payments in government health programs, such as SoonerCare, drain vital program dollars, hurting members and taxpayers. Such payments include those made for treatments or services that are not covered by program rules, that were not medically necessary, that were billed but never actually provided or that have missing or insufficient documentation to show whether the claim was appropriate. Improper SoonerCare payments can result from inadvertent errors, as well as intended fraud and abuse.

Unlike inadvertent errors, which are often due to clerical errors or a misunderstanding of program rules, fraud involves an intentional act to deceive for gain, while abuse typically involves actions that are inconsistent with acceptable business and medical practices. OHCA's claim processing system (MMIS) has hundreds of edits that stop many billing errors from being paid. However, no computer system can ever be programmed to prevent all potential billing errors.

The OHCA protects taxpayer dollars and the availability of SoonerCare services to individuals and families in need by coordinating an agency-wide effort to identify, recover and prevent inappropriate provider billings and payments.

Within Oklahoma, two major agencies share responsibility for protecting the integrity of the state SoonerCare program. The OHCA is responsible for ensuring proper payment and recovering misspent funds, while the Attorney General's Medicaid Fraud Control Unit (MFCU) is responsible for investigating and ensuring prosecution of Medicaid fraud.

In addition to the OHCA and MFCU, other state and federal agencies assist in dealing with SoonerCare improper payments. Because of their responsibility to ensure sound fiscal management in their states, state auditors may become involved in Medicaid payment safeguard activities through efforts such as testing payment system controls or investigating possible causes of mispayment. At the federal level, both the Centers for Medicare & Medicaid Services (CMS) and the Office of Inspector General of the Department of Health and Human Services (DHHS-OIG) oversee state program and payment integrity activities.

Actions resulting from the program and payment integrity efforts may include:

- clarification and streamlining of SoonerCare policies, rules and billing procedures;
- increased payment integrity, recovery of inappropriately billed payments and avoidance of future losses;
- education of providers regarding proper billing practices;
- termination of providers from participation in the Oklahoma SoonerCare program;
- referrals to the Attorney General's Medicaid Fraud Control Unit (MFCU).

Program and Payment Integrity Activities (continued)

Post-Payment Reviews and Recoveries

Various units within the OHCA are responsible for separate areas of potential recoveries, cost avoidance and fee collection. The Surveillance Utilization and Review Services (SURS) Unit staff safeguards against unnecessary utilization of care and services. The Pharmacy Unit reviews paid pharmacy claims to determine that claims are valid and in compliance with applicable federal and state rules and regulations. The Audit Management Unit staff perform audits and reviews of external providers in regard to inappropriate billing practices and noncompliance with OHCA policy. Reviews can be initiated based on complaints from other SoonerCare providers, members, concerned citizens or other state agencies, as well as risk-based assessments.

Peer Review Organization (PRO)

Some SoonerCare services are subject to utilization review by a Peer Review Organization (PRO) under contract with OHCA. The PRO conducts a medical hospital retrospective random sample review on services provided to SoonerCare Traditional members. The purpose of the inpatient hospital utilization review program is to safeguard against unnecessary and inappropriate medical care rendered to SoonerCare members. Medical services and/or records are reviewed for medical necessity, quality of care, appropriateness of place of service and length of stay. Federal regulations require this function to be performed by a PRO.

Figure 17 Post-Payment Review Recoveries, SFY2006

Provider Type	SFY2006
Behavioral Health	$3,457,484
Dental	$84,833
Durable Medical Equipment Suppliers	$1,350,520
Home and Community-Based Waiver	$1,242
Hospital	$1,572,971
Long-Term Care Facilities	$1,046,349
Pharmacy	$621,424
Physician/Other Practitioners	$606,737
School-Based Services	$135,778
Transportation Provider	$58,256
Vision	$34,369
Total – OHCA Recoveries	**$8,969,963**
Medicaid Fraud Control Unit—Other	$120,066
MFCU—National Settlements	$1,936,852
Total SoonerCare Recoveries	**$11,026,881**

OHCA recovery figures are a combination of amounts recovered from SURS, Pharmacy, Audit Management, contractor and PRO reviews.

Additionally, the PRO performs on-site inspection of care reviews for licensed psychiatric inpatient and day treatment facilities that provide services to SoonerCare members less than 21 years of age. These reviews include evaluation and monitoring of facility accreditation status, as well as evaluation of medical record documentation and program utilization. The PRO under contract with OHCA during SFY2006 was Oklahoma Foundation for Medical Quality (OFMQ). Additional information on OFMQ may be found at www.ofmq.com.

Program and Payment Integrity Activities (continued)

Post-Payment Reviews and Recoveries (continued)

Third Party Liability (TPL) Recoveries

The OHCA uses a combination of data matches, diagnosis code edits and referrals from providers, caseworkers and members to identify available third party resources such as health and liability insurance. The TPL program also ensures that SoonerCare recovers any costs incurred when available resources are identified through liens and estate recovery programs.

Estate Recoveries	$2,971,801
Other	$11,163,893
Total Recoveries SFY2006	**$14,135,694**

Cost Avoidance

Cost avoidance is the method of either finding alternate responsible payers as in other insurance coverage or by optimizing pharmaceutical treatment options.

Third Party Liability (TPL) Cost Avoidance

The Third Party Liability (TPL) program also reduces costs to the SoonerCare program by identifying third parties liable for payment of a member's medical expenses. States are federally required to have a system to identify medical services that are the legal obligation of third parties, such as private health or accident insurers. Such third party liability resources should be exhausted prior to the paying of claims with program funds (cost avoidance).

Medicare	$597,522,431
Private Insurance	$233,186,357
Total Cost Avoidance SFY2006	**$830,708,788**

Product Based Prior Authorization Cost Avoidance

The goal of the Product Based Prior Authorization (PBPA) program is to optimize each member's drug regimen with medication that best treats the patient's condition given his or her unique health status and circumstances.

The PBPA cost avoidance dollars represent savings the program achieved in five therapeutic classes: non-steroidal anti-inflammatory drugs (NSAIDs), anti-ulcer drugs (proton pump inhibitors), anti-hypertension drugs (ACE inhibitors, calcium channel blockers, and angiotensin receptor blockers), ADHD treatments and SSRI antidepressants. Each class of medication is divided into two or more tiers. Tier 1 products are available with no restrictions, and Tier 2 products require prior authorization. A member with clinical exceptions or who has not tolerated or achieved clinical success with a Tier 1 product can obtain a Tier 2 medication via the prior authorization process. Manufacturers of Tier 2 products have the option to participate in the Supplemental Drug Rebate Program, which moves their product into Tier 1 and removes the prior authorization requirement.

Product Based Prior Authorization Cost Avoidance—SFY2006 $30,830,010

State Maximum Allowable Cost Program

The State Maximum Allowable Cost (SMAC) program limits pharmacy reimbursement for generic products. For SFY2006, generics were dispensed for 63 percent of all SoonerCare prescriptions and in 93 percent of the prescriptions where a generic is available. When the SMAC program was started in 2000, there were four hundred products included. The most recent list includes over eleven hundred drug products.

By limiting the amount paid for generic drugs, OHCA was able to save more than $66 million in SFY2006.

Program and Payment Integrity Activities (continued)

Rebates and Fees

Supplemental Drug Rebate Program

The SoonerCare State Supplemental Drug Rebate program makes drugs available for members while ensuring cost-effectiveness for the taxpayer. The federal program allows pharmaceutical manufacturers to partner with the state to provide rebates for drugs that would otherwise require prior authorization. If the manufacturer agrees to provide a rebate for its products, then the products become available without prior authorization. This rebate is in addition to the federal Drug Rebate Program, which guarantees that the SoonerCare program receives a "best price" for each product. With the Supplemental Drug Rebate program, members receive medications quickly, providers do not face red tape, staff resource needs are reduced and manufacturers are able to maintain or increase the market share of their products.

Drug Rebate Program

The Federal Drug Rebate Program (established by the enactment of the Omnibus Budget Reconciliation Act of 1990) was designed to offset prescription expenditures and guarantee that states pay no more than the lowest price charged by a manufacturer for prescription drugs. In exchange for the rebate, states must make all products of a contracted manufacturer available to SoonerCare members within the framework of the federal requirements. Pharmacy reimbursement is continuously monitored to assure a fair price is paid in exchange for goods and services provided by pharmacists. Drug manufacturers are invoiced on a quarterly basis. Interest is assessed by the OHCA on late payments.

State Supplemental Drug Rebates	$7,876,306
Federal Drug Rebates	$120,882,994
Interest	$244,670
Total Collections SFY2006	**$128,303,764**

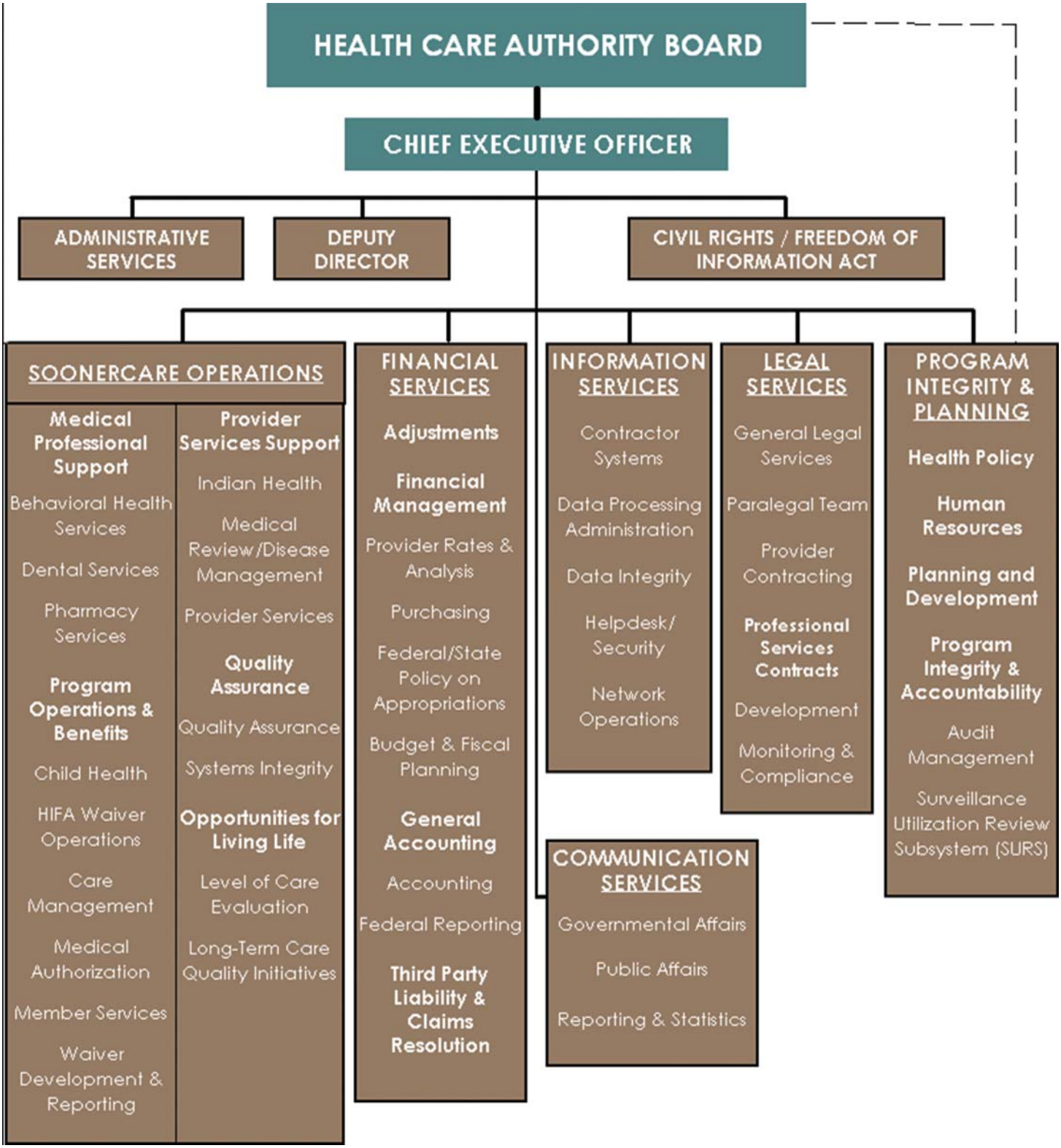
Long-Term Care Quality of Care Program Fees

In an effort to increase the quality of care received by long-term care members, the Quality of Care (QOC) Program was put into place. A fee per patient day is collected from long-term care facilities and placed in a revolving fund. Monies from this fund are used to pay for a higher facility reimbursement rate, increased staffing requirements, program administrative costs and other increased member benefits. Additionally, funds are being used by other state agencies, such as the Oklahoma State Department of Health, to maintain staff dedicated to investigations and on-site surveys of long-term care facilities and the Oklahoma Department of Human Services for 10 regional ombudsmen.

Facilities receive monthly invoices for fee payment based on their self-reported patient census and revenues. Quality of Care fees and/or reports not submitted in a timely manner are subject to a penalty.

Quality of Care Fees	$53,458,800
Penalties/Interest	$818,801
Total SFY2006	**$54,277,601**

Figure 18 OHCA's Organizational Chart



Organization as of June 2006.

Core Function Summary

The full time equivalent (FTE) counts per unit do not reflect the division directors and support staff. Therefore, FTE counts per unit may not equal the total filled FTE per division. FTE counts per unit and total filled FTE per division figures do not include vacant positions. The core function summary is a high-level, extremely simplified overview of unit responsibilities and does not necessarily reflect all of the required or performed functions of each unit.

EXECUTIVE OFFICE SUPPORT

Mike Fogarty, J.D., M.S.W., Chief Executive Officer *Total FTE Filled: 5*

Deputy Director assists the CEO in daily operations and administration of the agency. The Deputy Director serves as the liaison between various agencies and stakeholders. (1 FTE) *Deputy Director, Charles Brodt (405) 522-7091.*

Civil Rights/Freedom of Information Act office is responsible for managing all phases of the affirmative action program, including management and employee counseling. Additionally, handles Open Records requests. (1 FTE) *Director, Donna Huckleberry (405) 522-7452.*

ADMINISTRATIVE SERVICES

James Smith, Administrative Chief of Staff *Total FTE Filled: 11*

This unit answers and directs all calls that come into the main agency telephone number through the receptionist desk. We coordinate space requests and general maintenance issues. We perform the maintenance and monitoring of the agency's vehicles, security, and telephone systems. Our division sorts and delivers all incoming and outgoing mail. (11 FTE) *Administrative Chief of Staff, James Smith (405) 522-7150.*

I am the mother of an 11-year-old boy with the most brightest smile and outstanding personality. (Treatment details deleted for member privacy.) His doctor wanted to place him for post-op care and rehabilitation at a facility that was not covered by our private insurance. We do not qualify for SSI or Medicaid, but a social worker told me about TEFRA. An OHCA employee (name removed) spent countless time with me on multiple phone conversations trying to assist me with the application process. Had it not been for the OHCA employee (name removed) and her true act of kindness and dedication, I would not be where I am today in the TEFRA process! *SoonerCare TEFRA member mother*

Core Function Summary (continued)

SOONERCARE OPERATIONS

Lynn Mitchell, M.D., M.P.H., Director of SoonerCare *Total FTE Filled: 185*

Medical Professionals Support – Lynn Mitchell, M.D., M.P.H., Director

Behavioral Health Services interfaces with other state agencies, consumer groups, providers and other stakeholders to provide information about SoonerCare behavioral health programs and services. Our unit gathers information helpful to improving the quality and continuum of services. The Behavioral Health Services unit provides care management services to SoonerCare members in need of ongoing mental health care and treatment. We help providers and others in the community who need assistance on behalf of SoonerCare members in locating and accessing appropriate behavioral health treatment services. Our unit also provides contract oversight for areas of the peer review organization (APS) services and the Department of Mental Health and Substance Abuse and Office of Juvenile Affairs behavioral health services. (6 FTE) *Manager, Debbie Spaeth, L.M.F.T., L.P.C., C.A.D.C. (405) 522-7080.*

Dr. Leon D. Bragg, has been invited to fellowship in the American College of Dentists. The American College of Dentists is a nonprofit dental organization and its fellowships reward dentists who have demonstrated exceptional leadership and contributions to the profession.

Dental Services coordinates preventive and restorative dental services for enrolled children. Our goals are to enable them to retain their teeth for a lifetime and educate members as to the importance of oral health. We also provide ongoing consultations and guidance regarding policy changes as they pertain to SoonerCare dental benefits. Our unit provides training and education in all counties for dental providers and coordinates dental and pharmacy grievances. (6 FTE) *Manager, Ella Matthews, R.N. (405) 522-7314 and Leon Bragg, D.D.S (405) 522-7592.*

Pharmacy Services is divided into three sections: Pharmacy Operations, Clinical Services and Drug Rebate. The Pharmacy Operations team takes care of the daily tasks associated with processing claims, auditing payments and assisting members and providers. The Clinical Services group includes pharmaceutical disease management, provider education and member assistance projects. The Drug Rebate area processes invoices and payments under the Federal Drug Rebate Program and the SoonerCare State Supplemental Rebate Program. The Pharmacy division works closely with the Drug Utilization Review Board to formulate policy and improve the pharmacy benefit. We contract with the University of Oklahoma College of Pharmacy to provide a telephone help desk for pharmacists, members and prescribers. (12 FTE Filled) *Director, Nancy Nesser, D.Ph, J.D. (405) 522-7325.*

Program Operations & Benefits – Becky Pasternik-Ikard, R.N., J.D., Director

Child Health coordinates and monitors the benefits related to child health and perinatal care. This includes a focus on child health screens (Early and Periodic Screening, Diagnosis and Treatment - EPSDT) and follow up care to diagnose and treat any disorders or concerns. Our unit works with school districts, the State Department of Education and the State Department of Health in maximizing EPSDT/EI (Early Intervention) services to SoonerCare children through school-based and Early Intervention services. This unit also provides education for parents and providers regarding child health screens as well as participates in provider outreach. In addition, the Child Health unit is responsible for coordinating and improving benefits related to prenatal care and delivery services within SoonerCare. (7 FTE Filled) *Director, Terrie Fritz, L.S.W.C. (405) 522-7377.*

Core Function Summary (continued)

SOONERCARE OPERATIONS (continued)

Program Operations & Benefits – Becky Pasternik-Ikard, R.N., J.D., Director (continued)

HIFA Waiver Operations plans, implements and monitors the Oklahoma Employer/employee Partnership for Insurance Coverage (O-EPIC) program under the federally approved Health Insurance Flexibility and Accountability (HIFA) waiver. This unit is responsible for participating in monthly monitoring calls, compiling quarterly reports, submitting waiver amendments and evaluations and maintaining dialogue with our federal partners at the Centers for Medicare & Medicaid Services. Our unit also provides outreach and training to enrolled and potential employers and employees. (3 FTE Filled) *Manager, Matthew Lucas (405) 522-7273.*

Medical Authorization Unit reviews, responds and manually prices, when necessary, medical requests for durable equipment or other medical services that require prior authorization for SoonerCare enrolled children and adults. We also answer telephone inquiries from all sources regarding SoonerCare policy, scope and procedures regarding medical authorization. (11 FTE) *Manager, Sharon Adair (405) 522-7371.*

SoonerCare Care Management administers and facilitates care management services related to medically complex/special health care need members. Registered nurses (exceptional needs coordinators), licensed practice nurses (exceptional needs associates) and social service coordinators coordinate access to care with referrals being prompted by primary care providers, specialty providers, incident reports, member inquiries, interagency referrals and legislative requests. Staff members provide educational intervention for members with inappropriate ER visits, high service utilization, conditions in need of medical regimen reinforcement and dual medical/behavioral health needs. SoonerCare Care Management utilizes a clinical care management software system for tracking member activities and productivity measurements. (35 FTE) *Director, Marlene Asmussen, R.N. (405) 522-7123*

Giving Spirit

The OHCA staff carryover their drive to help others in need into their after work hours by participating in various charities and good will. Some of the activities are listed below:

- OHCA gives monetary donations as well as buys gifts and food for needy families and children in state custody during the holidays.
- Every year more than 150 stuffed animals are donated and distributed to various children shelters and hospitals.
- The agency raised over $1,300 in 2006 for the Casual for Kids Campaign which helps fund the prevention of child abuse.
- 20 to 25 staff members annually donate their time to raise funds for breast cancer research through the Race for the Cure.
- OHCA donations during the state charitable campaign increased to more than $13,000 in 2006.
- OHCA has an employee who shaves her head each year at “St. Baldrick’s Day”. This year she raised over $1,000 for the Children’s Oncology Group to help fight cancers that afflict children.

Core Function Summary (continued)

SOONERCARE OPERATIONS (Continued)

Program Operations & Benefits – Becky Pasternik-Ikard, R.N., J.D., Director (continued)

Member Services has the primary responsibility for the resolution to issues/concerns addressed in internal reports, incident reports and telephone calls and also monitors the enrollment agent. Our unit researches and resolves members' calls and issues related to dire medical needs and follows up with members on as needed basis to ascertain care received. We also identify and participate in outreach activities to promote member selection of PCP/CM. We also work in collaboration with the OKDHS county offices to resolve issues regarding member qualification. This unit also monitors all aspects of the SoonerRide program. (24 FTE Filled) *Director, Kevin Rupe, C.P.A. (405) 522-7498.*

Waiver Development & Reporting plans, develops, implements and monitors waivers for SoonerCare programs. This includes SoonerCare Choice, SoonerPlan, Oklahoma Cares and SoonerRide. This unit is responsible for participating in monthly monitoring calls, compiling quarterly reports, submitting waiver amendments and evaluations and maintaining dialogue with our federal partners at the Centers for Medicare & Medicaid Services (CMS). (4 FTE Filled) *Manager, Melinda Jones (405) 522-7125.*

Provider Services Support – J. Paul Keenan, M.D., Director

Indian Health performs Native American liaison services between OHCA and CMS, Indian Health Services (IHS) and the tribes of Oklahoma. We stay informed of state and national level issues, participate in Native American work groups, tribal consultation and policy development. Our unit monitors compliance and strives to eliminate health disparities. (3 FTE Filled) *Manager, Trevlyn Terry (405) 522-7303.*

Medical Review/Disease Management is responsible for making medical necessity, appropriateness of care and scope of coverage decisions after reviewing and researching requests for services submitted to the Medical Authorization Unit and medical records from the audit and quality assurance departments. In addition, our unit is in the process of developing and implementing a comprehensive disease management program to improve the delivery of quality of health care and improve clinical outcomes. The professional staff also provides medical/clinical expertise and support to other agency departments as needed. (1 FTE Filled) *Physician Medical Reviewer, Michael Herndon, D.O. (405) 522-7149.*

SoonerCare Provider Services is focused on the recruitment, development, contracting, retention and monitoring of the SoonerCare provider network. Additional responsibilities are provider training, and review of network sufficiency or access/quality issues related to program standards. Provider Services also communicates policies, procedures and program issues of particular importance to all providers. (30 FTE Filled) *Manager, Melody Anthony (405) 522-7360*

> If it weren't for the SoonerCare, I would not be able to afford to pay for this medication. They filled my prescription, and for 100 pills – and I only take one pill a day – was $900. There is no way that we could afford to pay that kind of money on only one income. Thank you, thank you, thank you." *SoonerCare Oklahoma Cares Member*

Core Functions Summary (continued)

SOONERCARE OPERATIONS (Continued)

Quality Assurance – Angela Shoffner, R.N., Director

Quality Assurance coordinates the quality assurance evaluation and monitoring processes for all OHCA medical programs. We do this by implementing and assessing necessary processes to meet federal guidelines. This unit also coordinates the agency quality assurance committee activities and provides technical support in developing and reporting federally required quality assurance functions. (11 FTE) *Manager, Angela Shoffner, R.N. (405) 522-7355.*

Systems Integrity maintains the reference file for the Medicaid Management Information System (MMIS), ensuring maintenance of all files according to current OHCA rules and policies. Our unit coordinates the integrity of the MMIS during the development of new programs for the SoonerCare program as well as assists in the development of OHCA's Billing and Procedure Manual to ensure that all programs and materials are in accordance with existing state and federal regulations. (5 FTE Filled) *Supervisor, Patricia Johnson (405) 522-7184.*

OPPORTUNITIES FOR LIVING LIFE

Cassell Lawson, Director *Total FTE Filled: 20*

Level of Care Evaluation Unit (LOCEU) coordinates the federal PASRR (Pre-Admission Screening and Resident Review) program statewide. PASRR provides Level I screening to all people entering SoonerCare certified nursing facilities (NFs) for possible mental retardation (MR) and/or mental illness (MI) related diagnosis. Level II assessments are conducted when necessary to ensure that this population requires NF level of care and receives proper treatment for MI and/or MR within the nursing facility. LOCEU also makes level of care decisions on all members entering public and private intermediate care facilities for the mentally retarded (ICF/MR), as well as on members applying for the Oklahoma Department of Human Services (OKDHS), Developmental Disabilities Services Division (DDSD) and Home and Community-Based Waivers. Our unit also audits all of the Home and Community-Based Services waiver programs. We also provide medical and categorical relationship determinations for disability and incapacity of OKDHS members and medical qualifications for the TEFRA program. (12 FTE) *Manager, Kathy Smith, L.C.S.W. (405) 522-7309.*

Long-Term Care Quality Initiatives (LTCQI) administers Quality of Care Reports from long-term care facilities, wage enhancement and trust audits. This unit monitors and reviews wavier programs to see that members' needs are being met. We work in partnerships with outside agencies to develop, coordinate and administer new programs. (6 FTE Filled) Interim Manager, Tana Parrot (405) 522-7538.

I have been in practice nearly 37 years, starting back when Medicaid was a four-letter word to this profession. Old attitudes and habits die hard, but when I speak to other dentists these days and share my "pearl," it is about the quality service now afforded dental providers by the Oklahoma Health Care Authority for the ultimate benefit of the health of Oklahoma's children. *SoonerCare Dental Provider, Enid*

Core Function Summary (continued)

INFORMATION SERVICES DIVISION

John Calabro, Director of Information Services *Total FTE Filled: 31*

Contractor Systems monitors problems identified in the Medicaid Management Information System (MMIS) and recommends appropriate actions to correct the deficiency, analyzes test results and coordinates all maintenance and modification system changes with ongoing enhancements. Our unit is responsible for the maintenance and modification of the MMIS. This unit is accountable for the fulfillment of data processing performed by the contracted fiscal agent, Electronic Data Systems (EDS). We also establish priorities for systems development and data processing projects according to departmental requirements, as well as develop plans for future utilization of data processing services in the overall agency program. (12 FTE) *Director, Donna Witty (405) 522-7242.*

Data Integrity analyzes federal and other agency reports to ensure accuracy and maximization of federal financial participation. This unit also compares reports against data from other sources to validate accuracy and determines corrective action if necessary. Our unit identifies user needs and develops appropriate systems interface to substantiate or dispel. Data Integrity also identifies agency Web site needs and develops system designs. (1 FTE Filled) *Senior Data Integrity Specialist, Richard Evans (405) 522-7101*.

Data Processing Administration is accountable for all data processing performed both within the division and development performed by the contracted fiscal agent, including equipment selection and purchase, systems analysis, programming, operations and data entry. We also make recommendations of new uses for data processes or for the abandonment of inefficient present uses. (4 FTE) *Administrator, Judi Worsham (405) 522-7222.*

Helpdesk/Security is the central point through which computer systems problems or issues are reported and resolutions are coordinated. This unit also provides support to the agency and other entities accessing our network and MMIS. The Security aspect of this area maintains and audits the integrity of all agency systems and assures our compliance with state and federal security regulations. This area also evaluates and tests the security for new applications, systems, and/or upgrades in addition to performing random audits on the various applications administered by the agency. (2 FTE) *Systems Security Officer/Help Desk Supervisor, DeBorah Boneta (405) 522-7033.*

The OHCA received a lot of great responses regarding our public Web site redesign. Here are a few:

- The new website looks awesome!! So much more modern, less institutionalized...Great job!
- the new website ... looks great! It even has a separate fee schedule for behavioral health, just what I was looking for.
- I just want to tell you that I think the new web-site, layout, ease of use, content--is exceptional --very easy to find what you need.

Network Operations performs programming implementation and operations for computer systems not covered by the fiscal agent contract. We are accountable for the fulfillment of data processing performed on the OHCA network, systems analysis and programming to implement requested changes. This unit designs applications to be flexible, cost-effective and relevant to address the needs of OHCA. We also coordinate agency data processing activities with other state agencies, private sector entities and all OHCA units or divisions for network operations. (10 FTE) *Director, Jeff Slotnick (405) 522-7152.*

Core Function Summary (continued)

FINANCIAL SERVICES

Anne Garcia, C.G.F.M., Director of Financial Services *Total FTE Filled: 58*

Adjustments researches and reconciles claims of erroneous provider payments as reported through various sources. We research and initiate corrective action on claims for which refunds have been received from medical providers. Our unit also identifies problem areas with the claims and recoupment process and recommends training be provided to individual providers or provider groups. Adjustments Unit is also responsible for the accounts receivable for the agency. (13 FTE) *Manager, Kelly Freeman (405) 522-7098.*

Budget and Fiscal Planning prepares the annual agency budget request. We prepare and process agency budget work programs and any necessary revisions. This unit also analyzes data, tracks expenditures and prepares financial forecasting for the agency's program budgeting. (4 FTE Filled) *Chief Budget Officer, Juarez McCann (405) 522-7122.*

Federal and State Policy on Appropriations provides advice and assistance related to congressional appropriations issues to OHCA staff as well as works with national associations on Medicaid related issues. This unit also prepares and submits informational reports for the purpose of assisting the Oklahoma congressional delegation in the development of state strategy as the delegation considers federal legislation and appropriations. (1 FTE Filled) *Senior Policy Advisor, Stephen Weiss (405) 522-7530.*

Financial Management researches and analyzes claims history and cost report data in order to develop, implement and support reimbursement rates for institutional providers and submit state plan documentation. (3 FTE Filled) *Director, Debbie Ogles (405) 522-7270.*

Provider Rates & Analysis reviews and maintains cost reports for nursing facilities and intermediate care facilities for the mentally retarded for the effective auditing of provider costs and calculating the annual "audit adjustment" along with reporting other annual costs for the purpose of rate setting. We also maintain copies of hospital cost reports for the determination of base year costs and establish payment rates to hospitals. (4 FTE Filled) *Manager, David Branson (405) 522-7294.*

Purchasing anticipates, initiates and processes purchase requests and encumbrance documents submitted by units within the agency, as well as follows up on purchase orders, monitors funding amounts, approves invoices and prepares change orders to increase, decrease or cancel encumbered funds. (3 FTE Filled) *Manager, Vickie Kersey (405) 522-7482.*

General Accounting draws administrative and SoonerCare program federal matching and maintains the general ledger for accounting of all funds. We post all receipts and expenditures of agency funds. This unit prepares the monthly financial statement reports and quarterly cost allocation schedules. We also make payment of claims for general agency operations and contracted services. We deposit all funds received by the agency and perform the billing, collection and administration of the Quality of Care fund. General Accounting also tracks and reconciles adjudication reports produced by the fiscal agent before authorizing weekly payments, processing all SoonerCare provider garnishments and tax levies. We reconcile and process all agency payrolls, and approving annual 1099 and W2 information. (10 FTE) *Director, Carrie Evans (405) 522-7359.*

Core Function Summary (continued)

FINANCIAL SERVICES (continued)

Third Party Liability (TPL) & Claims Resolution investigates the legal liability of third parties to pay for care and services furnished to SoonerCare members and seek reimbursement from the responsible third parties (TPL). We use the most cost-effective means of recovery, to cost-avoid the claim when there is probable existence of TPL at the time it is filed. For those claims that are not cost-avoided or a third party is discovered after SoonerCare has paid, the pay and chase method of recovery is utilized. Claims Resolution monitors the timely and accurate processing of claims for SoonerCare providers and resolves suspended edits during the claims processing cycle. (18 FTE) *Director, Lisa Gifford, J.D. (405) 522-7427.*

LEGAL SERVICES

Howard Pallotta, J.D., Director of Legal Services *Total FTE Filled: 29*

General Legal Services renders legal opinions and advises the CEO, board members and agency management on administrative legal issues and provides legal opinions to agency personnel on issues relating to contracts, state finance, procurement and rate matters. This unit also reviews possible legislation and advises legislators and legislative staff members regarding Medicaid law. We also advise advocacy and public interest groups regarding changes in Medicaid law. General Legal Services hears all administrative law judge appeals filed by providers and members and represent the agency before administrative, state and federal courts or tribunals. (4 FTE Filled) Director, Howard Pallotta, J.D. (405) 522-7431.

Legal Operations – Beth Van Horn, B.S.W., M.B.A., Director

Paralegal Team supports agency legal staff, coordinates the administrative appeals process and maintains legal files. (3 FTE Filled) *Director, Beth Van Horn, J.D. (405) 522-7234.*

Professional Services Contracts oversees the procurement and development of all the agency's professional services contracts, ensuring adherence to statutes, administrative procedures and agency regulations in the procurement of professional contracted services and interagency agreements. This unit also maintains long-term care databases and information regarding survey and certification functions as well as temporary and permanent suspensions of payments and civil monetary penalties related to contract breaches. (6 FTE Filled) *Director, Beth Van Horn (405) 522-7234.*

Monitoring and Compliance administers the MMIS fiscal agent contract, reviews and audits contractual compliance and coordinates agency HIPAA compliance. (3 FTE Filled) *Manager, Debra Johnson (405) 522-7346.*

Provider Contracting enrolls providers in all SoonerCare programs and maintains provider information databases. The unit operates and maintains a call center that answers inquiries about provider enrollment, reimbursement, provider and prescriber numbers, and provider contract types and requirements. (11 FTE Filled) *Manager, Peggy Hansen (405) 522-7370.*

Core Function Summary (continued)

PROGRAM INTEGRITY AND PLANNING

Cindy Roberts, C.P.A., C.G.F.M., Director *Total FTE Filled: 43*

Health Policy prepares upcoming policy issues for the Medical Advisory Committee (MAC) for the purpose of receiving direction from the members regarding additional research and receives requests from the members to research and subsequently report on other policy issues. Our unit coordinates with the Centers for Medicare & Medicaid Services (CMS) on questions related to Medicaid policy, compliance issues, expenditures and the State Plan. Additionally, Health Policy initiates revisions to OHCA rules through the OHCA Board and promulgates rules. (7 FTE Filled) *Director, Joanne Terlizzi (405) 522-7272.*

Human Resources monitors and assures agency compliance with all relevant state and federal personnel regulations. This unit also maintains a human resources information system for tracking recruitment, processes personnel transactions and is involved in employee evaluation activities, compensation management and supervisory training. We generate monthly, quarterly and annual personnel related reports, as well as conduct the human resources personnel transactions in a way that maximizes the agency's use of FTEs and allocated budget. Human Resources also serves as the liaison on employee benefits, retirement and ethics, and we monitor safety and workers' compensation issues. (4 FTE Filled) *Director, Ron Wilson (405) 522-7418.*

Planning & Development coordinates and facilitates the strategic planning process of the agency. This unit identifies key strategic opportunities and interfaces with executive staff, staff, and/or government agency officials in the development of strategic projects, developing alternative solutions and implementation strategies. We recommend appropriate action on program and policy issues. This unit demonstrates effective project planning including but not limited to: conducting extensive background research; facilitating and leading groups in the development of projects; analyzing options; establishing time frames needed to complete projects according to federal, state and/or agency management deadlines; monitoring projects in regard to milestones and deadlines; determining areas of weakness; recommending corrective actions; and ensuring timely project implementation. (4 FTE Filled) *Manager, Buffy Heater, MPH (405) 522-7545.*

Program Integrity & Accountability – Cindy Roberts, C.P.A., C.G.F.M., Director

Audit Management performs audits and reviews of organizational and functional activities and evaluates the adequacy and effectiveness of the management controls over these activities, subsequently reporting the results of the reviews and the extent to which organizational units are performing their planning, accounting, custodial or control activities in compliance with management instructions, applicable statements of policy and procedures in a manner consistent with both agency objectives and high standards of administrative practice. This unit also completes federally mandated Payment Error Rate Measurement, which requires performing a comprehensive claims payment review. (13 FTE Filled) *Manager, Kelly Shropshire, C.P.A. (405) 522-7131.*

Surveillance Utilization Review Subsystem (SURS) develops comprehensive statistical profiles and utilization patterns of health care delivery of individual providers and recipients to safeguard against unnecessary or inappropriate use of Medicaid services and associated payments, assess the quality of those services, and identify suspected instances of fraud and abuse according to federal regulations. (13 FTE Filled) *Manager, Jana Webb, R.N. (405) 522-7112*.

Core Function Summary (continued)

COMMUNICATION SERVICES

Nico Gomez, Director *Total FTE Filled: 11*

Communication Services acts as a primary connection point between OHCA and external audiences.

Governmental Affairs serves as the liaison between the agency and the legislative and executive branches of state government. This unit coordinates fiscal, policy and program impacts with agency staff regarding potential and pending legislation. The unit also provides clarification and information regarding agency programs and operations to governmental entities and through other external requests, including constituent assistance. (2 FTE Filled) *Director, Nico Gomez (405) 522-7484.*

Public Affairs develops comprehensive public information strategies, outreach activities and goals. The unit also produces written material for the agency, including all enrollment publications, informational and/or promotional materials to members and content management for the agency's public Web site. The unit also serves as the agency's primary contact for the media. (4 FTE Filled) *Manager, Jo Kilgore (405) 522-7474.*

Reporting and Statistics provides valid and relevant analyses of the SoonerCare program and related services. This unit extracts, compiles and analyzes data and/or statistical research studies based on Medicaid Management Information Systems (MMIS) data. The information collected impacts data-driven decision making, strategic planning and communication projects. Our unit fulfills both internal and external data requests. Reporting and Statistics also coordinates surveys and compliance with state and federal data reporting requirements. This unit produces data-driven reports such as the annual report and monthly statistical reports. (4 FTE Filled) *Manager, Connie Steffee (405) 522-7238.*

> A member wrote to say how nice it was that a Care Management person called her back instead of being transferred or given another number to call. She was very grateful and said she now has a very good understanding of our program and how it works. *SoonerCare Member*

A special thank you to all of the employees, providers and members that contributed an overwhelming number of testimonials and kudos to our agency and its employees. It is important to impart to the public what a caring and generous group of people have dedicated their life to public service through their employment at the Oklahoma Health Care Authority.

APPENDIX TABLE OF CONTENTS

oklahoma health care authority

Appendix A Glossary of Terms

ABD	The **A**ged, **B**lind and **D**isabled SoonerCare population.
Member	A person enrolled in Oklahoma SoonerCare.
CMS	**C**enters for Medicare & **M**edicaid **S**ervices, formally known as Health Care Financing Administration (HCFA), federal agency that establishes and monitors Medicaid funding requirements.
EDS	**E**lectronic **D**ata **S**ystems is OHCA's fiscal agent. EDS processes claims and payments within Oklahoma's Medicaid Management Information System (MMIS).
Enrollee	For this report, an individual who is qualified and enrolled in SoonerCare, who may or may not have received services during the reporting period.
Fee-For-Service (FFS)	The method of payment for the SoonerCare population that is not covered under SoonerCare Choice. Claims are generally paid on a per service occurrence basis.
FFY	**F**ederal **F**iscal **Y**ear**.** The federal fiscal year starts on October 1 and ends September 30 each year.
FMAP	**F**ederal **M**edical **A**ssistance **P**ercentage – The federal dollar match percentage.
ICF/MR	**I**ntermediate **C**are **F**acility for the **M**entally **R**etarded.
EPSDT	**E**arly and **P**eriodic **S**creening, **D**iagnosis and **T**reatment also known as "well child" screens.
MMIS	**M**edical **M**anagement **I**nformation **S**ystem—the claims processing system.
SCHIP	**S**tate **C**hildren's **H**ealth **I**nsurance **P**rogram for children age 19 and under who have no creditable insurance and meet income requirements. (Title XXI)
SFY	**S**tate **F**iscal **Y**ear — starts on July 1 and ends June 30 each year.
SoonerCare Choice	Oklahoma's partially capitated managed care program.
TANF/AFDC	**T**emporary **A**ssistance for **N**eedy **F**amilies, formerly known as **A**id to **F**amilies with **D**ependent **C**hildren. Categorized in this report as Parents and Children.
Title XIX	Federal Medicaid statute enacted in 1965 under the Social Security Act financed by both federal and state dollars.

Figure I Technical Notes

Throughout this report a combination of data sources were used to provide the most accurate information possible. Financial statement data represents actual cash expenditures as reported to the Office of State Finance while MMIS data warehouse expenditure data/detail breakdowns are the net of overpayments and adjustments. This will cause some variations in dollar figures presented. Provider billing habits can also cause claim variations. All report claim data is extracted with the date paid by OHCA being within the report period. Provided that a member is enrolled at the time of service, a provider has one year from the date of service to submit a claim. Some providers hold claims and submit them all at once. For example, if a member receives a service in May and the provider submits and is paid for the claim in July, that member will be counted as a member and the dollar totals will be included in the July reporting period, even if the member may not be enrolled within that same reporting timeframe. If that member is not enrolled at some point within the reporting period, he or she will not be counted in the "Enrollees."

Appendix B OHCA SFY2006 Expenditures

Figure I SFY2006 SoonerCare Expenditures by Payer

Category of Service	Total	Health Care Authority	Other State Agencies	Quality of Care Fund
ADvantage Waiver	$119,754,626	$0	$119,754,626	$0
Ambulatory Clinics	$47,288,326	$11,549,251	$34,606,348	$0
Behavioral Health—Case Mgmt.	$755,844	$677,072	$0	$0
Behavioral Health—Clinic	$56,434,908	$56,429,726	$0	$0
Behavioral Health—Inpatient	$78,006,677	$77,953,986	$0	$0
Behavioral Health—Outpatient	$4,042,205	$4,042,205	$0	$0
CMS Payments	$117,186,008	$117,186,008	$0	$0
Dentists	$99,905,740	$95,668,501	$0	$0
Family Planning Waiver	$5,161,353	$0	$5,161,353	$0
GME/IME/DME	$106,841,079	$874,571	$105,966,508	$0
Home & Community Based Waiver	$119,224,854	$0	$119,224,854	$0
Home Health Care	$12,750,807	$12,726,422	$0	$0
Homeward Bound Waiver	$92,514,270	$0	$92,514,270	$0
ICF/MR Private	$47,911,556	$29,113,147	$0	$18,133,231
ICF/MR Public	$76,074,247	$0	$76,074,247	$0
In-Home Support Waiver	$17,141,146	$0	$17,141,146	$0
Inpatient Acute Care*	$533,599,301	$470,932,914	$10,015,917	$486,687
Lab & Radiology	$14,388,707	$13,521,333	$0	$0
Medical Supplies	$50,868,040	$45,702,283	$0	$2,708,208
Misc. Medical Payments	$18,078,588	$16,680,053	$0	$0
Nursing Facilities	$438,789,904	$240,334,554	$0	$149,765,585
Other Practitioners	$21,253,787	$19,701,170	$822,090	$446,364
Outpatient Acute Care	$157,725,548	$139,702,236	$0	$41,604
Personal Care Services	$13,154,453	$0	$13,154,453	$0
Physicians	$275,003,462	$149,388,575	$18,230,935	$58,101
Premium Assistance**	$610,178	$0	$0	$0
Prescription Drugs	$404,270,572	$344,608,963	$0	$6,486,496
Residential Behavioral Mgmt.	$41,867,353	$0	$41,867,353	$0
SoonerCare Choice	$87,055,083	$70,977,818	$9,997,547	$0
Targeted Case Management	$36,174,277	$0	$36,174,277	$0
Therapeutic Foster Care	$113,094	$0	$113,094	$0
Transportation	$17,163,503	$16,550,111	$0	$555,705
Total SoonerCare Expenditures	**$3,111,109,496**	**$1,934,320,899**	**$700,819,018**	**$178,681,981**

Source: OHCA Financial Service Division, September 2006.
*Includes $24,192,504 encumbrance. **Paid from Fund 245.

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.

Appendix B OHCA SFY2006 Expenditures

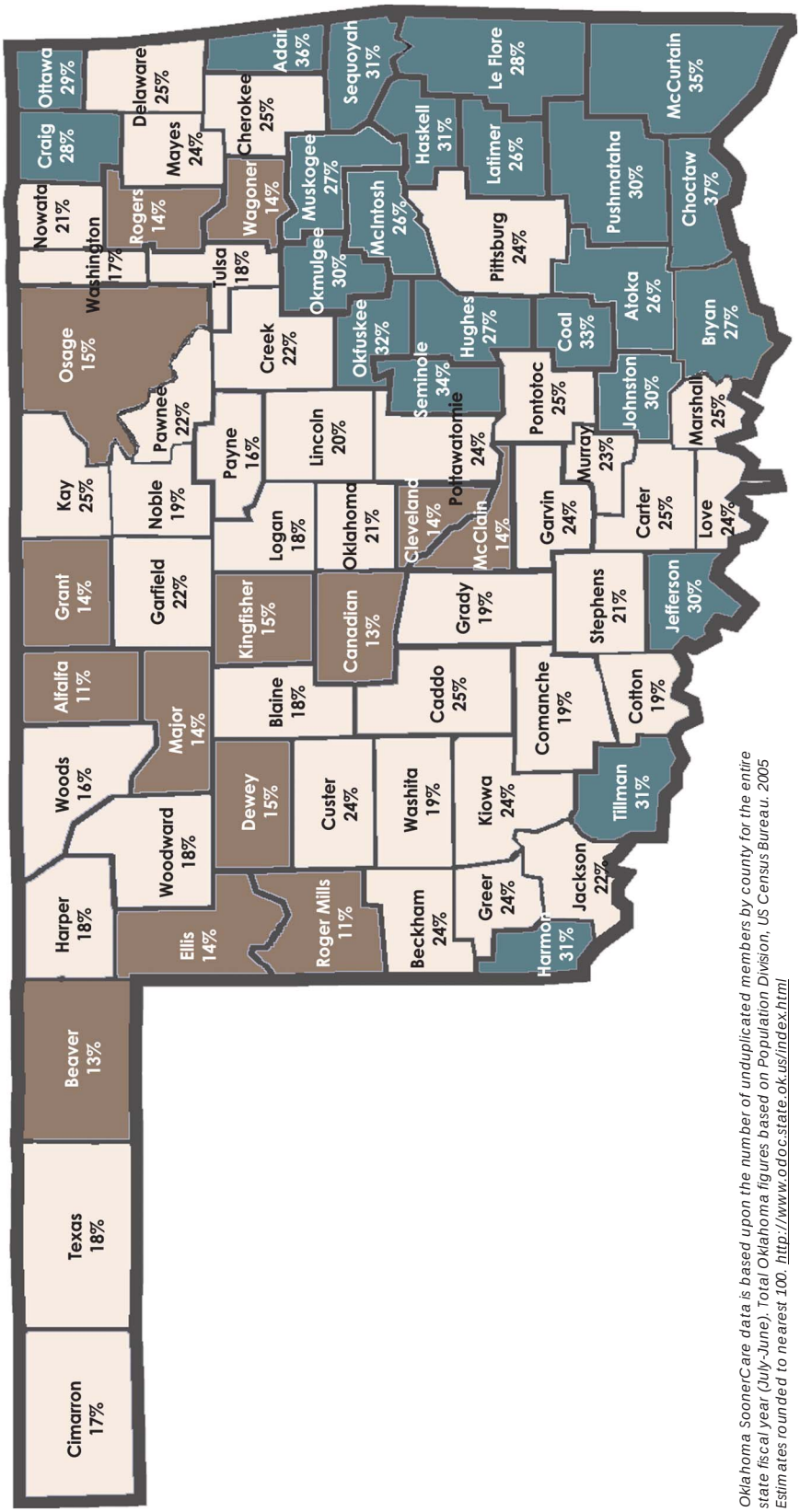
Figure I SFY2006 SoonerCare Expenditures by Payer (continued)

Category of Service	Total	Restricted Funds	Medicaid Program Fund	BCC Revolving Fund	HEEIA
ADvantage Waiver	$119,754,626	$0	$0	$0	$0
Ambulatory Clinics	$47,288,326	$789,559	$0	$343,168	$0
Behavioral Health—Case Mgmt.	$755,844	$0	$0	$78,772	$0
Behavioral Health—Clinic	$56,434,908	$0	$0	$5,182	$0
Behavioral Health—Inpatient	$78,006,677	$44,663	$0	$8,028	$0
Behavioral Health—Outpatient	$4,042,205	$0	$0	$0	$0
CMS Payments	$117,186,008	$0	$0	$0	$0
Dentists	$99,905,740	$0	$4,133,707	$103,532	$0
Family Planning Waiver	$5,161,353	$0	$0	$0	$0
GME/IME/DME	$106,841,079	$0	$0	$0	$0
Home & Community Based Waiver	$119,224,854	$0	$0	$0	$0
Home Health Care	$12,750,807	$0	$0	$24,385	$0
Homeward Bound Waiver	$92,514,270	$0	$0	$0	$0
ICF/MR Private	$47,911,556	$0	$665,178	$0	$0
ICF/MR Public	$76,074,247	$0	$0	$0	$0
In-Home Support Waiver	$17,141,146	$0	$0	$0	$0
Inpatient Acute Care*	$533,599,301	$5,973,728	$42,641,384	$3,548,671	$0
Lab & Radiology	$14,388,707	$477,595	$0	$389,779	$0
Medical Supplies	$50,868,040	$2,404,027	$0	$53,522	$0
Misc. Medical Payments	$18,078,588	$1,333,190	$0	$65,345	$0
Nursing Facilities	$438,789,904	$6,989,093	$41,680,829	$19,843	$0
Other Practitioners	$21,253,787	$237,557	$0	$46,606	$0
Outpatient Acute Care	$157,725,548	$14,520,281	$0	$3,461,427	$0
Personal Care Services	$13,154,453	$0	$0	$0	$0
Physicians	$275,003,462	$49,109,376	$49,886,038	$8,330,437	$0
Premium Assistance**	$610,178	$0	$0	$0	$610,178
Prescription Drugs	$404,270,572	$8,541	$51,732,750	$1,433,822	$0
Residential Behavioral Mgmt.	$41,867,353	$0	$0	$0	$0
SoonerCare Choice	$87,055,083	$5,954,391	$0	$125,327	$0
Targeted Case Management	$36,174,277	$0	$0	$0	$0
Therapeutic Foster Care	$113,094	$0	$0	$0	$0
Transportation	$17,163,503	$0	$621	$57,066	$0
Total SoonerCare Expenditures	**$3,111,109,496**	**$87,842,001**	**$190,740,507**	**$18,094,912**	**$610,178**

Source: OHCA Financial Service Division, September 2006. *Includes $24,192,504 encumbrance. **Paid from Fund 245. 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 Restricted Funds were appropriated by HB1088. The Medicaid Program Fund, BCC (Oklahoma Cares) Revolving Fund, and the HEEIA Fund are all funded by tobacco tax collections.

Appendix B Statewide SFY2006 Figures

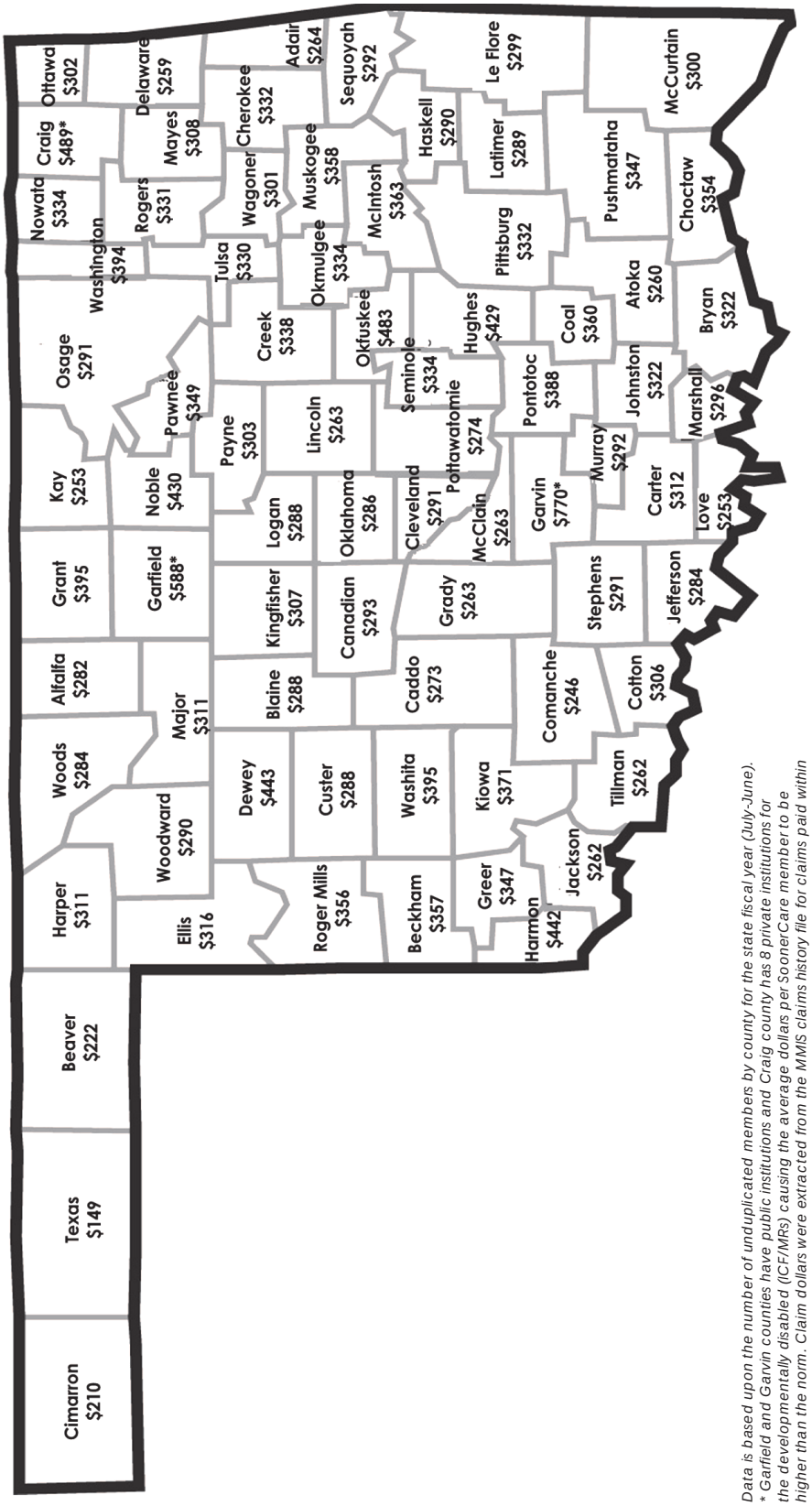
Figure II Unduplicated Persons Enrolled in SoonerCare as a Percent of the Total Oklahoma Population



Oklahoma SoonerCare data is based upon the number of unduplicated members by county for the entire state fiscal year (July-June). Total Oklahoma figures based on Population Division, US Census Bureau. 2005 Estimates rounded to nearest 100. http://www.odoc.state.ok.us/index.html

Appendix B Statewide SFY2006 Figures

Figure III Average Dollars Spent per SoonerCare Enrollee per Month



Data is based upon the number of unduplicated members by county for the state fiscal year (July-June).
** Garfield and Garvin counties have public institutions and Craig county has 8 private institutions for the developmentally disabled (ICF/MRs) causing the average dollars per SoonerCare member to be higher than the norm. 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.*

Appendix B Statewide SFY2006 Figures

Figure IV Statewide SoonerCare Figures

County	Population Proj. July 2005*	Rank	Unduplicated Enrollees**	Rank	Pop. Covered by SoonerCare	Rank
ADAIR	22,000	38	7,859	30	35.72%	2
ALFALFA	5,700	68	601	73	10.55%	77
ATOKA	14,500	46	3,768	44	25.99%	21
BEAVER	5,400	70	678	72	12.56%	75
BECKHAM	18,900	42	4,607	40	24.37%	33
BLAINE	12,900	50	2,376	56	18.42%	54
BRYAN	37,800	26	10,300	20	27.25%	19
CADDO	30,200	32	7,661	31	25.37%	26
CANADIAN	98,700	5	12,477	10	12.64%	74
CARTER	47,100	16	11,850	12	25.16%	27
CHEROKEE	44,700	19	11,191	17	25.03%	29
CHOCTAW	15,300	44	5,615	38	36.70%	1
CIMARRON	2,800	77	467	76	16.66%	61
CLEVELAND	224,900	3	30,671	3	13.64%	72
COAL	5,700	68	1,883	64	33.04%	5
COMANCHE	112,400	4	21,477	4	19.11%	52
COTTON	6,600	65	1,287	67	19.50%	49
CRAIG	15,100	45	4,171	42	27.62%	17
CREEK	68,700	9	15,000	7	21.83%	43
CUSTER	25,200	36	5,962	36	23.66%	38
DELAWARE	39,100	25	9,939	21	25.42%	24
DEWEY	4,600	72	710	70	15.44%	64
ELLIS	4,000	73	542	75	13.56%	73
GARFIELD	57,000	12	12,313	11	21.60%	44
GARVIN	27,200	34	6,637	34	24.40%	32
GRADY	49,400	14	9,474	24	19.18%	51
GRANT	4,800	71	691	71	14.40%	68
GREER	5,900	67	1,416	65	23.99%	36
HARMON	3,000	76	937	69	31.24%	7
HARPER	3,300	74	589	74	17.86%	58
HASKELL	12,200	52	3,727	46	30.55%	9
HUGHES	13,800	49	3,771	43	27.33%	18
JACKSON	26,500	35	5,956	37	22.48%	41
JEFFERSON	6,500	66	1,954	63	30.06%	12
JOHNSTON	10,300	59	3,114	52	30.23%	11
KAY	46,500	17	11,670	15	25.10%	28
KINGFISHER	14,300	48	2,079	62	14.54%	66
KIOWA	9,800	60	2,330	57	23.77%	37
LATIMER	10,600	58	2,720	54	25.66%	23
LEFLORE	49,500	13	14,018	8	28.32%	16

*Source: Population Division, US Census Bureau. Estimates rounded to nearest 100. http://www.odoc.state.ok.us/index.html **Enrollees listed above are the unduplicated count per last county on enrollee record for the entire state fiscal year (July-June).

Appendix B Statewide SFY2006 Figures (continued)

Figure IV Statewide SoonerCare Figures

County	Expenditures	Rank	Annual Per Capita	Rank	Monthly Per Enrollee	Rank
ADAIR	$24,876,577	32	$1,131	16	$264	64
ALFALFA	$2,034,444	74	$357	75	$282	61
ATOKA	$11,764,757	51	$811	44	$260	70
BEAVER	$1,804,373	75	$334	76	$222	75
BECKHAM	$19,733,547	41	$1,044	23	$357	17
BLAINE	$8,212,300	58	$637	57	$288	56
BRYAN	$39,767,057	22	$1,052	22	$322	32
CADDO	$25,065,519	31	$830	39	$273	63
CANADIAN	$43,869,399	15	$444	73	$293	46
CARTER	$44,343,862	14	$941	30	$312	34
CHEROKEE	$44,649,463	13	$999	27	$332	27
CHOCTAW	$23,867,279	35	$1,560	5	$354	19
CIMARRON	$1,173,639	77	$419	74	$210	76
CLEVELAND	$107,080,029	3	$476	70	$291	50
COAL	$8,138,318	60	$1,428	7	$360	15
COMANCHE	$63,441,530	6	$564	63	$246	74
COTTON	$4,722,166	67	$715	51	$306	39
CRAIG ‡	$24,468,025	33	$1,620	4	$489	3
CREEK	$60,761,873	8	$884	36	$338	23
CUSTER	$20,621,781	39	$818	42	$288	55
DELAWARE	$30,865,275	29	$789	46	$259	71
DEWEY	$3,774,288	70	$820	41	$443	5
ELLIS	$2,054,557	73	$514	69	$316	33
GARFIELD ‡	$86,947,018	4	$1,525	6	$588	2
GARVIN ‡	$61,307,951	7	$2,254	1	$770	1
GRADY	$29,874,432	30	$605	60	$263	66
GRANT	$3,278,424	71	$683	54	$395	9
GREER	$5,897,108	65	$1,000	26	$347	21
HARMON	$4,967,772	66	$1,656	3	$442	6
HARPER	$2,197,592	72	$666	55	$311	36
HASKELL	$12,952,828	47	$1,062	20	$290	52
HUGHES	$19,418,959	42	$1,407	8	$429	8
JACKSON	$18,758,238	43	$708	53	$262	68
JEFFERSON	$6,648,572	62	$1,023	24	$284	60
JOHNSTON	$12,037,192	50	$1,169	14	$322	31
KAY	$35,438,566	24	$762	47	$253	73
KINGFISHER	$7,658,956	61	$536	65	$307	38
KIOWA	$10,366,632	55	$1,058	21	$371	13
LATIMER	$9,421,177	56	$889	35	$289	54
LEFLORE	$50.262.717	10	$1.015	25	$299	44

‡Garfield and Garvin counties have public institutions and Craig county has 8 private institutions for the developmentally disabled (ICF/MRs) causing the average dollars per SoonerCare enrollee to be higher than the norm. 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. Non-member specific payments include $96,692,889 in Medicare Part A & B (Buy-In) payments; $20,493,119 in Medicare Part D (clawback) payments; $92,990,352 in Hospital Supplemental payments; $55,717,767 in GME payments to medical schools; $6,623,270 in Public ICF/MR cost settlements; $1,213,800 in FQHC wrap-around payments; $610,180 for O-EPIC premiums and ($5,858,351) in non-member specific claim adjustments.

Appendix B Statewide SFY2006 Figures (continued)

Figure IV Statewide SoonerCare Figures (continued)

County	Population Proj. July 2005*	Rank	Unduplicated Enrollees**	Rank	Pop. Covered by SoonerCare	Rank
LINCOLN	32,300	31	6,381	35	19.76%	48
LOGAN	36,900	27	6,737	33	18.26%	56
LOVE	9,100	61	2,184	60	24.00%	35
MCCLAIN	30,100	33	4,335	41	14.40%	69
MCCURTAIN	34,000	29	11,737	14	34.52%	3
MCINTOSH	20,000	40	5,146	39	25.73%	22
MAJOR	7,400	64	1,045	68	14.12%	71
MARSHALL	14,500	46	3,583	48	24.71%	30
MAYES	39,500	24	9,653	22	24.44%	31
MURRAY	12,900	50	2,995	53	23.22%	40
MUSKOGEE	70,600	7	19,162	5	27.14%	20
NOBLE	11,200	56	2,162	61	19.30%	50
NOWATA	10,900	57	2,270	58	20.82%	47
OKFUSKEE	11,400	55	3,620	47	31.75%	6
OKLAHOMA	684,500	1	143,042	1	20.90%	46
OKMULGEE	39,700	23	11,792	13	29.70%	14
OSAGE	45,400	18	6,981	32	15.38%	65
OTTAWA	32,900	30	9,653	22	29.34%	15
PAWNEE	16,900	43	3,751	45	22.19%	42
PAYNE	69,200	8	11,142	18	16.10%	62
PITTSBURG	44,600	20	10,482	19	23.50%	39
PONTOTOC	35,300	28	8,959	27	25.38%	25
POTTAWATOMIE	68,300	10	16,547	6	24.23%	34
PUSHMATAHA	11,700	53	3,511	51	30.01%	13
ROGER MILLS	3,300	74	357	77	10.81%	76
ROGERS	80,800	6	11,657	16	14.43%	67
SEMINOLE	24,800	37	8,465	29	34.13%	4
SEQUOYAH	40,900	22	12,489	9	30.54%	10
STEPHENS	42,900	21	9,009	26	21.00%	45
TEXAS	20,100	39	3,537	49	17.60%	59
TILLMAN	8,500	62	2,599	55	30.57%	8
TULSA	572,100	2	102,489	2	17.91%	57
WAGONER	64,200	11	9,169	25	14.28%	70
WASHINGTON	49,100	15	8,587	28	17.49%	60
WASHITA	11,500	54	2,190	59	19.04%	53
WOODS	8,500	62	1,324	66	15.57%	63
WOODWARD	19,100	41	3,516	50	18.41%	55
Other⁂	0		5,406			
TOTAL	**3,548,00**		**742,152**		**20.92%**	

*Source: Population Division, US Census Bureau. Estimates rounded to nearest 100. http://www.odoc.state.ok.us/index.html **Enrollees listed above are the unduplicated count per last county on enrollee record for the entire state fiscal year (July-June). ⁂OTHER could include state custody children or out of state enrollees.

Appendix B Statewide SFY2006 Figures

Figure IV Statewide SoonerCare Figures

County	Expenditures	Rank	Annual Per Capita	Rank	Monthly Per Enrollee	Rank
LINCOLN	$20,124,199	40	$623	59	$263	65
LOGAN	$23,250,798	36	$630	58	$288	57
LOVE	$6,633,909	63	$729	49	$253	72
MCCLAIN	$13,663,857	46	$454	72	$263	67
MCCURTAIN	$42,196,122	17	$1,241	11	$300	43
MCINTOSH	$22,433,225	37	$1,122	17	$363	14
MAJOR	$3,902,126	69	$527	67	$311	35
MARSHALL	$12,743,941	48	$879	37	$296	45
MAYES	$35,654,932	23	$903	34	$308	37
MURRAY	$10,506,698	53	$814	43	$292	48
MUSKOGEE	$82,218,254	5	$1,165	15	$358	16
NOBLE	$11,166,289	52	$997	28	$430	7
NOWATA	$9,107,836	57	$836	38	$334	25
OKFUSKEE ‡	$20,989,603	38	$1,841	2	$483	4
OKLAHOMA	$491,396,397	1	$718	50	$286	58
OKMULGEE	$47,330,183	11	$1,192	12	$334	24
OSAGE	$24,373,399	34	$537	64	$291	51
OTTAWA	$35,020,992	25	$1,064	19	$302	41
PAWNEE	$15,721,776	44	$930	32	$349	20
PAYNE	$40,531,744	21	$586	61	$303	40
PITTSBURG	$41,720,859	18	$935	31	$332	28
PONTOTOC	$41,666,993	19	$1,180	13	$388	12
POTTAWATOMIE	$54,311,171	9	$795	45	$274	62
PUSHMATAHA	$14,610,863	45	$1,249	10	$347	22
ROGER MILLS	$1,522,019	76	$461	71	$356	18
ROGERS	$46,326,192	12	$573	62	$331	29
SEMINOLE	$33,878,859	26	$1,366	9	$334	26
SEQUOYAH	$43,819,073	16	$1,071	18	$292	47
STEPHENS	$31,492,295	28	$734	48	$291	49
TEXAS	$6,306,945	64	$314	77	$149	77
TILLMAN	$8,175,389	59	$962	29	$262	69
TULSA	$405,966,241	2	$710	52	$330	30
WAGONER	$33,111,053	27	$516	68	$301	42
WASHINGTON	$40,628,757	20	$827	40	$394	11
WASHITA	$10,382,401	54	$903	33	$395	10
WOODS	$4,510,999	68	$531	66	$284	59
WOODWARD	$12,219,252	49	$640	56	$290	53
Other⁂	$283,640,819				$4,372	
TOTAL	**$3,077,780,653**		**$867**		**$346**	

‡ *Okfuskee County and Craig County have private institutions, and Garfield and Garvin counties have public institutions for the developmentally disabled (ICF/MRs) causing the average dollars per SoonerCare member to be higher than the norm.* ⁂*OTHER includes state custody children (15,157,793), out of state providers ($104,219,333) and any non-provider or non-member specific payments. Non-member or non-provider specific payments include $96,692,889 in Medicare Part A & B (Buy-In) payments; $20,493,119 in Medicare Part D (clawback) payments; $92,990,352 in Hospital Supplemental payments; $55,717,767 in GME payments to medical schools; $6,623,270 in Public ICF/MR cost settlements; $1,213,800 in FQHC wrap-around payments; $610,180 for O-EPIC premiums and ($5,858,351) in non-member specific claim adjustments. 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.*

Appendix B Statewide SFY2006 Figures

Figure V Dollars Paid to Providers and Members by County in SFY2006

County	Total Dollars Paid by Provider County	Total Dollars Paid by Member County	% of Dollars Staying in County
ADAIR	$10,855,124	$24,876,577	43.6%
ALFALFA	$1,280,155	$2,034,444	62.9%
ATOKA	$5,685,111	$11,764,757	48.3%
BEAVER	$1,121,723	$1,804,373	62.2%
BECKHAM	$15,996,015	$19,733,547	81.1%
BLAINE	$4,227,279	$8,212,300	51.5%
BRYAN	$46,959,043	$39,767,057	118.1%
CADDO	$16,738,200	$25,065,519	66.8%
CANADIAN	$25,886,978	$43,869,399	59.0%
CARTER	$38,631,874	$44,343,862	87.1%
CHEROKEE	$42,581,899	$44,649,463	95.4%
CHOCTAW	$13,816,010	$23,867,279	57.9%
CIMARRON	$584,706	$1,173,639	49.8%
CLEVELAND	$84,780,996	$107,080,029	79.2%
COAL	$3,646,693	$8,138,318	44.8%
COMANCHE	$60,859,393	$63,441,530	95.9%
COTTON	$2,259,235	$4,722,166	47.8%
CRAIG	$20,277,623	$24,468,025	82.9%
CREEK	$43,717,702	$60,761,873	71.9%
CUSTER	$17,742,233	$20,621,781	86.0%
DELAWARE	$17,800,862	$30,865,275	57.7%
DEWEY	$2,480,965	$3,774,288	65.7%
ELLIS	$1,582,969	$2,054,557	77.0%
GARFIELD	$80,228,760	$86,947,018	92.3%
GARVIN	$48,475,244	$61,307,951	79.1%
GRADY	$17,780,794	$29,874,432	59.5%
GRANT	$1,829,395	$3,278,424	55.8%
GREER	$3,349,805	$5,897,108	56.8%
HARMON	$3,729,197	$4,967,772	75.1%
HARPER	$1,802,669	$2,197,592	82.0%
HASKELL	$14,718,935	$12,952,828	113.6%
HUGHES	$8,902,554	$19,418,959	45.8%
JACKSON	$14,286,843	$18,758,238	76.2%
JEFFERSON	$3,537,379	$6,648,572	53.2%
JOHNSTON	$7,008,538	$12,037,192	58.2%
KAY	$26,714,483	$35,438,566	75.4%
KINGFISHER	$7,934,812	$7,658,956	103.6%
KIOWA	$9,773,491	$10,366,632	94.3%
LATIMER	$4,980,658	$9,421,177	52.9%
LEFLORE	$33,264,039	$50,262,717	66.2%

Appendix B Statewide SFY2006 Figures (continued)

Figure V Dollars Paid to Providers and Members by County in SFY2006 (continued)

County	Total Dollars Paid by Provider County	Total Dollars Paid by Member County	% of Dollars Staying in County
LINCOLN	$10,398,187	$20,124,199	51.7%
LOGAN	$13,642,150	$23,250,798	58.7%
LOVE	$2,881,650	$6,633,909	43.4%
MCCLAIN	$9,076,906	$13,663,857	66.4%
MCCURTAIN	$25,504,311	$42,196,122	60.4%
MCINTOSH	$21,728,402	$22,433,225	96.9%
MAJOR	$2,829,417	$3,902,126	72.5%
MARSHALL	$8,765,835	$12,743,941	68.8%
MAYES	$18,319,793	$35,654,932	51.4%
MURRAY	$5,675,797	$10,506,698	54.0%
MUSKOGEE	$75,244,304	$82,218,254	91.5%
NOBLE	$7,553,844	$11,166,289	67.6%
NOWATA	$5,263,581	$9,107,836	57.8%
OKFUSKEE	$14,498,979	$20,989,603	69.1%
OKLAHOMA	$709,238,622	$491,396,397	144.3%
OKMULGEE	$30,560,297	$47,330,183	64.6%
OSAGE	$6,007,518	$24,373,399	24.6%
OTTAWA	$30,362,038	$35,020,992	86.7%
PAWNEE	$9,755,087	$15,721,776	62.0%
PAYNE	$32,829,685	$40,531,744	81.0%
PITTSBURG	$36,317,050	$41,720,859	87.0%
PONTOTOC	$43,305,479	$41,666,993	103.9%
POTTAWATOMIE	$35,408,286	$54,311,171	65.2%
PUSHMATAHA	$14,474,772	$14,610,863	99.1%
ROGER MILLS	$232,015	$1,522,019	15.2%
ROGERS	$33,415,949	$46,326,192	72.1%
SEMINOLE	$24,350,820	$33,878,859	71.9%
SEQUOYAH	$40,060,193	$43,819,073	91.4%
STEPHENS	$24,857,084	$31,492,295	78.9%
TEXAS	$5,453,028	$6,306,945	86.5%
TILLMAN	$7,131,370	$8,175,389	87.2%
TULSA	$568,281,906	$405,966,241	140.0%
WAGONER	$10,196,120	$33,111,053	30.8%
WASHINGTON	$29,521,262	$40,628,757	72.7%
WASHITA	$4,585,229	$10,382,401	44.2%
WOODS	$3,257,262	$4,510,999	72.2%
WOODWARD	$10,405,365	$12,219,252	85.2%
Other⁂	$378,560,674	$283,640,819	
TOTAL	**$3,077,780,653**	**$3,077,780,653**	**Avg .72%**

⁂OTHER could include state custody children (15,157,793), out of state providers ($104,219,333) and any non-provider or non-member specific payments. Non-member or non-provider specific payments include $96,692,889 in Medicare Part A & B (Buy-In) payments; $20,493,119 in Medicare Part D (clawback) payments; $92,990,352 in Hospital Supplemental payments; $55,717,767 in GME payments to medical schools; $6,623,270 in Public ICF/MR cost settlements; $1,213,800 in FQHC wrap-around payments; $610,180 for O-EPIC premiums and ($5,858,351) in non-member specific claim adjustments. 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.

Appendix B Statewide SFY2006 Figures (continued)

Figure VI Expenditures by Service Type Totals

SFY2006 Service Type	Expenditures	Members Served*	Avg. per Member Served
Adult Day Care Services	$2,217,494	561	$3,953
Adv Comp Health Services	$54,204,309	11,993	$4,520
Advanced Practice Nurse (APN) Services	$2,078,426	16,621	$125
ADvantage Home Delivered Meals Services	$6,006,560	8,447	$711
Ambulatory Surgical Services	$4,167,091	11,124	$375
Architectural Modification Services	$519,551	246	$2,112
Audiology Services	$102,897	1,085	$95
Behavioral Health Services	$52,468,558	39,098	$1,342
Capitation (CAP) Services	$84,444,262	546,518	$155
Capitation (CAP) Services - GME to Medical Schools	$55,717,767	-	$0
Chiropractic Services	$14,298	219	$65
Clinic Services	$10,870,003	37,010	$294
Clinics - OSA Services	$7,085,395	81,703	$87
Community Mental Health	$37,288,535	18,539	$2,011
Dental Services	$98,993,524	192,355	$515
Direct Support Services	$167,316,149	4,233	$39,527
Employee Training Specialist Services	$22,744,649	2,572	$8,843
End Stage Renal Disease (ESRD) Services	$11,493,132	1,700	$6,761
Eye Care and Exam Services	$5,303,315	69,355	$76
Eyewear Services	$6,035,979	53,564	$113
Free Standing Birthing Center Services	$51,839	63	$823
Group Home Services	$14,359,180	578	$24,843
Home Health (HH) Services	$12,459,055	6,600	$1,888
Homemaker Services	$757,752	286	$2,649
Hospice Services	$604,058	52	$11,616
HSP - Indirect Medical Education (IME)	$25,077,370	-	$0
HSP - Graduate Medical Education (GME)	$26,056,562	-	$0
HSP - Acute DSH	$31,190,420	-	$0
HSP - Upper Payment Limit	$10,666,000	-	$0
ICF-MR Services	$123,970,611	1,857	$66,759
Inpatient Services	$470,030,099	118,701	$3,960
Laboratory Services	$14,790,367	149,920	$99

Appendix B Statewide SFY2006 Figures (continued)

Figure VI Expenditures by Service Type Totals (continued)

SFY2006 Service Type	Expenditures	Members Served*	Avg. per Member Served
Medicare Part A & B (Buy-In) Payments	$96,692,889	-	$0
Medicare Part D Payments	$20,493,119	-	$0
Mid Level Practitioner (MLP) Services	$232,131	3,154	$74
Medical Supplies/Durable Goods	$62,160,996	66,123	$940
Non-Emergency Transportation (NET)	$17,054,758	665,304	$26
Nursing Home Services	$438,498,446	22,280	$19,681
Nursing Services	$25,443,484	6,928	$3,673
Nutritionist Services	$390,952	676	$578
O-EPIC Out-of-Pocket	$6,481	-	$0
O-EPIC Premium	$610,180	-	$0
Outpatient Services	$151,447,055	359,107	$422
Personal Care Services	$35,316,690	18,462	$1,913
Physician Services	$281,227,252	491,900	$572
Podiatry Services	$689,912	4,597	$150
Prescribed Drugs Services	$392,853,727	473,455	$830
Prosthetic/Orthotic Services	$1,009,782	1,014	$996
Psychiatric Services	$67,493,452	4,266	$15,821
Residential Behavior Management	$31,763,812	3,074	$10,333
Respite Care Services	$374,142	116	$3,225
Room and Board Services	$158,290	679	$233
School Based Services	$5,695,341	13,817	$412
Specialized Foster Care/MR Services	$3,227,797	273	$11,823
Targeted Case Manager (TCM) Services	$51,970,544	37,290	$1,394
Therapy Services	$1,951,564	1,320	$1,478
Transportation Services	$24,149,209	58,429	$413
X-Ray Services	$2,326,995	31,919	$73
Unknown Services by Claim Type	$5,456,442	20,532	$266
TOTAL	**$3,077,780,653**	**727,224**	**$4,232**

Source: OHCA Financial Service Division, November 2006. 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 service type category.*

Appendix B Statewide SFY2006 Figures (continued)

Figure VII Expenditures by Service Type Percent Change SFY2005 vs. SFY2006

	SFY2005			SFY2006			Percent Change		
Type of Service	Expenditures	Members*	Avg.	Expenditures	Members*	Avg.	Expenditures	Members*	Avg.
Adult Day Care	$993,631	378	$2,629	$2,217,494	561	$3,953	123%	48%	50%
ADv Comp Health	$33,991,417	10,230	$3,323	$54,204,309	11,993	$4,520	59%	17%	36%
Advanced Practice Nurse	$1,952,861	15,231	$128	$2,078,426	16,621	$125	6%	9%	-2%
ADvantage Home Delivered Meals	$3,408,517	6,235	$547	$6,006,560	8,447	$711	76%	35%	30%
Ambulatory Surgery	$2,600,165	9,575	$272	$4,167,091	11,124	$375	60%	16%	38%
Architectural Modification	$527,110	250	$2,108	$519,551	246	$2,112	-1%	-2%	0%
Audiology	$96,464	802	$120	$102,897	1,085	$95	7%	35%	-21%
Behavioral Health	$60,642,885	49,436	$1,227	$52,468,558	39,098	$1,342	-13%	-21%	9%
Capitation (CAP)	$84,746,538	531,023	$160	$84,444,262	546,518	$155	0%	3%	-3%
Capitation (CAP) - GME	$51,212,519	-	$0	$55,717,767	-		9%	0%	0%
Chiropractic	$6,812	190	$36	$14,298	219	$65	110%	15%	82%
Clinic	$7,404,196	32,438	$228	$10,870,003	37,010	$294	47%	14%	29%
Clinics - OSA Services	$3,491,967	47,436	$74	$7,085,395	81,703	$87	103%	72%	18%
Community Mental Health	$25,222,593	17,949	$1,405	$37,288,535	18,539	$2,011	48%	3%	43%
Dental	$79,307,833	195,178	$406	$98,993,524	192,355	$515	25%	-1%	27%
Direct Support	$154,721,285	3,715	$41,648	$167,316,149	4,233	$39,527	8%	14%	-5%
Employee Training Specialist	$20,531,072	2,314	$8,873	$22,744,649	2,572	$8,843	11%	11%	0%
End Stage Renal Disease	$8,913,829	1,694	$5,262	$11,493,132	1,700	$6,761	29%	0%	28%
Eye Care and Exams	$4,404,264	73,617	$60	$5,303,315	69,355	$76	20%	-6%	28%
Eyewear	$6,049,607	55,726	$109	$6,035,979	53,564	$113	0%	-4%	4%
Free Standing Birthing Center	$60,254	70	$861	$51,839	63	$823	-14%	-10%	-4%
Group Home	$12,405,374	526	$23,584	$14,359,180	578	$24,843	16%	10%	5%
Home Health	$10,628,104	5,652	$1,880	$12,459,055	6,600		17%	17%	0%
Homemaker	$804,100	304	$2,645	$757,752	286	$2,649	-6%	-6%	0%
Hospice	$276,731	32	$8,648	$604,058	52	$11,616	118%	63%	34%
HSP - Indirect Medical Education (IME)	$24,136,338	-	$0	$25,077,370	-	$0	4%	0%	0%
HSP - Graduate Medical Education (GME)	$55,560,029	-	$0	$26,056,562	-	$0	-53%	0%	0%
HSP - Acute DSH	$31,175,702	-	$0	$31,190,420	-	$0	0%	0%	0%
HSP - Upper Payment Limit	$36,815,721	-	$0	$10,666,000	-	$0	-71%	0%	0%
ICF-MR Services	$113,132,664	1,950	$58,017	$123,970,611	1,857	$66,759	10%	-5%	15%
Inpatient	$354,090,639	116,045	$3,051	$470,030,099	118,701	$3,960	33%	2%	30%
Laboratory	$11,000,199	141,700	$78	$14,790,367	149,920	$99	34%	6%	27%
Medicare Part A & B (Buy-In) Payments	$81,270,142	-	$0	$96,692,889	-	$0	19%	0%	0%

Appendix B Statewide SFY2006 Figures (continued)

Figure VII Expenditures by Service Type Percent Change SFY2005 vs. SFY2006 (continued)

	SFY2005			SFY2006			Percent Change		
Type of Service	Expenditures	Members*	Avg.	Expenditures	Members*	Avg.	Expenditures	Members*	Avg.
Medicare Part D Payments	$0	-	$0	$20,493,119	-	$0	0%	0%	0%
Mid Level Practitioner	$360,844	6,052	$60	$232,131	3,154	$74	-36%	-48%	23%
Medical Supplies/ Durable Goods	$47,695,645	61,541	$775	$62,160,996	66,123	$940	30%	7%	21%
Non-Emergency Transportation (NET)	$15,061,074	647,563	$23	$17,054,758	665,304	$26	13%	3%	10%
Nursing Home	$448,632,220	22,705	$19,759	$438,498,446	22,280	$19,681	-2%	-2%	0%
Nursing	$16,416,360	6,460	$2,541	$25,443,484	6,928	$3,673	55%	7%	45%
Nutritionist	$280,604	709	$396	$390,952	676	$578	39%	-5%	46%
O-EPIC Out-of-Pocket**	$0	-	$0	$6,481	-	$0	0%	0%	0%
O-EPIC Premium**	$0	-	$0	$610,180	-	$0	0%	0%	0%
Outpatient	$89,756,261	338,475	$265	$151,447,055		$422	69%	6%	59%
Personal Care	$47,632,559	18,425	$2,585	$35,316,690	18,462	$1,913	-26%	0%	-26%
Physician Services	$224,369,524	401,868	$558	$281,227,252		$572	25%	22%	2%
Podiatry	$434,321	3,942	$110	$689,912	4,597	$150	59%	17%	36%
Prescribed Drugs	$466,791,681	456,667	$1,022	$392,853,727	473,455	$830	-16%	4%	-19%
Prosthetic/Orthotic	$880,677	1,088	$809	$1,009,782	1,014	$996	15%	-7%	23%
Psychiatric	$62,567,420	4,468	$14,003	$67,493,452	4,266	$15,821	8%	-5%	13%
Residential Behavior Management	$32,172,411	3,008	$0	$31,763,812	3,074	$10,333	-1%	2%	0%
Respite Care	$232,074	108	$2,149	$374,142	116	$3,225	61%	7%	50%
Room and Board	$157,895	611	$258	$158,290	679	$233	0%	11%	-10%
School Based	$5,551,722	12,997	$427	$5,695,341	13,817	$412	3%	6%	-4%
Specialized Foster Care/ MR	$3,251,128	263	$12,362	$3,227,797	273	$11,823	-1%	4%	-4%
Targeted Case Manager	$40,273,962	34,848	$1,156	$51,970,544	37,290	$1,394	29%	7%	21%
Therapy	$1,822,972	1,507	$1,210	$1,951,564	1,320	$1,478	7%	-12%	22%
Transportation	$16,415,576	37,095	$443	$24,149,209	58,429	$413	47%	58%	-7%
X-Ray	$1,329,616	34,530	$39	$2,326,995	31,919	$73	75%	-8%	89%
Unknown	$1,960,865	19,000	$103	$5,456,442	20,532	$266	178%	8%	158%
TOTAL	**$2,805,628,974**	**687,464**	**$4,081**	**$3,077,780,653**	**727,224**	**$4,232**	**10%**	**6%**	**4%**

Source: OHCA Financial Service Division, November 2006. 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 service type category.*

Appendix B Statewide SFY2006 Figures (continued)

Figure VIII Expenditures by Service Type and by Aid Category

Category of Service (Totals pages 78-79)	Aged	Blind/ Disabled	TANF/ Poverty Related	Breast & Cervical Cancer	Family Planning Waiver	TEFRA	Other*
Adult Day Care	$1,453,963	$763,530	$0	$0	$0	$0	$0
ADv Comp Health	$33,928,354	$20,275,955	$0	$0	$0	$0	$0
Advanced Practice Nurse	$34,476	$264,096	$1,728,192	$25,230	$26,202	$0	$230
ADvantage Home Delivered Meals	$3,664,175	$2,342,385	$0	$0	$0	$0	$0
Ambulatory Surgery	$528,614	$989,689	$2,523,545	$69,480	$55,489	$0	$274
Architectural Modification	$65,080	$454,471	$0	$0	$0	$0	$0
Audiology	$454	$27,491	$74,864	$89	$0	$0	$0
Behavioral Health	$1,003,655	$18,480,236	$32,934,606	$45,609	$0	$866	$3,587
Capitation (CAP)	$71,207	$11,640,600	$72,597,920	$130,270	$0	$4,600	-$335
Capitation (CAP) - GME	$0	$0	$0	$0	$0	$0	$55,717,767
Chiropractic	$7,008	$7,254	$37	$0	$0	$0	$0
Clinic	$894,687	$2,490,121	$6,988,672	$179,839	$314,848	$0	$1,835
Clinics - OSA Services	$6,781	$576,172	$4,373,422	$103,069	$2,000,576	$24,371	$1,004
Community Mental Health	$1,131,512	$25,494,332	$10,612,351	$42,569	$0	$0	$7,770
Dental	$476,548	$6,388,606	$91,991,512	$111,646	$0	$1,412	$23,801
Direct Support	$1,901,489	$165,414,660	$0	$0	$0	$0	$0
Employee Training Specialist	$296,956	$22,447,693	$0	$0	$0	$0	$0
End Stage Renal Disease	$1,801,711	$9,515,778	$175,643	$0	$0	$0	$0
Eye Care and Exams	$184,573	$579,446	$4,526,206	$10,836	$148	$206	$1,900
Eyewear	$20,316	$421,368	$5,587,573	$3,542	$0	$947	$2,233
Free Standing Birthing Center	$686	$0	$51,153	$0	$0	$0	$0
Group Home	$399,834	$13,959,347	$0	$0	$0	$0	$0
Home Health	$286,161	$8,793,801	$3,237,367	$26,914	$0	$114,774	$39
Homemaker	$797	$756,956	$0	$0	$0	$0	$0
Hospice	$1,742	$602,316	$0	$0	$0	$0	$0
HSP - Indirect Medical Education (IME)	$0	$0	$0	$0	$0	$0	$25,077,370
HSP - Graduate Medical Education (GME)	$0	$0	$0	$0	$0	$0	$26,056,562
HSP - Acute DSH	$0	$0	$0	$0	$0	$0	$31,190,420
HSP - Upper Payment Limit	$0	$0	$0	$0	$0	$0	$10,666,000
ICF-MR Services	$5,546,715	$118,326,445	$97,451	$0	$0	$0	$0
Inpatient	$21,815,357	$169,010,914	$275,490,705	$3,623,731	$986	$11,816	$76,589
Laboratory	$209,387	$2,406,095	$11,542,212	$302,247	$325,017	$586	$4,823

Appendix B Statewide SFY2006 Figures (continued)

Figure VIII Expenditures by Service Type and by Aid Category (continued)

Category of Service (Totals pages 78-79)	Aged	Blind/ Disabled	TANF/ Poverty Related	Breast & Cervical Cancer	Family Planning Waiver	TEFRA	Other
Medicare Part A & B (Buy-In) Payments	$96,692,889	$0	$0	$0	$0	$0	$0
Medicare Part D Payments	$20,493,119	$0	$0	$0	$0	$0	$0
Mid Level Practitioner	$976	$44,503	$182,789	$2,187	$1,664	$0	$13
Medical Supplies/ Durable Goods	$14,374,543	$34,847,286	$12,871,475	$57,446	$295	$9,784	$167
Non-Emergency Transportation (NET)	$1,586,638	$2,615,306	$12,785,569	$64,429	$0	$624	$2,194
Nursing Home	$344,436,120	$93,550,052	$492,431	$19,843	$0	$0	$0
Nursing	$13,215,260	$12,228,224	$0	$0	$0	$0	$0
Nutritionist	$8,176	$381,636	$1,140	$0	$0	$0	$0
O-EPIC Out-of-Pocket**	$0	$0	$0	$0	$0	$0	$6,481
O-EPIC Premium**	$0	$0	$0	$0	$0	$0	$610,180
Outpatient	$7,616,423	$37,005,277	$102,990,471	$3,413,067	$388,249	$2,638	$30,931
Personal Care	$19,738,325	$15,504,555	$73,810	$0	$0	$0	$0
Physician Services	$16,744,841	$79,784,753	$175,620,383	$8,554,235	$462,030	$11,341	$49,669
Podiatry	$98,338	$313,386	$273,444	$4,696	$0	$0	$48
Prescribed Drugs	$70,296,259	$192,565,827	$127,748,073	$1,898,410	$260,337	$51,128	$33,694
Prosthetic/Orthotic	$118,987	$632,811	$257,931	$0	$0	$52	$0
Psychiatric	$468,634	$12,405,911	$54,593,313	$5,452	$0	$0	$20,143
Residential Behavior Management	$39,672	$559,455	$31,144,720	$0	$0	$0	$19,966
Respite Care	$103,906	$270,236	$0	$0	$0	$0	$0
Room and Board	$487	$21,828	$133,135	$2,840	$0	$0	$0
School Based	$263	$2,603,488	$3,084,940	$140	$0	$6,511	$0
Specialized Foster Care/MR	$0	$3,227,797	$0	$0	$0	$0	$0
Targeted Case Manager	$6,924,972	$25,721,693	$19,313,096	$543	$1,511	$257	$8,473
Therapy	$14,778	$1,533,562	$402,525	$0	$0	$698	$0
Transportation	$1,918,728	$13,684,387	$8,477,809	$65,888	$0	$0	$2,398
X-Ray	$272,568	$766,268	$1,185,855	$102,251	$0	$15	$39
Unknown	$130,510	$1,091,457	$3,434,744	$148,328	$631	$0	$650,772
Grand Total	**$691,027,651**	**$1,133,789,451**	**$1,079,601,082**	**$19,014,825**	**$3,837,984**	**$242,625**	**$150,267,036**
Members Served*	**58,733**	**96,993**	**557,135**	**5,984**	**23,009**	**73**	

Source: OHCA Financial Service Division, November 2006. 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 service type category. **O-EPIC figures are included in the Other category, O-EPIC dollars are represented in only to these two categories of service.*

Appendix B Statewide SFY2006 Figures (continued)

Figure IX Adult and Children Expenditures by Service Type

SFY2006	Adult Totals			Children Totals		
Service Type	Expenditures	Members Served*	Avg. per Adult	Expenditures	Members Served*	Avg. per Child
Adult Day Care Services	$2,187,083	552	$3,962	$30,411	9	$3,379
Adv Comp Health Services	$54,204,309	11,993	$4,520	$0	-	$0
Advanced Practice Nurse (APN)	$935,090	6,483	$144	$1,143,336	10,138	$113
ADvantage Home Delivered Meals	$6,006,560	8,447	$711	$0	-	$0
Ambulatory Surgical Services	$1,966,867	6,456	$305	$2,200,225	4,668	$471
Architectural Modification	$447,357	221	$2,024	$72,195	25	$2,888
Audiology Services	$5,822	105	$55	$97,075	980	$99
Behavioral Health Services	$18,031,037	10,441	$1,727	$34,437,521	28,657	$1,202
Capitated (CAP) Services	$17,940,220	105,041	$171	$66,504,043	441,477	$151
Capitated (CAP) Services - GME to Medical Schools	$0		$0	$55,717,767	-	$0
Chiropractic Services	$14,298	219	$65	$0	-	$0
Clinic Services	$5,242,217	17,497	$300	$5,627,786	19,513	$288
Clinics - OSA Services	$2,132,346	19,888	$107	$4,953,048	61,815	$80
Community Mental Health	$27,233,920	9,178	$2,967	$10,054,615	9,361	$1,074
Dental Services	$5,234,119	14,081	$372	$93,759,405	178,274	$526
Direct Support Services	$151,775,108	3,221	$47,120	$15,541,041	1,012	$15,357
Employee Training Specialist	$21,981,237	2,428	$9,053	$763,412	144	$5,301
End Stage Renal Disease (ESRD)	$11,409,592	1,683	$6,779	$83,540	17	$4,914
Eye Care and Exam Services	$608,756	8,979	$68	$4,694,559	60,376	$78
Eyewear Services	$62,886	564	$112	$5,973,092	53,000	$113
Free Standing Birthing Center	$36,017	30	$1,201	$15,822	33	$479
Group Home Services	$13,091,231	535	$24,470	$1,267,950	43	$29,487
Home Health (HH) Services	$2,669,861	3,056	$874	$9,789,195	3,544	$2,762
Homemaker Services	$430,274	162	$2,656	$327,478	124	$2,641
Hospice Services	$604,058	52	$11,616	$0	-	$0
Hospital - Indirect Medical Education (IME)	$25,077,370	-	$0	$0	-	$0
Hospital - Graduate Medical Education (GME)	$13,882,863	-	$0	$12,173,699	-	$0
Hospital - Acute DSH	$0	-	$0	$31,190,420	-	$0
Hospital - Upper Payment Limit	$0	-	$0	$10,666,000	-	$0
ICF/MR Services	$120,057,151	1,788	$67,146	$3,913,460	69	$56,717
Inpatient Services	$247,295,278	62,632	$3,948	$222,734,820	56,170	$3,965
Laboratory Services	$7,820,476	59,181	$132	$6,969,891	90,739	$77
Medicare Buy-In Payments	$96,692,889	-	$0	$0	-	$0

Appendix B Statewide SFY2006 Figures (continued)

Figure IX Adult and Children Expenditures by Service Type (continued)

SFY2006	Adult Totals			Children Totals		
Service Type	Expenditures	Members Served*	Avg. per Adult	Expenditures	Members Served*	Avg. per Child
Medicare Part D Payments	$20,493,119	-	$0	$0	-	$0
Mid Level Practitioner (MLP)	$69,213	914	$76	$162,918	2,240	$73
Medical Supplies/Durable Goods	$40,658,041	45,763	$888	$21,502,955	20,360	$1,056
Non-Emergency Transportation (NET) Services	$5,045,603	194,564	$26	$12,009,156	470,740	$26
Nursing Home Services	$437,711,867	22,244	$19,678	$786,580	36	$21,849
Nursing Services	$25,437,364	6,924	$3,674	$6,119	4	$1,530
Nutritionist Services	$381,929	648	$589	$9,024	28	$322
O-EPIC Out-of-Pocket	$6,481	-	$0	$0	-	$0
O-EPIC Premium	$610,180	-	$0	$0	-	$0
Outpatient Services	$66,770,611	130,047	$513	$84,676,443	229,060	$370
Personal Care Services	$34,830,305	18,356	$1,897	$486,386	106	$4,589
Physician Services	$147,795,090	174,912	$845	$133,432,163	316,988	$421
Podiatry Services	$476,772	3,874	$123	$213,140	723	$295
Prescribed Drugs Services	$254,815,225	170,431	$1,495	$138,038,503	303,024	$456
Prosthetic/Orthotic Services	$367,184	635	$578	$642,598	379	$1,696
Psychiatric Services	$508,654	394	$1,291	$66,984,798	3,872	$17,300
Residential Behavior Management Services	$0	-	$0	$31,763,812	3,074	$10,333
Respite Care Services	$334,647	102	$3,281	$39,495	14	$2,821
Room and Board Services	$35,504	183	$194	$122,787	496	$248
School Based Services	$309	2	$155	$5,695,032	13,815	$412
Specialized Foster Care/MR	$1,781,914	141	$12,638	$1,445,883	132	$10,954
Targeted Case Manager (TCM)	$29,412,893	11,836	$2,485	$22,557,652	25,454	$886
Therapy Services	$968,499	873	$1,109	$983,065	447	$2,199
Transportation Services	$16,731,441	41,683	$401	$7,417,768	16,746	$443
X-Ray Services	$1,624,393	15,502	$105	$702,602	16,417	$43
Unknown Services by Claim Type	$2,245,481	5,765	$390	$3,210,961	14,767	$217
TOTAL	**$1,944,189,008**	**238,351**	**$8,157**	**$1,133,591,646**	**494,506**	**$2,292**

Source: OHCA Financial Service Division, November 2006. 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 service type category.*

Appendix B Statewide SFY2006 Figures (continued)

Figure X TANF/Poverty Related Only Adult and Children Expenditures by Service Type

SFY2006—TANF ONLY	Adult TANF Totals			Children TANF Totals		
Service Type	TANF Expenditures	TANF Members Served*	Avg. per TANF Adult	TANF Expenditures	TANF Members Served*	Avg. per TANF Child
Adult Day Care Services			$0			$0
Adv Comp Health Services			$0			$0
Advanced Practice Nurse (APN)	$631,117	3,099	$204	$1,097,075	9,792	$112
ADvantage Home Delivered Meals			$0			$0
Ambulatory Surgical Services	$429,625	857	$501	$2,093,920	4,454	$470
Architectural Modification			$0			$0
Audiology Services	$348	8	$44	$74,516	889	$84
Behavioral Health Services	$2,443,021	3,321	$736	$30,491,585	26,433	$1,154
Capitated (CAP) Services	$9,181,610	68,466	$134	$63,416,310	428,742	$148
Capitated (CAP) Services - GME to Medical Schools			$0			$0
Chiropractic Services	$37	2	$19			$0
Clinic Services	$1,708,758	6,020	$284	$5,279,914	18,444	$286
Clinics - OSA Services	$391,156	5,229	$75	$3,982,266	56,229	$71
Community Mental Health	$1,869,922	2,049	$913	$8,742,429	8,498	$1,029
Dental Services	$1,865,714	5,171	$361	$90,125,798	171,709	$525
Direct Support Services			$0	$0	0	$0
Employee Training Specialist			$0			$0
End Stage Renal Disease (ESRD)	$153,061	40	$3,827	$22,583	6	$3,764
Eye Care and Exam Services	$75,030	668	$112	$4,451,176	57,408	$78
Eyewear Services	$436	8	$55	$5,587,137	49,856	$112
Free Standing Birthing Center	$36,017	30	$1,201	$15,136	31	$488
Group Home Services			$0			$0
Home Health (HH) Services	$243,963	424	$575	$2,993,404	3,183	$940
Homemaker Services			$0	$0	0	$0
Hospice Services			$0			$0
Hospital - Indirect Medical Education (IME)			$0		0	$0
Hospital - Graduate Medical Education (GME)			$0	$0		$0
Hospital - Acute DSH			$0	$0		$0
Hospital - Upper Payment Limit			$0	$0		$0
ICF/MR Services	$16,747	2	$8,374	$80,703	9	$8,967
Inpatient Services	$84,900,061	53,352	$1,591	$190,590,644	384,165	$496
Laboratory Services	$5,047,430	32,835	$154	$6,494,783	86,181	$75
Medicare Buy-In Payments			$0			$0

Appendix B Statewide SFY2006 Figures (continued)

Figure X TANF/Poverty Related Only Adult and Children Expenditures by Service Type (continued)

SFY2006—TANF ONLY	Adult TANF Totals			Children TANF Totals		
Service Type	TANF Expenditures	TANF Members Served*	Avg. per TANF Adult	TANF Expenditures	TANF Members Served*	Avg. per TANF Child
Medicare Part D Payments			$0			$0
Mid Level Practitioner (MLP)	$26,114	355	$74	$156,675	2,154	$73
Medical Supplies/Durable Goods	$1,387,072	2,877	$482	$11,484,403	17,834	$644
Non-Emergency Transportation (NET) Services	$1,240,775	68,654	$18	$11,544,793	456,515	$25
Nursing Home Services	$462,703	89	$5,199	$29,729	3	$9,910
Nursing Services	$737	7	$105			$0
Nutritionist Services			$0	$402	4	$101
O-EPIC Out-of-Pocket			$0			$0
O-EPIC Premium			$0			$0
Outpatient Services	$23,600,807	47,187	$500	$79,389,664	219,373	$362
Personal Care Services	$18,041	21	$859	$55,769	15	$3,718
Physician Services	$55,981,961	61,311	$913	$119,638,422	305,406	$392
Podiatry Services	$75,010	214	$351	$198,434	671	$296
Prescribed Drugs Services	$24,649,623	54,700	$451	$103,098,450	290,980	$354
Prosthetic/Orthotic Services	$188	1	$188	$257,744	210	$1,227
Psychiatric Services	$4,842	9	$538	$54,588,471	3,299	$16,547
Residential Behavior Management Services			$0	$31,144,720	3,008	$10,354
Respite Care Services			$0			$0
Room and Board Services	$26,942	137	$197	$106,193	413	$257
School Based Services			$0	$3,084,940	11,424	$270
Specialized Foster Care/MR			$0	$0	0	$0
Targeted Case Manager (TCM)	$145,066	887	$164	$19,168,030	23,755	$807
Therapy Services	$0	0	$0	$402,525	231	$1,743
Transportation Services	$2,176,845	5,547	$392	$6,300,963	14,519	$434
X-Ray Services	$519,066	5,462	$95	$666,788	15,643	$43
Unknown Services	$725,981	1,492	$487	$2,708,762	13,822	$196
TOTAL	**$220,035,828**	**84,084**	**$2,617**	**$859,565,253**	**476,727**	**$1,803.06**

Source: OHCA Financial Service Division, November 2006. 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 service type category.*

Appendix B Statewide SFY2006 Figures (continued)

Figure XI Home and Community-Based Waiver Expenditures by Service Type

Home and Community-Based Waiver Service Type	ADvantage	Community	Homeward Bound	In-Home Support
Adult Day Care Services	$1,758,772	$271,202	$0	$187,520
Adv Comp Health Services	$54,204,309	$0	$0	$0
ADvantage Home Delivered Meals	$6,006,560	$0	$0	$0
Architectural Modification Services	$93,567	$183,099	$134,906	$107,979
Audiology Services	$0	$761	$649	$0
Behavioral Health Services	$0	$854,548	$416,485	$56,297
Clinic Services	$0	$0	$0	$0
Dental Services	$0	$64,936	$56,703	$6,857
Direct Support Services	$0	$75,570,306	$78,817,201	$12,928,642
Employee Training Specialist	$0	$15,138,885	$5,167,730	$2,438,034
Eye Care and Exam Services	$0	$166	$0	$0
Eyewear Services	$0	$673	$0	$0
Group Home Services	$0	$14,238,460	$120,720	$0
Home Health Services	$0	$27,600	$0	$0
Homemaker Services	$0	$590,733	$12,559	$154,460
Hospice Services	$604,058	$0	$0	$0
MSDG Services	$10,100,173	$1,876,853	$962,649	$724,020
Nursing Home Services	$33,658	$0	$0	$0
Nursing Services	$21,863,658	$1,194,054	$2,385,771	$0
Nutritionist Services	$0	$191,023	$194,772	$1,865
Personal Care Services	$22,194,512	$0	$0	$0
Physician Services	$0	$2,361,167	$1,159,442	$130,535
Prescribed Drugs Services	$5,697,887	$587,105	$892,978	$57,968
Prosthetic/Orthotic Services	$1,365	$0	$0	$0
Respite Care Services	$327,579	$39,536	$0	$7,027
Specialized Foster Care/MR	$0	$3,184,277	$43,520	$0
Targeted Case Manager (TCM)	$10,908,097	$0	$0	$0
Therapy Services	$0	$534,706	$324,347	$83,820
Transportation Services	$0	$3,302,433	$2,685,500	$366,237
Unknown Services by Claim Type	$0	$385	$0	$0
Total	**$133,794,196**	**$120,212,909**	**$93,375,933**	**$17,251,261**
Unduplicated members	**19,174**	**2,595**	**813**	**1,720**
Average cost per member	**$6,978**	**$46,325**	**$114,854**	**$10,030**

Source: OHCA Financial Service Division, November 2006. 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 service type category.*

Appendix B Statewide SFY2006 Figures (continued)

Figure XII Behavioral Health Expenditures by Service Type by Child and Adult

Service Type	Expenditures	Members Served*	Average per Member Served
Behavioral Health Services for Children			
Inpatient (Acute - General)	8,269,044	1,662	$4,975
Inpatient (Acute - Freestanding)	$9,136,235	1,613	$5,664
Psychiatric Residential Treatment Facility (PRTF)	$57,848,563	3,425	$16,890
Outpatient (Private)	$26,241,326	21,925	$1,197
Outpatient - Community Mental Health Center—CMHC (Public)	$4,340,419	4,571	$950
Outpatient - CMHC (Contracted)	$9,685,064	9,361	$1,035
Outpatient - Substance Abuse	$257,718	645	$400
Psychologist	$3,852,655	5,830	$661
Psychiatrist	$1,545,814	4,918	$314
Residential Behavior Management Services (Group)	$9,593,623	1,332	$7,202
Residential Behavior Management Services (TFC)	$22,170,189	2,020	$10,975
Targeted Case Management (TCM)	$123,811	720	$172
Other Outpatient Behavioral Health Services	-	-	-
Children Total (under age 21)	**$153,064,462**	**38,925**	**$3,932**
Behavioral Health Services for Adults			
Inpatient (Acute - General)	$10,179,183	2,370	$4,295
Inpatient (Acute - Freestanding)	$508,654	83	$6,128
Psychiatric Residential Treatment Facility (PRTF)	-	-	-
Outpatient (Private)	$12,930,856	6,185	$2,091
Outpatient - CMHC (Public)	$3,465,278	2,389	$1,451
Outpatient - CMHC (Contracted)	$25,948,146	11,297	$2,297
Outpatient - Substance Abuse	$706,180	1,468	$481
Psychologist	$914,408	1,658	$552
Psychiatrist	$1,602,709	5,842	$274
Residential Behavior Management Services (Group)	-	-	-
Residential Behavior Management Services (TFC)	-	-	-
Targeted Case Management (TCM)	$736,769	3,149	$234
Other Outpatient Behavioral Health Services	$563,321	294	$1,916
Adult Total	**$57,555,504**	**20,592**	**$2,795**
Total All Behavioral Health Services	**$210,619,966**	**59,406**	**$3,545**

Source: OHCA Financial Service Division, November 2006. 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 service type category. Numbers between categories may vary from actuals due to discrepancies in the provider enrollment file.*

Appendix C Contracted SoonerCare Providers

Provider Type	SFY2006
Adult Day Care	36
Advance Practice Nurse	524
Advantage Comprehensive Health Care	32
Advantage Home Delivered Meal	20
Ambulatory Surgical Center (ASC)	64
Audiologist	73
Capitation Provider - IHS Case Manager	23
Case Manager (Targeted)	106
Certified Registered Nurse Anesthetist (CRNA)	564
Chiropractor	47
Clinic - Family Planning Clinic	6
Clinic - Federally Qualified Health Clinic (FQHC)	11
Clinic - Group	2,070
Clinic - Rural Health	66
Clinic - Speech/Hearing Clinic	4
DDSD - Architectural Modification	65
DDSD - Employee Training Specialist	102
DDSD - Homemaker Services	255
DDSD - Non-Federal Medical	737
DDSD - Supportive Living Arrangements	48
DDSD - Volunteer Transportation Provider	341
Dentist	602
Direct Support Services	285
DME/Medical Supply Dealer	1,447
End-Stage Renal Disease Clinic	39
Extended Care Facility - Facility Based Respite Care	97
Extended Care Facility - ICF/MR	66
Extended Care/Skilled Nursing Facilities	344
Free Standing Birthing Center	2

Provider Type	SFY2006
Home Health Agency	182
Hospital - Acute Care	643
Hospital - Critical Access	55
Hospital - Psychiatric	25
Hospital - Residential Treatment Center	43
Laboratory	143
Long Term Care Authority Hospice	19
Mental Health Provider - Counselor	72
Mental Health Provider - Psychologist	318
Mental Health Provider - Social Worker	169
Mid-Level Practitioner	646
Nutritionist	117
Optometrist	442
Outpatient Mental Health Clinic	184
Personal Care Services	37
Pharmacy	916
Physician - Allergist	44
Physician - Anesthesiologist	948
Physician - Cardiologist	595
Physician - General Pediatrician	1,678
Physician - General Practitioner	2,493
Physician - General Surgeon	677
Physician - Internist	1,818
Physician - Obstetrician/ Gynecologist	638
Physician - Other Specialist	3,777
Physician - Radiologist	1,011
Residential Behavior Management Services (RBMS)	18
Respite Care	240
School Corporation	236
Specialized Foster Care/MR	231
Therapist - Physical	284
Therapist - Occupational	148
Therapist - Speech/Hearing	316
Transportation Provider	194
X-Ray Clinic	57
TOTAL	**27,384**

The term "contracted" is defined as a provider that was enrolled with Oklahoma SoonerCare within SFY2006, 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.

Appendix D OHCA Board Approved Rules

July 14, 2005

- Emergency rule to incorporate provisions of the Foster Care Independence Act by providing SoonerCare coverage to children up to age 21 who leave custody on their 18th birthday. (Reference APA WF # 05-07)
  Total annual cost: $1,668,544; State share: $ 500,563
  Effective: September 1, 2005

- Emergency rule to remove deprivation as a condition of qualifying for low-income families to eliminate the marriage penalty so that two-parent households may qualify for SoonerCare. (Reference APA WF # 05-08)
  Annual total cost: $12,718,412; State share: $3,760,834
  Effective: September 1, 2005

- Emergency rule to provide coverage in specific situations to individuals in the custody of the Office of Juvenile Affairs or the Department of Corrections who are admitted as inpatients in a hospital, nursing facility, juvenile psychiatric facility or intermediate care facility. (Reference APA WF # 05-09)
  Budget neutral
  Effective: September 1, 2005

August 24, 2005

- Emergency rule for long-term care facilities to increase the payment for Part A co-insurance for Medicare skilled nursing facilities to 100 percent of the difference between the Medicare allowable and the Medicare payment. (Reference APA WF # 05-12)
  Estimated total cost: $5,700,000; State share: $1,800,000
  Effective: October 3, 2005

- Emergency rule for nurse midwives and advance practice nurses to clarify the requirement that out of state providers are licensed by the state in which they practice. (Reference APA WF # 05-13)
  Budget neutral
  Effective: October 3, 2005

- Emergency rule to bring the scope and payment for ambulance services more in line with current Medicare methods. (Reference APA WF # 05-14)
  Estimated total cost: $8,000,000; State share: $2,600,000
  Effective: October 3, 2005

- Emergency rule to revise hospital reimbursements to adopt use of Diagnosis Related Groups for most inpatient hospital services and to enhance the scope of outpatient hospital services. (Reference APA WF # 05-15)
  Estimated total cost: $117,100,000; State share: $37,400,000
  Effective: October 3, 2005

- Emergency rule to implement the Oklahoma Employer/employee Partnership for Insurance Coverage (O-EPIC) program. (Reference APA WF # 05-16)
  Estimated total cost from October 2005 through June 2006: $58,821,204
  State share: $19,016,326
  Effective: October 3, 2005

Appendix D OHCA Board Approved Rules (continued)

October 13, 2005

- Emergency rule to increase the redetermination period for low-income families with children from 6 to 12 months. (Reference APA WF # 05-18)
  Total initial cost for six months: $6,329,225; State share: $1,501,072
  Effective: December 1, 2005

- Emergency rule to implement a rate increase appropriated by the Legislature for waiver employment services for persons with mental retardation for Developmental Disabilities Services. (Reference APA WF # 05-10)
  Budget neutral
  Effective: December 1, 2005

December 8, 2005

- Emergency rule to reinstate hospital pre-admission procedure language inadvertently removed from rules. (Reference APA WF # 05-21)
  Budget neutral
  Effective: February 1, 2006

- Emergency rule to increase the annual expenditure limits for Individual and group family training services for Developmental Disabilities Services. (Reference APA WF # 05-22)
  Budget neutral to this agency
  Effective: February 1, 2006

- Emergency rule for the Oklahoma Employer/employee Partnership for Insurance Coverage (O-EPIC) program to require: (1) applications to be dated and time stamped by regions; (2) regions to be established based on population density statistics as determined through local and national data and to be periodically adjusted to assure statewide program availability; (3) employers exempt from filing an OES-3 form to verify their employee count; (4) the Qualified Health Plan coverage to begin on the first day of the month and continue through the last day of the month; (5) the employer to notify the TPA of new hires within 30 days of qualifying for the health plan; and (6) the enrollment period to end the last day of the 12th month or when coverage through a health plan requires renewal or an open enrollment period occurs. (Reference APA WF # 05-27)
  Budget neutral
  Effective: February 1, 2006

Dates represent the date of approval by the OHCA board.
APA (Administrative Procedure Act) WF (Work Folder) # (Number) assigned to that particular rule change is the tracking device used in the register for reference purposes.

Appendix D OHCA Board Approved Rules (continued)

January 12, 2006

- Emergency rule to revise appeals rules to: (1) accurately reflect the agency that would hear eligibility appeals for the Oklahoma Employer/employee Partnership for Insurance Coverage program (O-EPIC); (2) relocate appeal language to the appropriate sections of rules; (3) provide clarity to HIPAA appeal language; and (4) correct various rule citations. (Reference APA WF # 05-24)
  Budget neutral
  Effective: March 9, 2006

- Permanent rule to revise Developmental Disabilities Services rules to bring rules in line with current practice to: (1) address situations in which Waiver-funded residential supports can be provided; (2) provide for members who refuse nutrition services and specify requirements for nutrition services for persons not receiving residential supports; (3) govern the provisions of specialized medical supplies; (4) specify requirements for authorization of habilitation training specialist services; (5) clarify requirements for providers of daily living supports services to receive additional staff supports; and (6) cite new rules governing alternative group homes established to implement Senate Bill 1583 and to remove the prohibition on serving persons with pending criminal charges in alternative group homes. (Reference APA WF # 05-19)
  Budget neutral to the agency as well as the Oklahoma Department of Human Services, which pays the state share.
  Effective: May 25, 2006

March 9, 2006

- Permanent rule to revise radiological mammographer rules to remove limited specific codes used by providers when billing for screening and follow-up mammograms. (Reference APA WF # 05-28)
  Budget neutral
  Effective: June 25, 2006

- Permanent rule to remove inconsistencies in language regarding the Preadmission Screening and Resident Review (PASSR) program. (Reference APA WF # 05-45A and 05-45B)
  Budget neutral
  Effective: June 25, 2006

- Permanent rule to revise case management services for under 21 rules to: (1) provide language consistent with the approved Medicaid state plan; (2) require site specific provider numbers; (3) add specific documentation of records requirements to match those of other behavioral health providers; and (4) clarify procedures to providers and remove language that was previously relocated to the provider billing manual. (Reference APA WF # 05-44)
  Budget neutral
  Effective: June 25, 2006

- Permanent rule to revise co-payment rules for Medicare HMO eligible individuals. (Reference APA WF # 05-25)
  Budget neutral
  Effective: June 25, 2006

Appendix D OHCA Board Approved Rules (continued)

March 9, 2006 (continued)

- Permanent rule to allow flexibility, under certain conditions, for group homes in meeting the treatment needs of children and obtaining signatures of OKDHS workers and family members by fax regarding treatment plans. (Reference APA WF # 05-29)
  Budget neutral
  Effective: June 25, 2006

- Permanent rule for psychologist rules to: (1) clarify language; (2) add detailed language on allowable services to match them with actual services; (3) establish guidelines for maximum services billed per day/month; and (4) match language on documentation of records with behavioral health policy. (Reference APA WF # 05-38)
  Budget neutral
  Effective: June 25, 2006

- Permanent rule to allow removal of benign skin lesions for adults when medically necessary. (Reference APA WF # 05-20)
  Annual cost to the agency: State share of $15,000
  Effective: June 25, 2006

- Permanent rule to clarify and update the dental services covered by SoonerCare. (Reference APA WF # 05-42)
  Budget neutral
  Effective: June 25, 2006

- Permanent rule to issue Programs of All-Inclusive Care for the Elderly (PACE) and establish program requirements for a Cherokee Nation pilot program. (Reference APA WF # 05-36)
  Cost benefit expected to grow over time
  Effective: June 25, 2006

- Permanent rule for child health rules to reflect recommendations, related to the periodicity schedule, of providers and advocates of child health, and to correct inconsistencies. (Reference APA WF # 05-23)
  Budget neutral
  Effective: June 25, 2006

- Permanent rule for behavioral health rules to include: (1) Mental Health Clubhouse requirements for the Severally Mentally Ill (SMI); (2) family support and training service for the Severally Emotionally Disabled (SED) within a system of care program; (3) community/recovery support service for the SMI; (4) extending behavioral health aid services to Oklahoma Juvenile Affairs and Oklahoma Department of Human Services custody children residing in a residential behavioral management services facility; (5) clarifying language for providers of alcohol and other drug treatment disorders and outpatient behavioral health; and (6) clarifying guidelines for maximum services billed per day/month. (Reference APA WF #05-30)
  Budget neutral
  Effective: June 25, 2006

APA (Administrative Procedure Act) WF (Work Folder) # (Number) assigned to that particular rule change is the tracking device used in the register for reference purposes.

Appendix D OHCA Board Approved Rules (continued)

March 9, 2006 (continued)

- Permanent rule for residential behavior management services in foster care settings rules to: (1) establish guidelines for an on-site Inspection of care; (b) provide clarity and specificity to language regarding the inspection of care and recoupment process; and (c) establish guidelines for use of electronic signatures. (Reference APA WF # 05-35)
  Budget neutral
  Effective: June 25, 2006

- Permanent rule to revise Inpatient psychiatric hospital rules to: (1) reorganize the rules to be user friendly; (2) add definitions; (3) allow 18- through 20-year-old members to make decisions regarding their treatment; and (4) establish guidelines for use of electronic copies and signatures. (Reference APA WF # 05-48)
  Budget neutral
  Effective: June 25, 2006

- Permanent rule to establish guidelines for use of electronic medical records and signatures. (Reference APA WF # 05-32)
  Budget neutral
  Effective: June 25, 2006

- Permanent rule to establish encounter criteria for Indian Health Services/Tribal Clinics/Urban Tribal Clinics and allow providers to bill for multiple encounters on the same day. (Reference APA WF # 05-39)
  Budget neutral
  Effective: June 25, 2006

- Permanent rule to establish a five step intervention program for smoking cessation. (Reference APA WF # 05-40)
  Budget neutral
  Effective: June 25, 2006

- Permanent rule to revise Early Intervention program rules to add certified child development specialists as providers for behavioral/developmental counseling. (Reference APA WF # 05-37)
  Budget neutral
  Effective: June 25, 2006

Appendix D OHCA Board Approved Rules (continued)

April 13, 2006

- Emergency rule to revise purchasing rules to: (1) allow the use of agency purchasing cards; and (2) clarify existing purchasing rules. (Reference APA WF # 06-04)
  Budget neutral
  Effective: June 7, 2006

- Emergency rule for Developmental Disabilities Services Division specialized foster care rules to allow transportation service reimbursement to certain providers and individuals. (Reference APA WF # 06-05)
  Budget neutral
  Effective: June 7, 2006

- Emergency rule to revise Federally Qualified Health Centers rules to: (1) provide rule clarity through reorganization of the rules; (2) add definitions; and (3) expand the scope of services through the reimbursement of certain types of professionals. (Reference APA WF # 06-01)
  Budget neutral
  Effective: June 7, 2006

- Emergency rule to revise pharmacy rules to provide clarification by defining "written prescription" and "signature log" for record retention. (Reference APA WF # 06-03)
  Budget neutral
  Effective: June 7, 2006

- Emergency rule for Developmental Disabilities Services Division rules to require a prescription for occupational therapy, physical therapy, speech/language and audiology services. (Reference APA WF # 06-07)
  Budget neutral
  Effective: June 7, 2006

June 8, 2006

- Emergency rule to remove the prior authorization requirement for the initial evaluation and first three visits of children's speech and hearing services. (Reference APA WF # 06-06)
  Budget neutral
  Effective: Pending gubernatorial approval as of 07/12/2006

- Emergency rule to revise rape and abuse examination rules to clarify that the exam as well as all completed medically necessary procedures are reimbursable. (Reference APA WF # 06-16)
  Budget neutral
  Effective: Pending gubernatorial approval as of 07/12/2006

- Emergency rule to: (1) allow all SoonerCare Choice members to self refer to family planning services; and (2) clarify that vision for refractions services are only available for children. (Reference APA WF # 06-10)
  Budget neutral
  Effective: Pending gubernatorial approval as of 07/12/2006

APA (Administrative Procedure Act) WF (Work Folder) # (Number) assigned to that particular rule change is the tracking device used in the register for reference purposes.

Appendix D OHCA Board Approved Rules (continued)

June 8, 2006

- Emergency rule to add retrospective review of outpatient observation services. (Reference APA WF # 06-09)
  Agency expects a positive budget impact.
  Effective: Pending gubernatorial approval as of 07/12/2006

- Emergency rule to add coverage of an environmental inspection service for children with persistently elevated blood lead levels. (Reference APA WF # 06-17)
  Budget neutral
  Effective: Pending gubernatorial approval as of 07/12/2006

- Emergency rule to exclude non-emergency transportation services to persons in Institutions for Mental Disease. (Reference APA WF # 06-18)
  Estimated annual total savings of $8,465 and a state share savings of $2,716
  Effective: Pending gubernatorial approval as of 07/12/2006

- Emergency rule to exclude persons in Institutions for Mental Disease from the SoonerCare Choice program. (Reference APA WF # 06-19)
  Expected annual total savings of $22,715 including a state share savings of $7,289.
  Effective: Pending gubernatorial approval as of 07/12/2006

- Emergency rule for State Plan personal care rules to transfer the responsibility of the care plan development and monitoring from the OKDHS nurses to home care provider agency nurse. (Reference APA WF # 06-13)
  Budget neutral
  Effective: Pending gubernatorial approval as of 07/12/2006

- Emergency rule for Developmental Disabilities Services Division's skilled and registered nursing services rules to establish three-tier reimbursement structure enabling DDSD to retain and recruit providers of these services. (APA WF # 06-14)
  Budget neutral.
  Effective: Pending gubernatorial approval as of 07/12/2006

APA (Administrative Procedure Act) WF (Work Folder) # (Number) assigned to that particular rule change is the tracking device used in the register for reference purposes.

Appendix E SoonerCare Benefits Overview

	SoonerCare Traditional		***SoonerCare Choice***		
Please note all covered services must be medically necessary	***Children Under 21***	***Adults 21 and Over***	***Children Under 21***	***Adults 21 and Over***	**SoonerPlan**
Behavioral health and substance abuse services	Covered, some services may require prior authorization	Covered, some services may require prior authorization	Covered - some services may require prior authorization	Covered - some services may require prior authorization	No coverage
Care management services	Covered for complex and/or unusual health care needs	Covered for complex and/or unusual health care needs	Covered for complex and/or unusual health care needs	Covered for complex and/or unusual health care needs	Covered for complex and/or unusual health care needs
Certain prosthetic devices	Covered when prior authorized	Limited coverage with prior authorization	Covered when prior authorized	Limited coverage with prior authorization	No coverage
Child Health Wellness Screens - including health & immunization history; physical exams, various health assessments and counseling; lab & screening tests and necessary follow-up care	Covered services	No coverage	Covered services	No coverage	No coverage
Dental services	Preventive, restoration and maintenance	Emergency extractions only	Preventive, restoration and maintenance	Emergency extractions only	No coverage
Diabetic supplies - 100 glucose strips and lancets per month - One glucometer, one spring-loaded lancet device, three replacement batteries per year	Covered	Covered	Covered	Covered	No coverage
Durable medical equipment	Covered when prescribed by medical provider and may require prior authorization	Covered when prescribed by medical provider and may require prior authorization	Covered when prescribed by medical provider and may require prior authorization	Covered when prescribed by medical provider and may require prior authorization	No coverage
Family planning services	Birth control information and supplies - Pap smears - pregnancy tests	Birth control information and supplies - Pap smears - pregnancy tests - tubal ligations and vasectomies	Birth control information and supplies - Pap smears - pregnancy tests	Birth control information and supplies - Pap smears - pregnancy tests - tubal ligations and vasectomies	All age 19 and over - Birth control information and supplies - Pap smears - pregnancy tests for women. persons 21 and older - tubal ligations & vasectomies
Home health care services	36 visits covered annually without prior authorization when prescribed by a physician	36 visits covered annually without prior authorization when prescribed by a physician	36 visits covered annually without prior authorization when prescribed by a physician	36 visits covered annually without prior authorization when prescribed by a physician	No coverage

Please note all covered services must be medically necessary	SoonerCare Traditional		SoonerCare Choice		SoonerPlan
	Children Under 21	Adults 21 and Over	Children Under 21	Adults 21 and Over	
Inpatient hospital services (acute care only)	Covered	Covered medically necessary	Covered medically necessary	Covered medically necessary	No coverage
Laboratory and X-ray	Covered medically necessary	Covered medically necessary	Covered medically necessary	Covered medically necessary	Services related to family planning only
Long-term care	Covered medically necessary	Covered medically necessary	No coverage	No coverage	No coverage
Maternity services	Prenatal, delivery, postpartum visit	Prenatal, delivery, postpartum visit	Prenatal, delivery, postpartum visit	Prenatal, delivery, postpartum visit	No coverage
Nurse midwife and birthing center services	Covered medically necessary	Covered medically necessary	Covered medically necessary	Covered medically necessary	No coverage
Orthodontic services	Covered when prior authorized	No coverage	Covered when prior authorized	No coverage	No coverage
Outpatient hospital and surgery services	Covered medically necessary	Covered medically necessary	Covered medically necessary	Covered medically necessary	Services related to family planning only
Over-the-counter contraceptives	Covered medically necessary	Covered medically necessary	Covered medically necessary	Covered medically necessary	Contraceptives related to family planning only
Patient Advice Line (Mon–Fri - 5:00 pm to 8:00 am, available 24 hours on weekends & state holidays)	Covered service	Covered service	Covered service	Covered service	No coverage
Personal care	Covered as prescribed in treatment plan	Covered as prescribed in treatment plan	Covered as prescribed in treatment plan	Covered as prescribed in treatment plan	No coverage
Physician services	Unlimited coverage	Limited to 4 visits per month, including any specialty visits	Unlimited PCP visits	Unlimited PCP visits and up to 4 specialty visits per month	Physician visits and physical exams related to family planning only
Prescription drugs	Unlimited coverage	Limited coverage	Unlimited coverage	Limited to 6 per month	Contraceptives only
Therapy services - Physical, Speech, Occupational	Covered when prior authorized	No coverage	Covered when prior authorized	No coverage	No coverage
Transplant services	Covered when prior authorized	Covered when prior authorized	Covered when prior authorized	Covered when prior authorized	No coverage
Transportation related to medical emergencies	Covered	Covered	Covered	Covered	No coverage
Transportation to non-emergency covered medical services - SoonerRide	Covered	Covered	Covered	Covered	No coverage
Vision services	Coverage for exams, glasses, eye disease or injuries	Coverage for eye diseases or eye injuries only	Coverage for exams, glasses, eye disease or injuries	Coverage for eye diseases or eye injuries only	No coverage

This overview represents the basic covered SoonerCare benefits. Coverage of above benefits is dependent upon meeting requirements provided in accordance with various state and federal regulations.

Appendix F FFY2006 Disproportionate Share Hospital Payments

Disproportionate Share Hospitals	FFY2006
Arkansas Children's Hospital	$804,419
Blackwell Regional Hospital	$17,766
Bristow Medical Center	$8,413
Carl Albert Community Mental Health Center	$550,826
Choctaw Memorial Hospital	$13,419
Cimarron Memorial Hospital	$2,226
Claremore Regional Hospital	$33,950
Cleveland Area Hospital	$10,189
Comanche County Memorial Hospital	$226,837
Community Hospital Lakeview	$2,057
Craig General Hospital	$15,623
Cushing Regional Hospital	$38,093
Deaconess Hospital	$213,305
Destiny: FutureQuest, Inc/Lane Frost	$1,403
Duncan Regional Hospital, Inc.	$82,572
Elkview General Hospital	$9,881
Fairfax Memorial Hospital	$3,072
Grady Memorial Hospital	$32,755
Great Plains Regional Medical Center	$24,720
Griffin Memorial Hospital	$1,311,309
Harmon Memorial Hospital	$4,771
Haskell County Hospital	$19,157
Henryetta Medical Center	$13,304
Holdenville General Hospital	$12,568
Integris Baptist Medical Center	$551,828
Integris Baptist Regional Health Center	$90,119
Integris Bass Health & Bass/Pavilion	$156,041
Integris Canadian Valley Regional Hospital	$27,913
Integris Clinton Regional Hospital	$18,666
Integris Grove General Hospital	$37,312
Integris Marshall County Medical Center	$8,423
Integris Southwest Medical Center	$414,432
J.D. McCarty Center	$840,486
Jackson County Memorial Hospital	$96,030
Jane Phillips Memorial Medical Center, Inc.	$116,530
Jim Taliaferro Community Mental Health Center	$139,197
Mary Hurley Hospital	$4,263
Mayes County Medical Center	$18,124
McAlester Regional Health Center	$123,580

Disproportionate Share Hospitals	FFY2006
McCurtain Memorial Hospital	$4,247
Medical Center Of Southeastern Oklahoma	$117,318
Memorial Hospital Of Texas County	$16,025
Mercy Health Center	$142,270
Mercy Memorial Health Center	$169,292
Midwest Regional Medical Center	$150,163
Newman Memorial Hospital	$6,959
Norman Regional Hospital	$296,863
NW Center for Behavioral Health	$927,158
Okeene Municipal Hospital	$3,656
Okmulgee Memorial Hospital	$26,574
OU Medical Center	$25,546,749
Park View Hospital	$22,768
Parkside, Inc.	$344,757
Pauls Valley General Hospital	$18,214
Pawnee Municipal Hospital	$9,523
Perry Memorial Hospital	$2,778
Pinnacle Therapy Services, LLC (Valir)	$3,260
Prague Municipal Hospital	$4,634
Purcell Municipal Hospital	$12,197
Pushmataha Hospital	$11,492
Saint Francis Hospital	$915,270
Saint Francis Hospital at Broken Arrow	$21,902
Share Medical Center	$4,390
SouthCrest Hospital	$134,740
St. Anthony Hospital	$1,168,196
St. John Medical Center, Inc.	$592,506
St. Mary's Regional Medical Center	$68,729
Stillwater Medical Center	$79,187
Tahlequah City Hospital	$38,275
Unity Health Center	$107,092
Wagoner Community Hospital	$252,717
Weatherford HA Dba SW Memorial Hospital	$11,792
TOTAL	**$37,327,273**

Important Telephone Numbers

OHCA Main Number 405-522-7300

Customer Service — Beneficiary	405-522-7171	1-800-522-0310
1 — Eligibility Questions/OKDHS	5 — Enrollment Questions	
2 — Claim Status	6 — Patient Advice Line	
3 — ***SoonerCare*** Member Services	7 — Spanish Assistance/EDS Call Center	
4 — Pharmacy Inquiries	9 — Repeat Options	

***SoonerCare* Helpline** **1-800-987-7767**

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

OHCA Internet Resources

Oklahoma Health Care Authority **www.okhca.org**

Oklahoma Department of Human Services **www.okdhs.org**

Medicaid Fraud Control Unit **www.oag.state.ok.us**

Oklahoma State Auditor and Inspector **www.sai.state.ok.us**

Centers for Medicare and Medicaid **www.cms.gov**

Office of Inspector General of the Department of Health and Human Services **www.oig.hhs.gov**

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