Oklahoma Health Care Authority

Pioneering Health Care Coverage in Oklahoma

SFY2007 Annual Report

July 2006 through June 2007

November 16, 2007

Celebrating Oklahoma's 100th year of statehood.

Oklahoma Health Care Authority offices are located at:

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www.okhca.org

www.insureoklahoma.org

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.

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State of Oklahoma

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51st Legislature (2006-2007)

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OHCA Board Members

(left to right): Vice-Chairman, Charles (Ed) McFall, DPH; Sandra Langenkamp; Chickasaw Governor Bill Anoatubby; Wayne Hoffman; Anne M. Roberts; George Miller; Chairman, Lyle Roggow.

Message from the Chief Executive Officer

Pioneering Health Care Coverage in Oklahoma

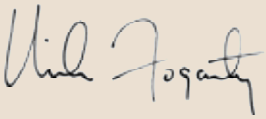
Oklahoma's Centennial is a wonderful time to look back and to celebrate our grand history and the progress Oklahoma has made in these 100 years. But it also reminds us to focus on the opportunities and challenges that lie before us. When we at the Oklahoma Health Care Authority look to the future, our goal is to see all Oklahomans able to access affordable, quality health care and to help our residents achieve optimal health status.

Oklahoma will celebrate its 100th anniversary of statehood Nov. 16, 2007. Here at the OHCA we're also celebrating a more recent landmark event as Gov. Henry and the Legislature enacted the All Kids Act and extended coverage of the Insure Oklahoma (Oklahoma Employer/employee Partnership for Insurance Coverage - O-EPIC) to thousands of uninsured working Oklahomans. These two health coverage plans are key steps toward reaching our goal.

The All Kids Act will help purchase health insurance for children in families with incomes up to 300 percent of the federal poverty level. For all practical purposes, it means that NO CHILD in Oklahoma should be without access to health care. Insure Oklahoma provides premium assistance to small businesses to help purchase health insurance on the private market for qualified employees and their spouses. It will soon be available to Oklahoma businesses with up to 250 employees and their workers with household incomes up to 250 percent of the poverty level. Pending federal approval, we believe we will be able to implement both of these programs in early 2008.

These are just two of the new health care plans available to Oklahomans. In this report, you will find more examples of our state's pioneer spirit. You will discover important new benefits and services, including dental care for expectant mothers, pay-for-performance for nursing facility services, certified nurse aide training program, more opportunities for home-based independent living, prescription drug assistance, and the list goes on.

As steadily and tenaciously as the occupants of covered wagons made their way across the Plains years ago, the residents of the 46th state are working to improve the health of its people. So we invite you this year to celebrate Oklahoma's unique history and anticipate her extraordinary future.



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SFY2007 Highlights

Members

- There were 763,565 unduplicated members enrolled in either SoonerCare (Oklahoma Medicaid) or Insure Oklahoma during SFY2007 (July 2006 through June 2007).
- A total of 745,474 Oklahoma SoonerCare members received services during SFY2007.
- Overall SoonerCare enrollees increased by 2.9 percent and the number served increased 2.5 percent from SFY2006 (July 2005 through June 2006).
- Children age 18 and under are the majority of Oklahoma SoonerCare enrollees at 61 percent.
- SoonerCare covers more than 50 percent of the births in Oklahoma. (Calendar year 2006, there were 30,877 SoonerCare births compared with 53,878 total statewide, according to the Oklahoma State Department of Health.)
- During SFY2007, Oklahoma provided coverage to 34,549 SoonerPlan enrollees and 7,818 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. Fifty-eight percent of expenditures are made for services provided to the aged, blind and disabled, who made up an average of 18 percent of SoonerCare members for SFY2007.
- SoonerCare funded 70 percent of Oklahoma's total long-term care actual bed days.
- OHCA expended $28.4 million on behalf of the Breast and Cervical Cancer enrollees and more than $5.3 million on SoonerPlan enrollees.
- Quality of Care revenues totaled $53,253,512.
- Dollars recovered by OHCA through post payment reviews totaled $9,233,075.
- Drug rebate collections totaled $86,667,403.
- By limiting the amount paid for generic drugs, OHCA saved more than $75.7 million through the State Maximum Allowable Cost (SMAC) program.

Administration

- The OHCA processed 45 emergency rules, 40 permanent rules, and 22 State Plan amendments.
- There were 153 group provider training/seminars attended by more than 8,300 providers. OHCA and EDS held 4,021 individual on-site provider training sessions during SFY2007.
- OHCA received and investigated 1,707 SoonerCare member complaints. This represents less than 1 percent of the 763,565 SoonerCare enrollees.
- There were 38 provider and 45 member formal appeals filed. This is less than one quarter of 1 percent of both populations.
- OHCA administrative costs comprised 1.84 percent of the total SoonerCare expenditures. OHCA operating costs represent 48 percent of OHCA administrative costs, and the other 52 percent are contract costs.

SFY2007 Year in Review

Insure Oklahoma Individual Plan Implemented; Employer-Sponsored Insurance Plan Expands

The Insure Oklahoma (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. The state share of Insure Oklahoma costs come from the state's tobacco tax revenues.

The Insure Oklahoma Individual Plan (IP), implemented in March 2007, extends coverage to 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 allows qualified Oklahomans to buy a health plan directly through the state.

The Insure Oklahoma Employer-Sponsored Insurance (ESI) plan is an initiative to use public and private partnerships to insure Oklahomans. ESI is designed to assist Oklahoma small business owners in purchasing health insurance on the private market for their income eligible employees (at or below 185 percent of federal poverty level). In June 2006, Governor Henry signed a bill into law that raised the number of employees a qualifying small business can have from 25 to 50. As of June 2007, there were 1,030 businesses participating in the plan.

Legislation was passed in 2007 that will expand both Insure Oklahoma programs to businesses with 250 or fewer employees and increase the household income threshold to 250 percent of the federal poverty level.

Dental Services Added for Pregnant Women

Women who are pregnant or have recently delivered and are enrolled in a SoonerCare program qualify for the perinatal dental benefit effective May 1, 2007. Basic dental care such as examinations, cleanings and fillings are some examples of dental benefits offered. Pregnant women can continue this benefit for up to 60 days following the end of the pregnancy. This represents the first time adult members have had access to dental benefits other than emergency extractions.

This dental care benefit for women who are pregnant or have recently delivered has been well received. In the first two months of service, 468 pregnant or post-partum women age 21 or older received dental services. More than 1,750 services, including initial examinations and other procedures, have been rendered. Dentists statewide are providing these services.

SFY2007 Year in Review (continued)

Legislature Passes Plan to Provide Access to Health Care for More Children

In an effort to extend access to health care coverage to uninsured Oklahoma children, the Oklahoma Legislature passed the "All Kids Act." The All Kids Act allows SoonerCare to increase qualification for children from 185 percent of the federal poverty level up to 300 percent – the maximum allowed by the federal government. It is anticipated this will enable OHCA to provide coverage for as many as 42,000 additional uninsured Oklahoma children. The program will also be funded by revenue from the state's tobacco tax.

OHCA Receives Money Follows the Person Rebalancing Demonstration Grant

In July 2006, the Money Follows the Person Committee was formed as a collaboration of the Oklahoma Health Care Authority, Oklahoma Department of Human Services, Oklahoma State Department of Health, and Progressive Independence to apply for a Real Choice Systems Change Demonstration grant which was submitted to the Centers for Medicare & Medicaid Services (CMS) in November 2006.

In January 2007, the Oklahoma Long-Term Living Choice Project was awarded $50,166,429 over a five-year period ending September 2011. The primary goals of the grant are designed to increase the use of home- and community-based, rather than institutional, services; increase choice and control for the Self-Directed Service Delivery System; and have long-term supports coordinated with affordable and accessible housing.

This OHCA project won a Governor's Commendation for Excellence Award at the 2007 Quality Oklahoma Team Day.

Agencies Prepare for Citizenship and Identity Verification Changes

In March 2007, to comply with federal requirements, the OHCA board approved permanent rules pertaining to citizenship and identity. OHCA has worked to make verifying citizenship and identity as easy as possible for current members and new applicants. It is OHCA's goal to ensure that individuals are not denied coverage when they are working with us to provide proper documentation.

OHCA worked with OSDH to perform system matches within their Vital Records Department on citizenship for both members and new applicants. OHCA worked with OKDHS to sort out Medicare and Social Security Income (SSI) members exempt from this requirement. OHCA has also worked with OKDHS to train their county enrollment workers regarding citizenship requirements. Training materials have been developed and placed on the OHCA public Web site and also mailed to various public and private organizations that assist OHCA in enrollment and education. OHCA has provided training sessions to its own as well as contracted staff. OHCA and OKDHS have teamed up to form a Centralized Verification Unit (CVU) that will assist members and applicants having trouble providing citizenship documentation. The citizenship and identity rules will be implemented on July 1, 2007.

SFY2007 Year in Review (continued)

Focus on Excellence

The Focus on Excellence program created out of House Bill 2842 is an incentive-based rate plan for nursing facilities. The design of this program is to measure improvements in the quality of life, care and services. These objectives will be driven by a set of 11 performance data components that will be used to reward demonstrated value, support evidence-based quality improvement by nursing homes, and furnish consumers with frequently updated information to use as they compare and choose nursing homes. Oklahoma is the first state to take on this type of quality initiative.

To date, 269 facilities have joined the program representing 85 percent of the state's nursing homes. Enrollment in this program is not mandatory, but it is strongly incentivized. The OHCA has paid participating SoonerCare providers a 1 percent participation bonus for the first year, beginning July 1, 2007, and intends to fund additional provider bonuses of up to 4 percent of their normal daily rate beginning October 1, 2007. As always, the added payments are dependent on sufficient annual legislative appropriations.

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

The Certified Nurse Aide (CNA) program has offered free nurse aide training to qualified applicants since 2005. Two of the continued goals of this program are to improve the quality of life for residents in long-term care facilities and to decrease staff turn-over rate. Prospective students must sign an agreement with OHCA that states they will work in a SoonerCare facility for 12 out of 24 months after they receive their certification.

The CNA training program has expanded beyond Logan and Oklahoma counties and is now offered to all Oklahoma residents. Originally, the OSU-OKC campus was the only place where classes were offered; however, since March 2007 classes have been added to nursing facilities in Collinsville, Weatherford, Sallisaw and Ardmore. In the near future, this partnership has plans to open classes in the Enid, Altus, McAlester and Vinita areas. The 1,000th CNA benefiting from this program will graduate in the August 2007.

Project Aims to Expand Oklahomans' Options for Long-Term Care Insurance

The Long-Term Care Partnership (LTC-P) is a project enacted into law by House Bill 1547. Its mission is to create a LTC-P program that allows the state to promote the purchase of long-term care insurance policies. This project will allow Oklahomans who purchase a long-term care partnership insurance policy to protect assets equal to the value of their policies. By purchasing the insurance, the insured will be able to provide for their own long-term care needs and still retain assets for their loved ones and family left behind. People will be protected from having to become impoverished to qualify for SoonerCare, and at the same time, the state will be able to avoid bearing the entire burden of long-term care costs.

The LTC-P is a collaborative effort between OHCA, the Oklahoma Insurance Department, industry providers and the Oklahoma Department of Human Services.

SFY2007 Year in Review (continued)

SoonerCare Member Outreach

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

SoonerCare Choice members are surveyed to find out how much they know about the program and if they know 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.

OHCA is devoted to intensive care management with members of the Oklahoma Cares Breast and Cervical Cancer Treatment program. An average of 478 new cases are certified each month. Approximately 26,800 successful telephone contacts were made to Oklahoma Cares members for SFY2007. In October 2006, National Breast Cancer Awareness month, more than 540 new Oklahoma Cares applications were certified. This represented the highest number of new applications received in a single month.

Disabled children enrolled under TEFRA 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 SoonerCare women who have recently delivered a baby, as well as men and women turning 19 who traditionally lose SoonerCare coverage based on age.

OHCA staff educate SoonerCare members identified as potential over-utiliziers of emergency room (ER) services. The goals of this outreach initiative are to coordinate routine care with a primary care provider (PCP) for improved continuity of care for SoonerCare members and reduce spending for inappropriate use of the ER for primary care 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 that is available from 5 p.m. to 8 a.m. and 24 hours a day on state holidays and weekends. OHCA sends letters to members staff cannot reach by telephone.

OHCA sends ER utilization profiles and letters twice a year to SoonerCare Choice primary care providers. These letters and profiles show how many office visits and ER visits were made by the members assigned to the PCP.

A decrease of more than 11,500 ER visits by contacted members has resulted since the project's inception.

SFY2007 Year in Review (continued)

SoonerCare Member Outreach (continued)

OHCA launched the Newborn Outreach Initiative in an effort to educate and inform parents about the importance of child health screens and how to navigate the health care system. The initiative was implemented in January 2006 as a small pilot project to a random sample of selected households with newborns. By October 2006, the effort had expanded to target all households identified with newborns born the previous month with a telephone number on file. A total of 17,649 households were identified for an outbound educational outreach call attempt from July 2006 to June 2007. OHCA plans to extend its outreach by sending letters to all identified households to ensure that at least one form of educational contact is attempted for every household with a newborn.

A secondary outcome of this initiative is the overall education on SoonerCare benefits for the entire family. Parents of newborns have given positive feedback on the outreach efforts. Based on this project, a new initiative is planned to provide education to expectant mothers and high-risk newborns receiving SoonerCare benefits.

OHCA staff also visit children receiving skilled nursing care. Assessments are done to determine if private duty nursing care is warranted. Initial evaluations can take up to an hour and a half each. More than 470 in-home evaluations for 156 children receiving private duty nursing were completed.

New Well-Child Screening Schedule Released

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program realized some important changes as the result of the work of the EPSDT Advisory Work Group. The membership was composed of individuals from 33 organizations including OHCA, other state agencies, provider organizations, and medical and dental colleges. The work group assessed the timing of well-child screenings, content of services, and documentation and reporting issues.

As a result of their efforts, a new periodicity schedule was implemented. This periodicity schedule sets forth the minimum requirements for the frequency and content of childhood screening visits. Additional screenings are allowed and encouraged as needed to provide optimal care. The new schedule contains both required and optional screenings.

In addition to creating and distributing materials to support the implementation of the new EPSDT periodicity schedule, emphasis was placed on increasing awareness of the importance of developmental assessments for children. New educational and training materials, provider manual, fliers, easy-to-read booklets for parents and guardians (English and Spanish versions), and forms that providers can use for EPSDT visits were created and distributed to providers. The EPSDT provider manual was also revised and includes the new age-specific child health forms. Both the provider manual and periodicity schedule are available on the OHCA Web site.

SFY2007 Year in Review (continued)

Pilot Strategies to Improve Child Health Screening in SoonerCare

The OHCA is working with the Oklahoma University Health Sciences Center (OUHSC) to determine if practice facilitators (PFs) can be helpful to practices that take care of SoonerCare children. The PFs have master's-level training and experience in primary health care settings and have been trained to help practices make changes in their processes of care.

Five practices are participating in the pilot. Each practice agreed to generate patient lists to perform chart reviews for quality and quantity of child health screening (EPSDT) visits and to meet with the practice facilitator once weekly to discuss any necessary changes in care processes. To date, the PF has provided feedback on findings and helped these practices make changes in their processes of care. Results of this project are being evaluated for potential usefulness across Oklahoma to improve child health screenings in SoonerCare.

Pharmacy Partnerships Help Oklahomans with Prescription Costs

Oklahomans struggling with the high cost of prescription medications may be able to find help through two programs funded by the Oklahoma Department of Commerce in partnership with the Oklahoma Health Care Authority, RX for Oklahoma and the new OklahomaRx Discount Card.

The RX for Oklahoma program is a free service that helps low-income residents access prescription assistance programs provided by pharmaceutical manufacturing companies. Since the inception of the program in December 2005, more than 15,000 people across the state have been helped. (More information about the program is available at www.RX4OKLA.com)

The OklahomaRx Discount Card is available to all state residents. The program charges a minimal annual membership fee which could be paid by the state for some qualifying individuals. With the OklahomaRx Discount Card, discounts range from 10 percent to 55 percent, depending on the drugs and where they are purchased. Generic drugs will save consumers the most money. More than 570 pharmacies in Oklahoma are participating in the program, including most major retailers. (More information is available at www.okrxdiscount.com)

Contract Saves Nearly $5 Million

With the introduction of national provider identification (NPI) numbers, Medicare determined that it would not accept claims from providers without an NPI number. Since OHCA does not have an NPI number, OHCA could not bill Medicare directly for services that were paid by SoonerCare but should have actually been paid by Medicare.

In response and well ahead of the deadline, OHCA hired a third-party contractor called Health Management Systems (HMS) to assist with the transition of this process. Twice a year, HMS matches OHCA data with the Medicare database and recoups funds from providers after they have been correctly paid by Medicare. Since the contract with HMS began, OHCA has collected nearly $5 million for these Medicare billings.

SFY2007 Year in Review (continued)

SoonerCare Provider Services Expands Role to Better Serve Our Provider Networks

With the passage of the Medicaid Reform Act of 2006, the Provider Service Unit at OHCA reorganized to better serve the SoonerCare provider networks. New staff was added, existing personnel's roles expanded and new systems were developed to assist providers.

Currently, 22 dedicated and professional provider representatives are available to assist providers with program, policy and claims issues/questions. Provider representatives are also responsible for the recruitment and retention of providers. Staff provide on-site support and training in the provider's office upon request. New full-time positions were created to work directly with provider staffs and local health care delivery systems to reduce unnecessary emergency room utilization. This is done by developing educational strategies and materials and providing on-site educational assistance to providers concerning ER utilization. OHCA also has registered nurses who provide clinical expertise during on-site visits and medical record reviews. They assist providers in the evaluation and interpretation of billed charges and clinical documentation to ensure that OHCA requirements are met and the services provided are appropriate as mandated by the Centers for Medicare & Medicaid Services (CMS).

New and updated telephone systems have increased the availability of OHCA staff. A direct, toll-free phone number is available for providers who have detailed and complex questions. This phone number is staffed from 7:30 a.m. to 5:30 p.m. Monday through Friday. Calls are answered directly, with no need to leave a message and wait for a response. Calls are documented and recorded for tracking purposes. More than 33,350 calls were received by Provider Services in SFY2007.

Also new in SFY2007 is the availability for providers to send secure, HIPAA-compliant e-mail messages through the SoonerCare Secure Web site. It is a safe alternative to contacting OHCA via telephone to inquire about policy, coverage, contract compliance or general questions. Since becoming operational in late spring of 2007, more than 600 secure e-mails have been received and answered by the Provider Services staff.

SFY2007 Year in Review (continued)

Health Information Exchange Analysis Begins

Part of the Medicaid Reform Act of 2006 mandated writing a needs analysis report regarding health information exchange (HIE). HIE is the mobilization of health information electronically across different systems and organizations. Initially, OHCA will focus on connecting state agencies to share health care information for common patients, sharing data with providers using agreed upon rules and sharing data with the patients themselves.

Future agency plans include continuing research and proposing options on a system of patient identification that will allow speedy and convenient acquisition of information across all levels of health care and develop a single authorization for release of information. The agency's plan of action also includes engaging providers and their systems, adoption of advance health information technology, involving consumers, and developing sustainable funding.

Behavioral health Collaboratives Benefit Providers and Members

In SFY2007, the Oklahoma Behavioral Health Collaboratives, made up of all the state agencies who provide or contract for state and federally funded behavioral health services to our state's children and adults, made great progress on a few of their many projects toward improving the state's behavioral health care system.

One project is the Behavioral Health Collaborative Documentation Work Group, which was developed after a year's worth of stakeholder focus groups were held across the state. The top complaint was that providers spend 65-80 percent of their time on documentation and wanted more time with their patients. This work group was made up of a dedicated group of public and private behavioral health providers, consumers, and state agency staff who worked through all of the different types of required documentation that behavioral health providers have to complete. The work group was successful in getting a consensus on reducing paperwork requirements that have resulted in a 40-60 percent decrease in documentation time for providers.

Another project, the Policy Work Group, charged with developing consistency between state agency policies including definitions of terms; and requirements for documentation, professional credentials and training; and the development of new evidence-based practice services. Providers and consumer advocates have supported these efforts as they result in more time spent with patients and an easier system to navigate. This work group next will tackle topics such as the development of a state-run system for agency accreditation and a unified behavioral health provider contract.

SFY2007 Year in Review (continued)

OHCA Receives Third Performance Reporting Award

OHCA's Service Efforts and Accomplishments (SEA) SFY2006 report received the Certificate of Excellence from the Association of Government Accountants. This is the third 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.

2007 Quality Oklahoma Team Day Award-Winning Projects

OHCA highlighted 12 projects at the 2007 Quality Oklahoma Team Day held at the state capitol. Award-winning projects, goals and outcomes are included below. One additional winner of the Governor's Commendation for Excellence award, the Money Follows the Person Grant, is detailed on page 10.

Reform Before The Storm: Redesigning Oklahoma's Health Care Delivery System

Goal: To reduce costs while improving services to SoonerCare members by adopting a new health care delivery system incorporating many features of managed care modified to meet Oklahoma's specific health care needs.

- More exceptional needs coordinators were hired for members with high-risk needs.
- Prescription drug limits were increased.
- Hospital day limits were eliminated for acute care.
- Hospital payment rates increased and the payment methodology was reformed.
- Eligibility processes were improved so members would not lose eligibility on a periodic basis.
- Total annual savings to the taxpayers totaled $85,493,692.

This project received the 2007 Greatest Cost Savings award, the Extra Mile award and a Governor's Commendation of Excellence.

SFY2007 Year in Review (continued)

2007 Quality Oklahoma Team Day Award-Winning Projects (continued)

The projects below received a Governor's Commendation of Excellence.

Collaboration Reduces Out-of-State Behavioral Health Treatment For Children

Goal: To develop new and expanded clinical programs within Oklahoma that would meet the needs of SoonerCare children and consequently reduce the number of out-of-state placements.

- OHCA collaborated with the Oklahoma Department of Human Services and the provider community including provider organizations and behavioral health related corporations.
- The group defined and clarified expectations for priority programs and developed criteria to ensure the highest level of clinical quality.
- A methodology for enhanced rates to appropriately reimburse providers for these high-end services was developed.
- As a results there was a 17 percent decrease in out-of-state placement.
- Days placed out of state decreased by 21 percent.
- There was a 28 percent decrease in cost of out of state placements.

Behavioral Health High-End Utilizers Project

Goal: To improve member services and use resources efficiently by coordinating the care of 50 SoonerCare members under the age of 21 who are identified as high users of impatient behavioral health care services.

- The project resulted in a 40 percent decrease in hospital inpatient days for a savings of $1,111,964.
- Members receiving follow-up care within two weeks of discharge increased from 50 percent to 62 percent.
- All members of the intervention group released from inpatient care received follow up care within 45 days.
- Other agencies serving children with behavioral health service needs are considering implementing similar practices.

Medical History for Children in Custody or Adoption Status

Goal: To utilize the SoonerCare and Oklahoma Department of Human Services data systems to successfully communicate health care information to caseworkers and medical clinic homes for children in foster care and adoption.

- Sharing data allows case workers and physicians to have access to vital information about children's previous health care.
- Caseworkers are aware of health encounters occurring during foster placement.
- Existing databases from both agencies were used to construct a medical history and maintain an ongoing medical record for foster children.

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 Uninsured

SoonerCare and the Economy

The Great Seal of the State of Oklahoma is a tribute to the state's Native American heritage and its hope for the future. The central design consists of one large star, representing the state of Oklahoma, surrounded by 45 small stars, representing each of the other states of the Union. The large star that symbolizes Oklahoma features five radiating arms, one for each of the five Civilized Indian Nations. The top ray is for the Chickasaw Nation and holds a warrior with a bow and a shield. The upper right ray represents the Choctaw Nation, with a bow, three arrows and a tomahawk. The lower right ray honors the Seminole Nation, with a hunter in a canoe. The lower left ray is for the Creek Nation, and holds a sheaf of wheat and a plow. And the upper left ray is the seal of the Cherokee Nation, with a seven-pointed star and a wreath of oak leaves. The center of the main star shows a Native American shaking hands with a white man, symbolizing the merging of cultures. Olive branches encircle this image, representing the hope for peace. The state motto, "Labor Omina Vincit," or "Labor Conquers All," displays on the seal, and the entire seal is ringed with "Great Seal of the State of Oklahoma 1907."

Information retrieved from http://www.netstate.com/states/symb/seals/ok_seal.htm and http://www.state.ok.us/osfdocs/stinfo.html.

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 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;
- is called SoonerCare in Oklahoma.

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 2007 Federal Poverty Guidelines (FPL)

Family Size	Annual (Monthly) Income			
	100%	185%	250%	300%
1	$10,210 ($851)	$18,889 ($1,574)	$25,525 ($2,127)	$30,630 ($2,553)
2	$13,690 ($1,141)	$25,327 ($2,111)	$34,225 ($2,852)	$41,070 ($3,423)
3	$17,170 ($1,431)	$31,765 ($2,647)	$42,925 ($3,577)	$51,510 ($4,293)
4	$20,650 ($1,721)	$38,203 ($3,184)	$51,625 ($4,302)	$61,950 ($5,163)
5	$24,130 ($2,011)	$44,641 ($3,720)	$60,325 ($5,027)	$72,390 ($6,033)
6	$27,610 ($2,301)	$51,079 ($4,257)	$69,025 ($5,752)	$82,830 ($6,903)
7	$31,090 ($2,591)	$57,517 ($4,793)	$77,725 ($6,477)	$93,270 ($7,773)
8	$34,570 ($2,881)	$63,955 ($5,330)	$86,425 ($7,202)	$103,710 ($8,643)

SOURCE: Federal Register, Vol. 72, No. 15, January 24, 2007, pp. 3147–3148; http://aspe.hhs.gov/poverty/07poverty.shtml
For family units with more than eight members, add $3,480 for each additional member.

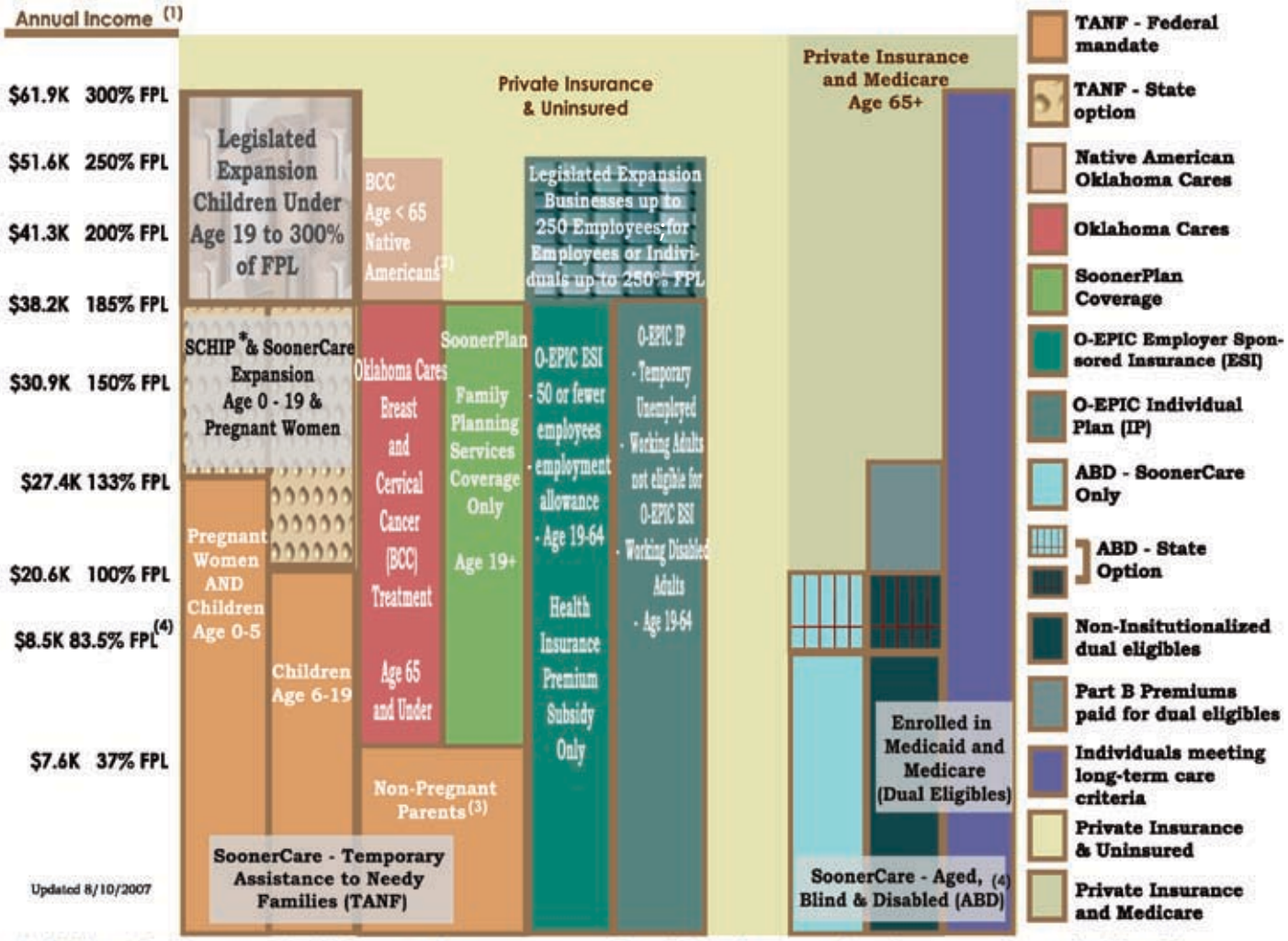
The designation of some groups as mandatory and others as optional is an artifact of Medicaid's origins as a health care provider for traditional welfare populations. Through laws enacted over the past 40 years, eligibility has been extended to include not only people who are receiving cash-assistance programs but also 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 Insure Oklahoma) 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 2007 Federal Poverty Guidelines (FPL) and Coverage



(1) 2007 Federal Poverty Guidelines. U.S. Department of Health and Human Services. Based on a family of four.
(2) Oklahoma Cares qualifications are up to 250% FPL for Native Americans only.
(3) 37 federal poverty level (FPL) based on single parent family.
(4) Incomes shown are for single individuals.
*** SCHIP is the State Children's Health Insurance Program.**
IMPORTANT - the above information is a very basic overview of the federal poverty level and coverage groups. Each group has varying qualifying criteria, specific details can be found at www.okhca.org under Individuals.

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 primary care 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 not qualified for SoonerCare Choice. The member accesses services from contracted providers, and the OHCA pays the provider on a fee-for-service basis. SoonerCare Traditional provides coverage for 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 are enrolled under one of the Home and Community-Based Service waiver programs.

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

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.

SoonerPlan is a benefit plan covering limited services related to family planning. SoonerPlan provides family planning services and contraceptive products to women and men age 19 and older who do not traditionally qualify for full SoonerCare benefits.

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

Employer-Sponsored Insurance (ESI) is a benefit plan providing premium assistance to qualified workers and spouses employed by an Oklahoma small business that has 50 or fewer workers. With ESI, the cost of health insurance premiums is shared by the employer, the employee and the OHCA.

Individual Plan (IP) is a health insurance option for qualified Oklahomans. This benefit plan offers some basic health services to qualified adults who are not eligible for ESI and work for an Oklahoma employer with 50 or fewer employees, or are unemployed or who are working disabled individuals.

For more information about Insure Oklahoma, go to page 33 of this report or at www.insureoklahoma.org.

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. Overall, 42 percent of SoonerCare enrollees do not receive any type of cash assistance.

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. Only 10 percent of the children enrolled in SoonerCare under TANF guidelines were in state-custody or received cash assistance. Additionally, more than 52,000 low-income adults in families with children were enrolled under TANF guidelines. The majority of these members receive the SoonerCare Choice benefit package.

Figure 3 SFY2007 SoonerCare Children Under 21

Total Unduplicated Children under 21	497,737
Children Qualified under TANF	430,881
Children Qualified under Blind and Disabled	17,496
Children Qualified under TEFRA	176
Children Qualified under SCHIP	112,511

Children above may be counted in multiple qualifying groups.

Aged. Nearly 61,000 adults age 65 and older, excluding persons who are blind or disabled, were covered by SoonerCare in SFY2007. Twenty-eight 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 SFY2007, more than 88,200 Oklahomans who are blind or have chronic conditions and disabilities were enrolled in SoonerCare. Seventy 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 nearly 90,000* dually eligible enrollees at some point during SFY2007. These members receive SoonerCare Supplemental or SoonerCare Traditional benefits and are reported under the Aged, Blind and Disabled (ABD) or Other categories.

*Dually eligible 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. The SCHIP program federal reauthorization is due by September 30, 2007. During SFY2007 an average of 65,489 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.

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

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). In SFY2007, 8,238 children and/or pregnant women qualified through this expansion. These enrollees receive SoonerCare Choice benefits and are categorized under Parents/Children.

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 176 children who qualified through the TEFRA program in SFY2007.

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, precancerous 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 have been 11,593 women qualified through Oklahoma Cares since its inception in January 2005.

Who are the Members of SoonerCare? (continued)

Additional Qualifying Groups (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 SFY2007, 34,549 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 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 (HCBS) waivers:

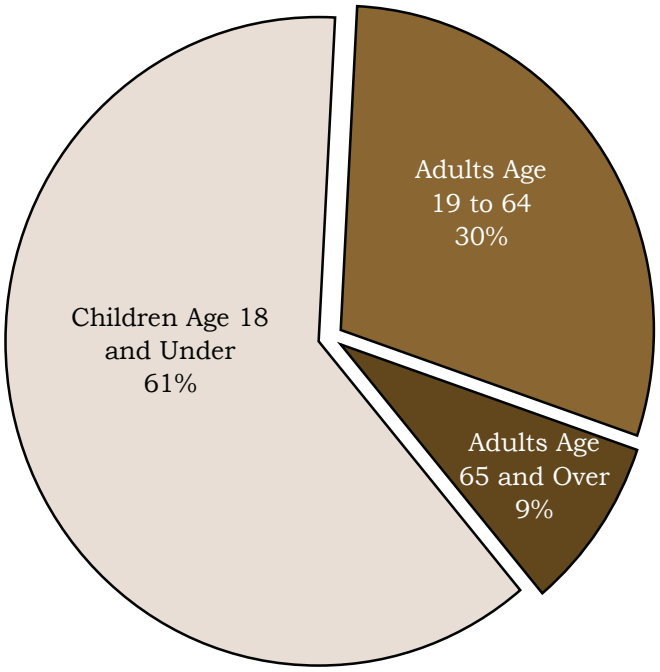
- *ADvantage Waiver:* Serves the "frail elderly" (age 65 years and older) and adults over age 21 with physical disabilities that qualify for placement in a nursing facility. Approximately 23,900 members receive services through this waiver program.
- *Community Waiver:* Serves approximately 2,500 members 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.
- *Homeward Bound Waiver:* Designed to serve the needs of individuals with mental retardation 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 nearly 800 individuals.
- *In-Home Supports Waiver for Adults:* Designed to assist the state in removing adults (ages 18 and older) with mental retardation from a waiting list for waiver services. This waiver serves more than 1,550 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 SFY2007 this waiver served 724 children who qualified for placement in an ICF/MR.

What is a Waiver?

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

Who are the Members of SoonerCare? (continued)

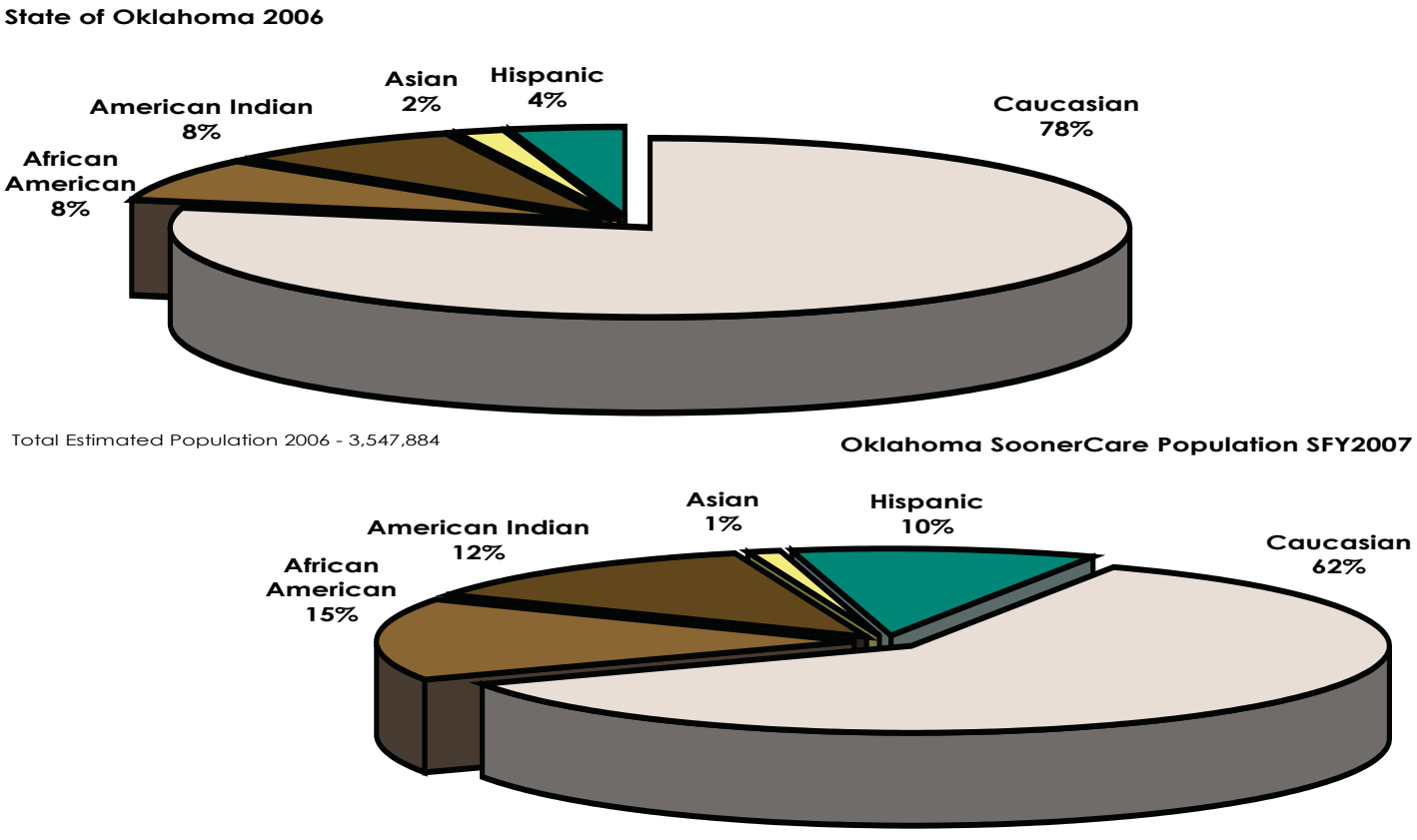
Figure 4 Age of SoonerCare Enrollees



Approximately 1 in 5 Oklahomans Enrolled in SoonerCare

There were 763,565 unduplicated members enrolled in the SoonerCare program during SFY2007. On average, 600,917 members were enrolled each month of the state fiscal year.

Figure 5 State and SoonerCare Population by Race



Oklahoma state totals based upon US Bureau of the Census Oklahoma State Data Center 2006 Population. Oklahoma SoonerCare unduplicated counts based upon data extracted from member eligibility files on July 16, 2007. 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. 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 6 HISTORIC FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP)

Federal Fiscal Year	FMAP Rate	SCHIP‡	Federal Fiscal Year	FMAP Rate	SCHIP‡
FFY94	70.39%		FFY03—Qtr. 1 & 2	70.56%	79.39%
FFY95	70.05%		FFY03—Qtr. 3 & 4*	73.51%	79.39%
FFY96	69.89%		FFY04—Qtr. 1-3*	73.51%	79.17%
FFY97	70.01%		FFY04—Qtr. 4	70.24%	79.17%
FFY98	70.51%	79.36%	FFY05	70.18%	79.13%
FFY99	70.84%	79.59%	FFY06	67.91%	77.54%
FFY00	71.09%	79.76%	FFY07	68.14%	77.70%
FFY01	71.20%	79.87%	FFY08	67.10%	76.97%
FFY02	70.43%	79.30%			

‡ SCHIP: State Children's Health Insurance Program. 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 SFY2007 totaled over $2.2 billion.

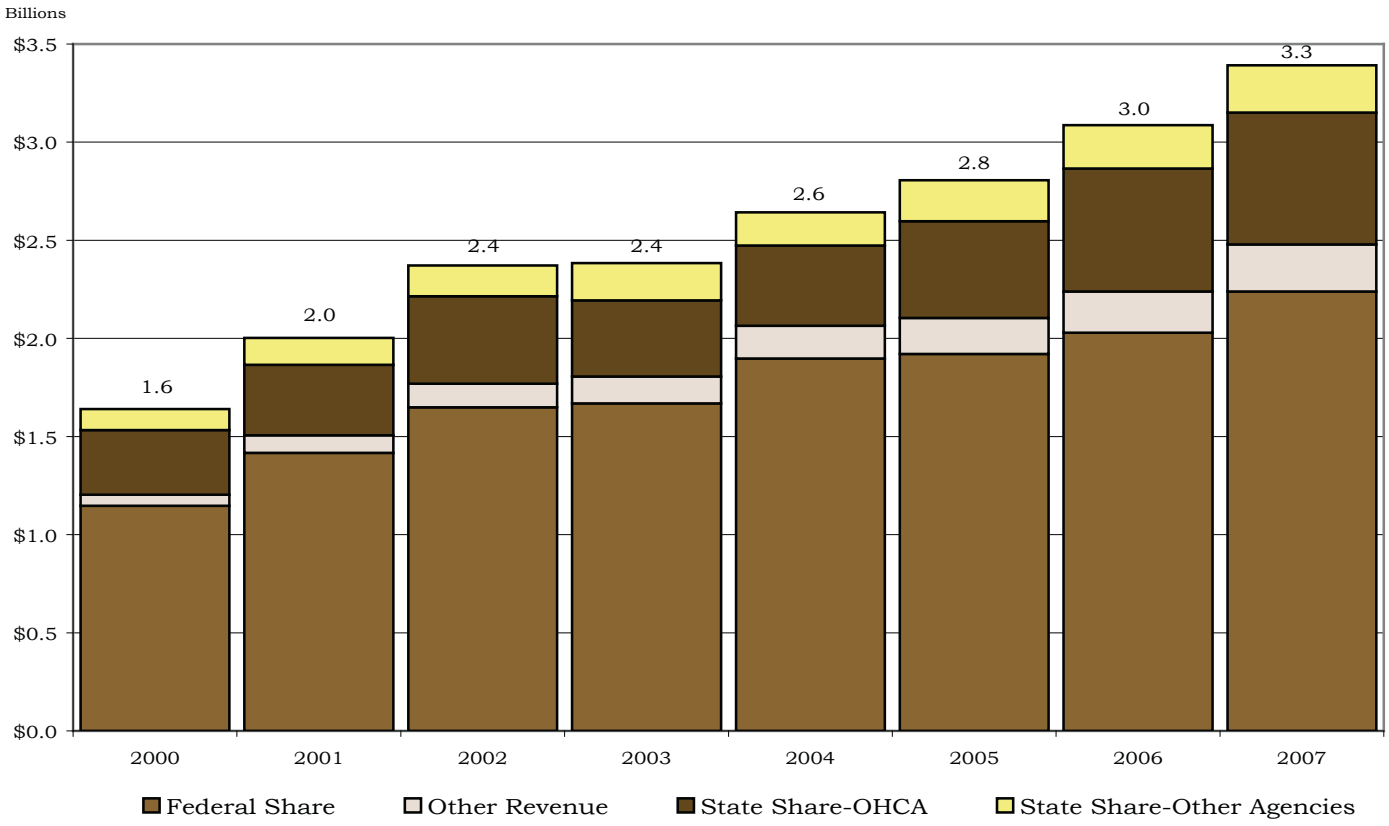
FIGURE 7 CONDENSED SUMMARY OF OHCA REVENUES

Revenue Source	Actual Revenues
State Appropriations	$ 701,964,163
Federal Funds—OHCA	$1,766,494,172
Federal Funds for Other State Agencies	$515,391,765
Refunds from Other State Agencies	$240,677,151
Tobacco Tax Funds	$87,512,146
Drug Rebate	$86,667,403
Medical Refunds	$22,402,344
Quality of Care Fees	$53,253,512
Prior Year Carryover	$69,466,124
Other Revenue	$18,521,188
Total Revenue	**$3,562,349,968**

Source: OHCA Financial Services Division (September 2007). 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 8 Summary of Expenditures and Revenue Sources, Federal Fiscal Year 2000-2007



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
2007	$3,391,417,550	$2,238,775,881	$240,533,188	$671,201,181	$240,907,299

Source: 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.

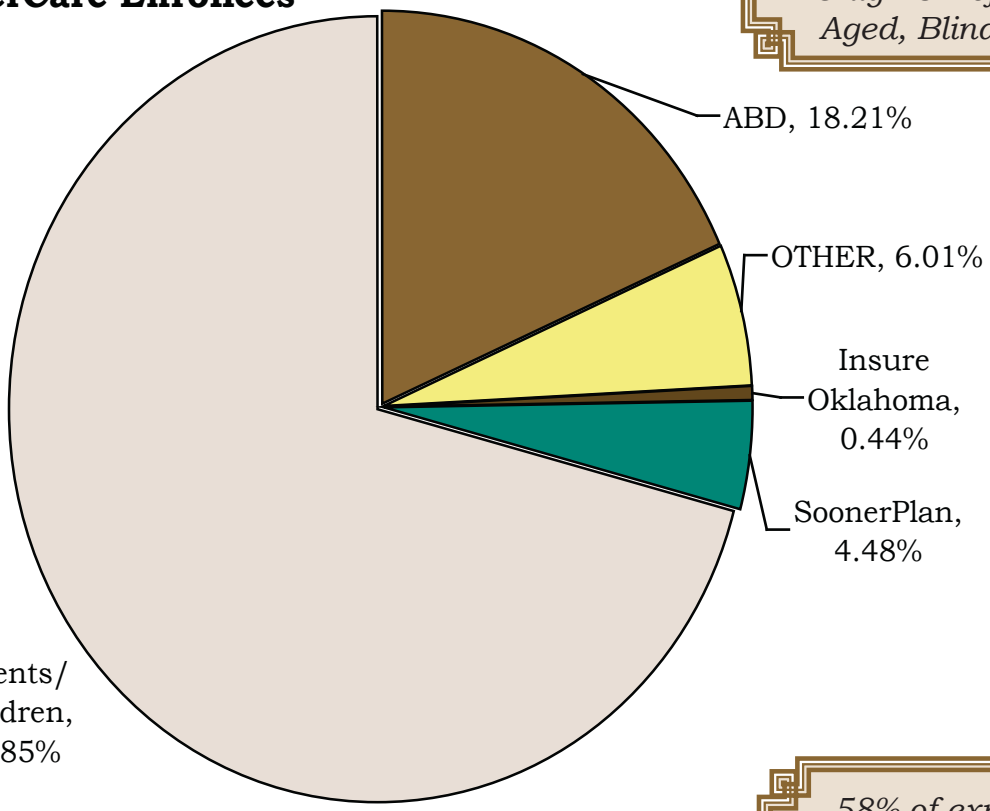
More than 5 of every 10 SoonerCare dollars were paid for services rendered to the Aged, Blind and Disabled (ABD) population. This group includes dual eligibles, persons with chronic medical conditions or residents of long-term care facilities.

Where are the SoonerCare Dollars Going?

Figure 9 SoonerCare Enrollees and Expenditures by Aid Category Percentages

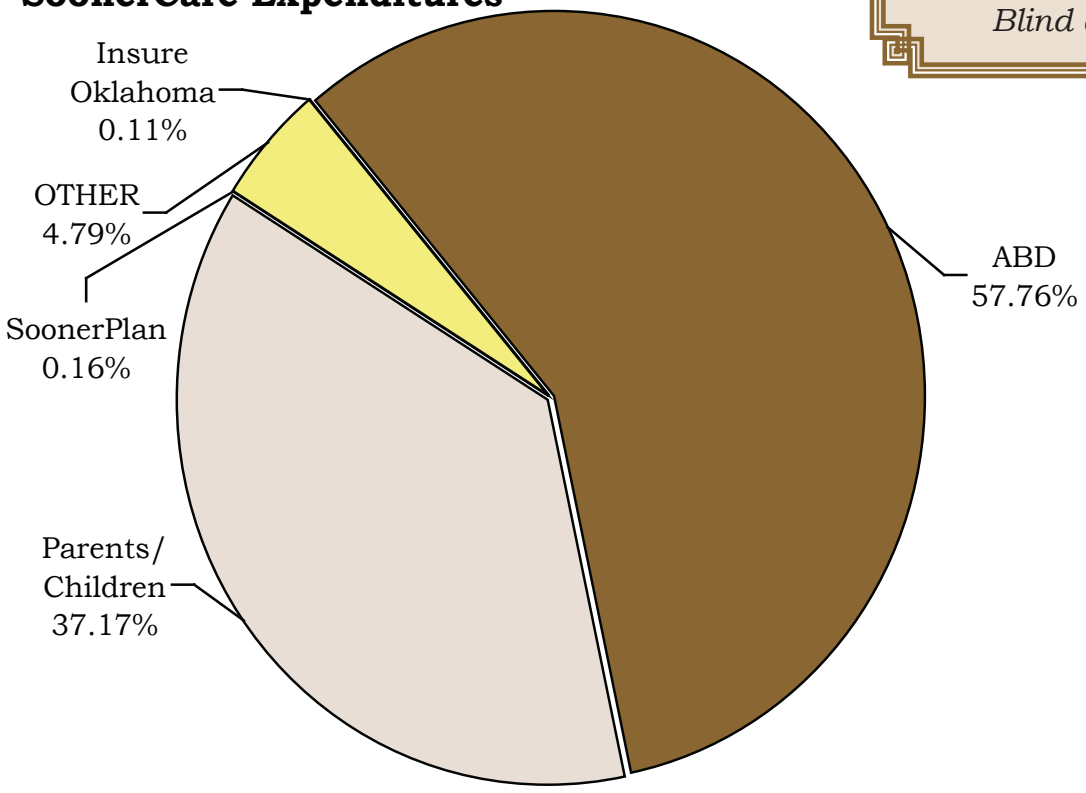
SoonerCare Enrollees

Only 18% of enrollees were Aged, Blind and Disabled.



SoonerCare Expenditures

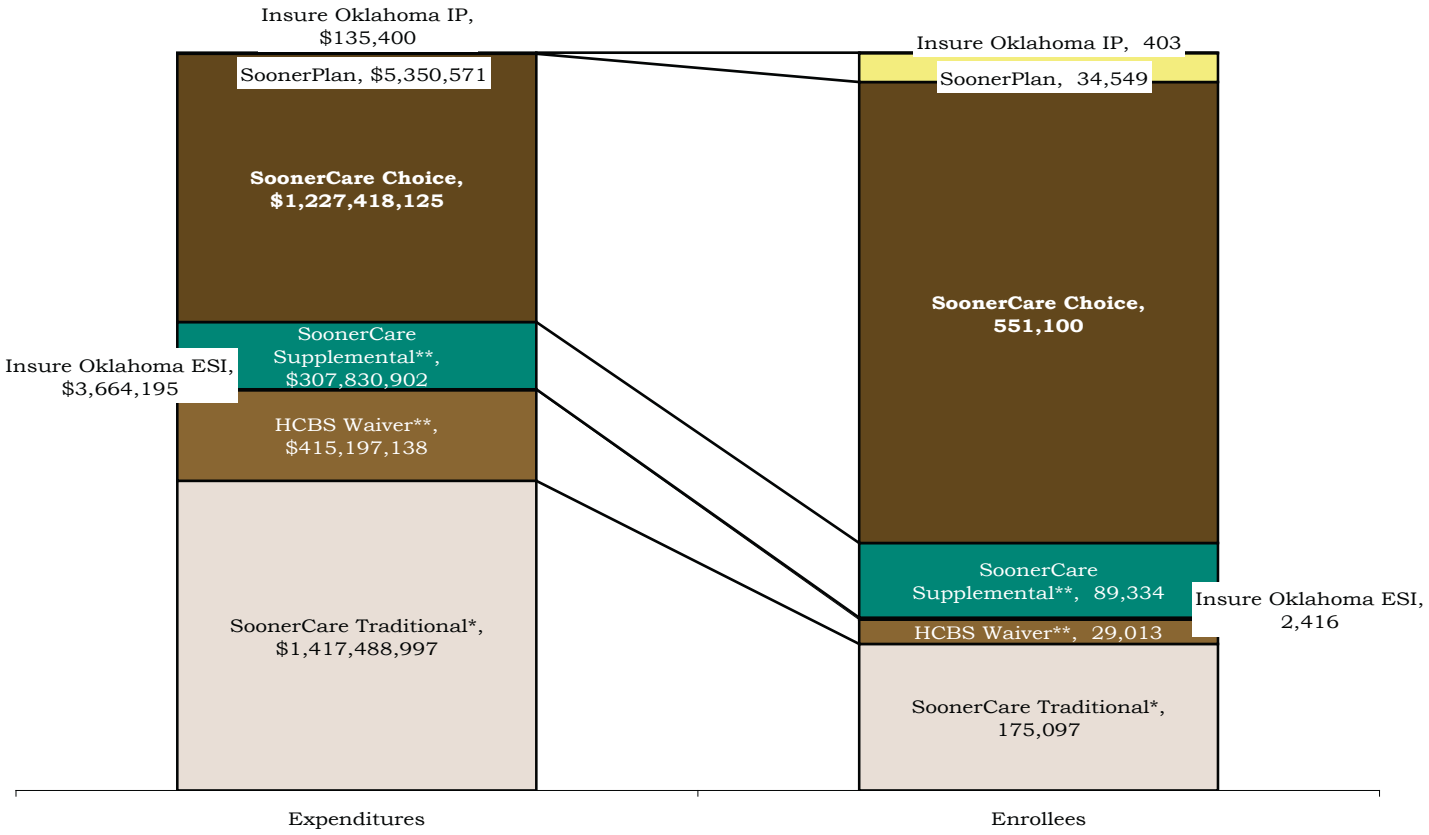
58% of expenditures were paid on behalf of the Aged, Blind and Disabled.



OTHER includes—Child Custody, Refuge, SLMB, DDSD Supported Living and TB member enrollees and expenditures. ABD includes TEFRA enrollees and expenditures. OTHER expenditures also include GME/IME/DSH and UPL hospital payments.

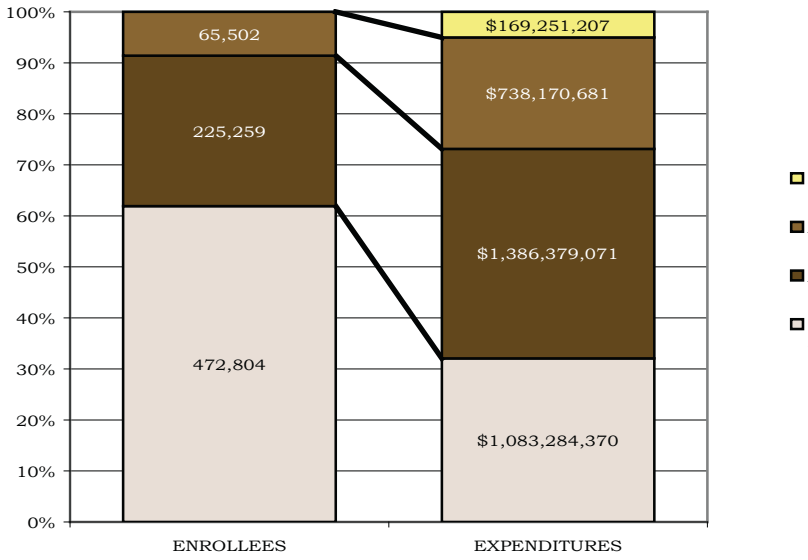
Where are the SoonerCare Dollars Going? (continued)

Figure 10 Oklahoma SoonerCare Enrollees and Expenditures by Benefit Plan—SFY2007



*SoonerCare Choice members will be enrolled under SoonerCare Traditional until their SoonerCare Choice becomes effective. Choice enrollees are not included in the Traditional counts. **SoonerCare Supplemental and Home and Community-Based Services (HCBS) waiver enrollees are also included in the SoonerCare Traditional counts. Expenditures include GME/IME/DSH and UPL hospital payments.

Figure 11 Oklahoma SoonerCare Enrollees and Expenditures by Age—SFY2007



*Non-age specific payments include $103,064,320 in Hospital Supplemental payments; $57,711,032 in GME payments to Medical schools; $4,560,481 in Public ICF/MR cost settlements; $3,732,228 in FQHC wrap-around payments and $183,146 in non-member specific provider adjustments. $107,753,230 in Medicare Part A & B (Buy-In) payments and $53,193,255 in Medicare Part D (clawback) payments are included in Ages 65 and over.

WHERE ARE THE SOONERCARE DOLLARS GOING? (CONTINUED)

FIGURE 12 TOP 20 SOONERCARE EXPENDITURES—SFY2007

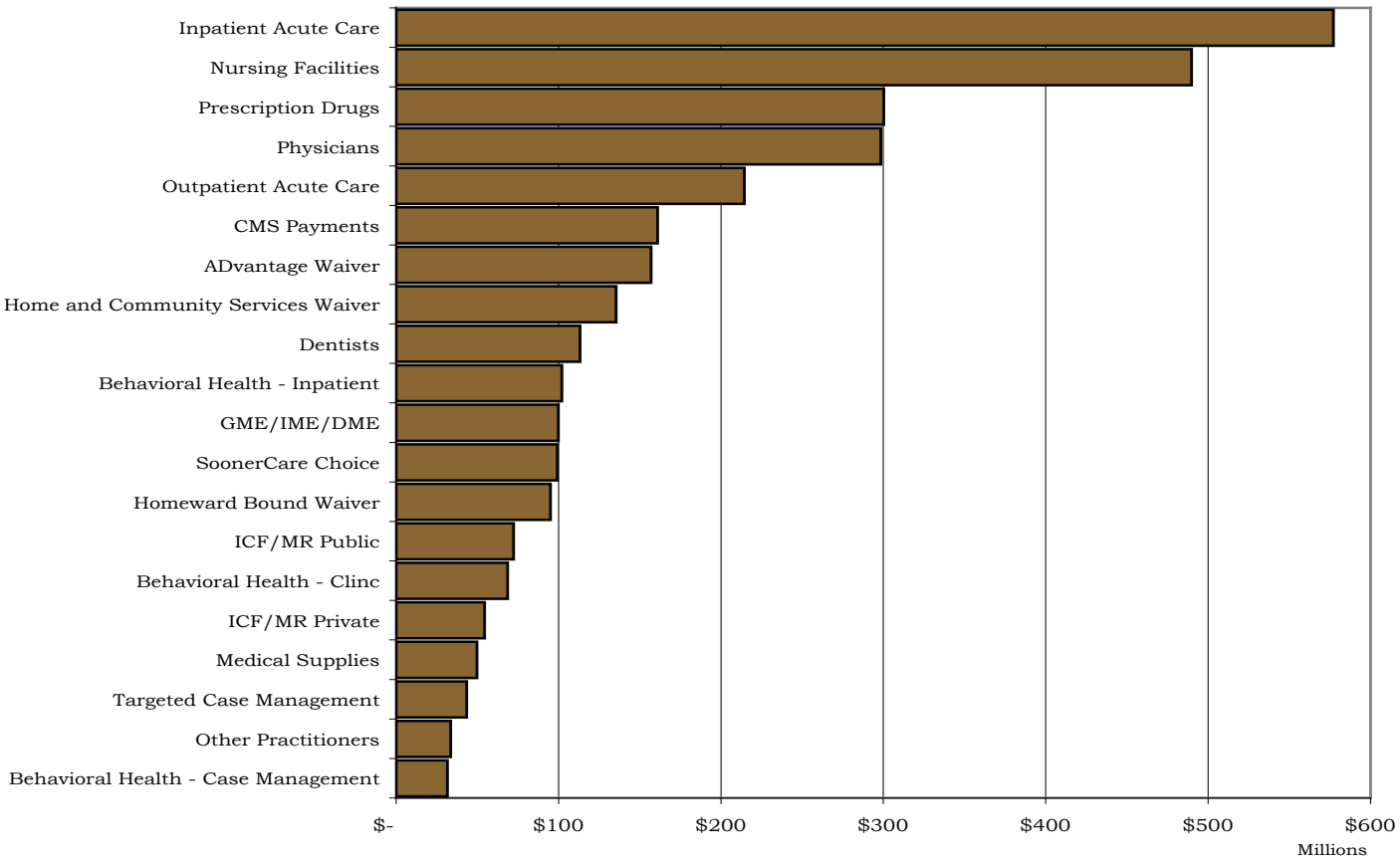


FIGURE 13 SOONERCARE CHOICE CAPITATION PAYMENTS—SFY2007

Aged, Blind and Disabled (ABD)	Member Months	Capitation Payments
ABD Adults	321,111	$8,844,045
ABD Children	143,682	$3,475,037
IHS ABD Adults	6,926	$20,778
IHS ABD Children	3,470	$10,410

Temporary Assistance to Needy Families (TANF)	Member Months	Capitation Payments
TANF Adults	412,702	$12,358,508
TANF Children	3,825,614	$72,941,465
IHS TANF Adults	7,439	$14,878
IHS TANF Children	88,117	$186,193

Miscellaneous Capitation (not limited to SoonerCare Choice)	Member Months	Capitation Payments
Insure Oklahoma - IP	810	$2,430
Non-Emergency Transportation	6,159,811	$22,728,388

IHS indicates Indian Health Services Members

Oklahoma's Uninsured

According to the Census Bureau's Current Population Survey (CPS), more than 660,000 Oklahomans were uninsured in 2006. Nearly 114,000 of the uninsured Oklahomans were children under age 18.

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.

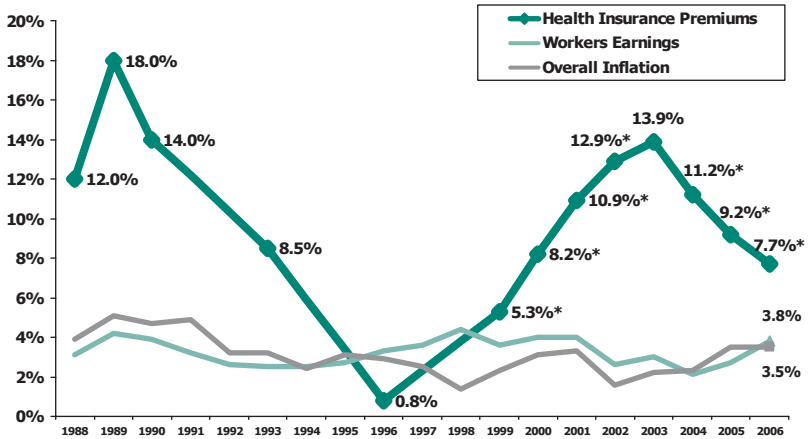
For adults, being uninsured even on a temporary basis can have serious implications for state economies. Uninsured workers are less likely to receive adequate and timely health care and, as a result, suffer more serious illnesses that often threaten their work productivity and job retention.

Oklahoma's Response to the Uninsured

In spite of access problems and other barriers 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.

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. Additionally, 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.

Figure 14 Annual Percent Increase of Health Insurance Premiums Compared to Increases in Earnings and Inflation



*Estimate is statistically different from the previous year shown at p<0.05.

Note: Data on premium increases reflect the cost of health insurance premiums for a family of four.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2006; KPMG Survey of Employer-Sponsored Health Benefits, 1993, 1996; The Health Insurance Association of America (HIAA), 1988, 1989, 1990; Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1988-2006; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1988-2006 (April to April).

Source: Chart retrieved from "*Health Care Costs a Primer*", The Henry Kaiser Family Foundation, August 2007.

Oklahoma's Response to the Uninsured (continued)

Insure Oklahoma - Oklahoma Employer/Employee Partnership for Insurance Coverage

The OHCA received approval to help increase Oklahomans' access to health care coverage under the Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative. Since implementation, the OHCA has enrolled more than 3,000 employees, spouses and individuals under Insure Oklahoma.

Insure Oklahoma Employer-Sponsored Insurance (ESI) is open to small businesses with 50 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 (with applicable income disregards) of the federal poverty level (FPL) 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.

Insure Oklahoma Individual Plan (IP) is available to qualified uninsured Oklahomans who are self-employed, unemployed or working disabled. Individuals are responsible for minimal premiums and any applicable deductibles and co-payments.

Expansions legislated by the Oklahoma legislature during SFY2007 are awaiting federal approval. These expansions will offer health coverage options to more Oklahomans. One legislated expansion will offer coverage to uninsured children whose family income is up to 300 percent of the FPL.

The Insure Oklahoma program has also been legislated to increase the employer size to 250 employees. Additionally, the income qualifications for the employee or individual will be raised to 250 percent of FPL.

Basic requirements for individual participation in the Insure Oklahoma programs are:

- 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.

Employer-Sponsored Insurance (ESI) - requires the above, plus:

Employees:

- Contribute up to 15 percent of premium costs; and
- Enroll in a qualified health plan offered by their employer.

Employers:

- Be located in Oklahoma;
- Have 50 or fewer employees;
- Contribute at least 25 percent of enrolled employees' premium costs; and
- Offer a qualified health plan.

Individual Plan (IP) Requirements, included the basic for individuals above, plus:

- Not be eligible for ESI and work for an Oklahoma business with 50 or fewer employees; or
- Temporarily unemployed and eligible to receive unemployment benefits; or
- Working disabled who works for any size employer and has a ticket to work.

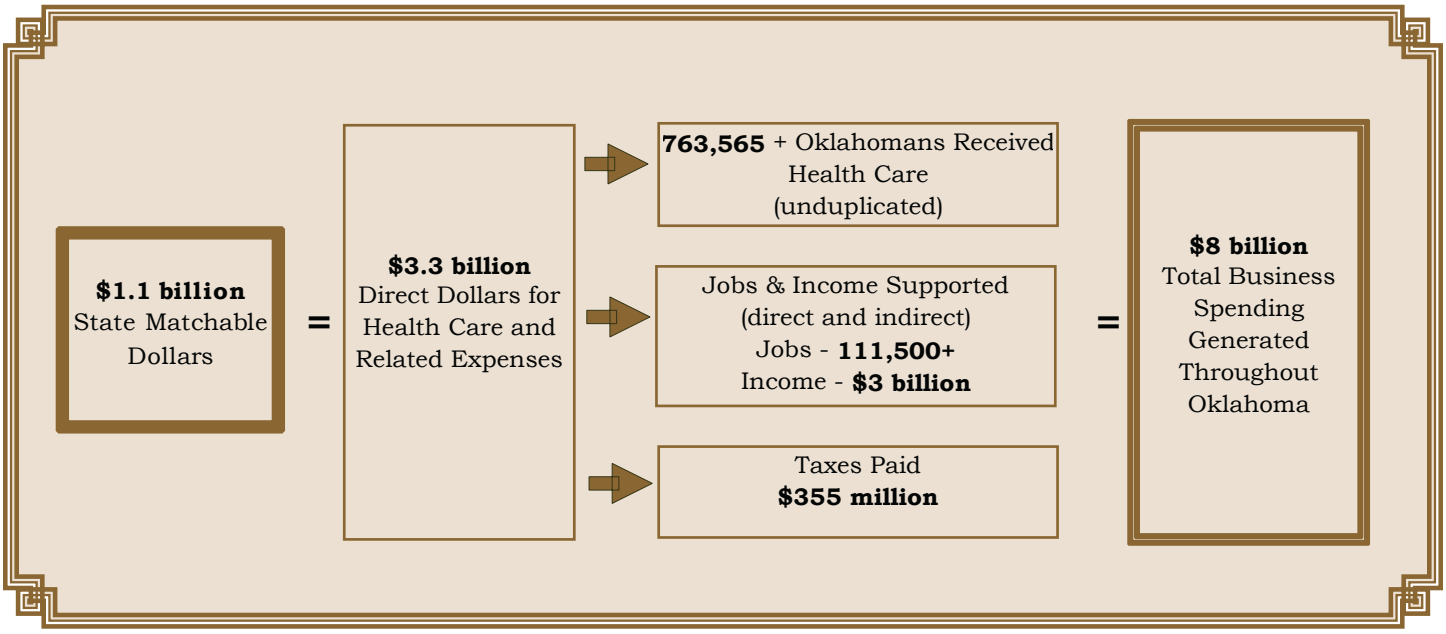
For more specific qualifying requirements, go to the Web site, www.insureoklahoma.org.

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.

*Available for direct medical services and administrative costs.

Figure 15 Economic Impact of SoonerCare on the Oklahoma Economy



Source: "The Economic Impact of the Medicaid Program on Oklahoma's Economy", June 2007, National Center for Rural Health Works, Oklahoma State University, Oklahoma Cooperative Extension Service.

OKLAHOMA SOONERCARE

What Benefits Does SoonerCare Cover?

Oklahoma SoonerCare Benefits

SoonerCare and Native Americans

SoonerCare and Our Providers

The Oklahoma flag prominently displays an Osage warrior's shield made from buffalo hide and decorated with seven eagle feathers hanging from the lower edge. The shield is centered on a field of blue borrowed from the blue flag that Choctaw soldiers carried during the Civil War. This flag honors more than 60 groups of Native Americans and their ancestors.

The shield is decorated with six white crosses (stars) representing high ideals. Superimposed over the shield are symbols of peace and unity from the cultures of the Native American and European-American settlers in the territory: the calumet or ceremonial peace pipe and the olive branch.

Retrieved from http://www.netstate.com/states/symb/flags/ok_flag.htm and http://www.odl.state.ok.us/almanac/2005/5-colorsec.pdf

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 C of this report.

Cost Sharing

States are permitted to require certain members to share some of the costs of Medicaid by imposing deductibles, 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 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 Services Waivers (except for their prescription drugs). Additionally, some services do not require co-pays, such as family planning and emergency services.

$3 Co-Pay

*Inpatient Hospital**

Outpatient Hospital

Ambulatory Surgical Services

Prescription Co-Pay

$1 for each prescription under $30

$2 for each prescription $30 and over

$1 Co-Pay

Physicians (not PCP/CM)

Certified Registered Nurse Anesthetists

Home Health Agencies

Rural Health Clinics

Federally Qualified Health Centers

Optometrists

*Co-payments for inpatient care paid under the Diagnosis Related Groups (DRG) methodology are calculated on the actual length of stay and are capped at $90.

Oklahoma SoonerCare Benefits

Behavioral Health Services

SoonerCare is the behavioral health treatment lifeline for many Oklahomans dealing with stressful life situations/changes, 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 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/or substance abuse assessments,
  - mental health and/or 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.

Children under age 21 accounted for 63 percent of the members receiving behavioral health services and 75 percent of the expenditures.

Child Health Services (Early and Periodic Screening, Diagnosis and Treatment)

Children are the largest number of enrollees in the SoonerCare program, with 497,737 in SFY2007. That means 48 percent of Oklahoma's children under age 21 (1,043,931, according to 2006 U.S. 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.

Child Health Services (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)

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

Early and Periodic Screening, Diagnosis and Treatment (EPSDT, called Child Health Services in Oklahoma) is a federally-mandated set of comprehensive health services for children up to age 21. Child Health Services 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 Services provide immunizations and educate parents on safety, nutrition and child development.

Dental Services

Oral health is a key component of an overall healthy and happy lifestyle. The earlier children are introduced to dentistry, the better their chances of keeping their teeth for the rest of their lives. The greatest challenge is prevention—teaching parents and care-givers to focus on dental interactions, intervention and treatment is crucial.

Dental services are federally mandated for children under age 21 through Child Health Services (Early and Periodic Screening, Diagnosis and Treatment - EPSDT); this program covers dentistry for children based on medical necessity. Dental care includes emergency care, preventive services and therapeutic services for dental diseases which, if left untreated, may become acute dental problems or may cause irreversible damage to the teeth or supporting structures.

178,274 children received dental services and accounted for 95 percent of the dental expenditures in SFY2007.

Oklahoma SoonerCare contracted with 602 dental providers in SFY2007.

Dental services have recently been extended to pregnant women. Basic dental care such as examinations, cleanings and fillings are offered for up to 60 days after the end of their pregnancy. Nonpregnant adults age 21 and over are covered for emergency extractions only.

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 and 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.

Hospital expenditures accounted for 23 percent of the total SoonerCare expenditures.

Oklahoma SoonerCare Benefits (continued)

Medicare "Buy-In" Program - SoonerCare Supplemental

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:

SFY2007 "Buy-In" expenditures totaled $107,753,230.

An average of 2,859 Part A premiums and 80,694 Part B premiums were paid each month during SFY2007.

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.

Medicare Part D is a federal program to assist Medicare beneficiaries with the costs of prescription drugs. It was enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and went into effect January 1, 2006.

Oklahoma SoonerCare Benefits (continued)

Opportunities For Living Life (OLL)—Home and Community-Based Services Waivers

The Home and Community-Based Service waivers give Oklahoma the flexibility to offer SoonerCare-qualified individuals alternatives to being placed in long-term care facilities under OLL. Services through these waiver programs are available for qualified members who 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 and the specific waiver he or she is 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.

Statewide, Oklahoma nursing facilities have a 68.1 percent occupancy rate.

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

Oklahoma SoonerCare Benefits (continued)

Opportunities For Living Life (OLL)—Nursing Home Services

With nursing home or institutional care coverage largely unavailable through Medicare or traditional private health insurance plans, Medicaid is the nation's de facto financing system. In Oklahoma, SoonerCare OLL funds approximately 70 percent 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.

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 his or her MI and/or MR diagnosis.

SoonerCare funded 5,152,932 nursing facility bed days for SFY2007; this represents 70 percent of the total actual nursing facility occupied bed days in the state.

Facility Type	Unduplicated members	Bed Days	Reimbursement	Yearly Average Per Person*	Average Per Day
Nursing Homes*	21,414	5,152,932	$490,658,264	$22,913	$95
ICFs/MR (Private)	1,429	488,349	$54,507,204	$38,144	$112
ICFs/MR (Public)	399	138,390	$71,262,166	$178,602	$515
ICFs/MR (ALL)	1,828	626,739	$125,769,370	$68,802	$201

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)

Pharmacy Services

The pharmacy benefit is accessed by nearly 58 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 their 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. Restrictions such as medical necessity, step therapy, prior authorization and quantity limits 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 that of SoonerCare Choice, plus members who are not Medicare eligible 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."

The average cost per prescription funded by SoonerCare was $67.50 and the average monthly prescription cost per patient was $165.00 for SFY2007.

SoonerCare has one of the highest generic utilization rates of any pharmacy benefit plan in the nation with an average of more than 68 percent of all prescriptions being dispensed as a generic drug.

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.

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.

OHCA contracts with more than 200 school districts across the state. 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 medically necessary 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 early medical intervention and treatment for children age birth to 3 years who are developmentally delayed. Services for the EI program such as targeted case management and 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.

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 age 19 and over who do not traditionally qualify for full benefits under SoonerCare.

SoonerPlan benefits may be obtained from any SoonerCare provider who offers family planning. They include:

- 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.

An average of 9,488 members per month used the SoonerRide services for a total of more than 614,978 transports.

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

SoonerCare and Native Americans

Oklahoma is home to 39 tribal governments and, according to the 2006 Census estimates, nearly 400,000 Native Americans live here. During SFY2007, more than 92,350 Native Americans were 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 (IHS), Tribal health facilities, or urban clinics (I/T/U). There are more than 50 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.

Program of All-Inclusive Care for the Elderly (PACE)

The OHCA and the Cherokee Nation of Oklahoma continue efforts to establish a PACE program. PACE will provide the entire continuum of care and services to qualified seniors, certified by the state to need nursing home care, who can be safely served in a community setting. The Cherokee Nation sent a PACE application to the Centers for Medicare & Medicaid Services for approval in June 2007.

SoonerCare covers more than 72,000 Native American children under the age of 21.

During SFY2007, OHCA had more than 3,200 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.

Physicians

In Oklahoma, a prearranged monthly 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). 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.

Oklahoma SoonerCare has contracts with more than 8,500 physicians.

During SFY2007, OHCA continued to pay physician rates equal to 100 percent of Medicare rates—which are considered national benchmark rates. All relative value unit (RVU) based procedure codes as well as the actuarial value of primary care and case management capitation rates have been valued at 100 percent of Medicare rates since August 1, 2005.

Nursing Homes

Nursing homes in Oklahoma play an essential role in our health care system, caring for approximately 30,500 elderly and disabled persons who are temporarily or permanently unable to care for themselves but who do not require the level of care furnished in an acute care hospital. They provide a variety of services to residents, including nursing and personal care; physical, occupational, respiratory, and speech therapy; and medical social services. On average 70 percent of nursing home residents in Oklahoma have their care paid for through the SoonerCare program, while eight percent are covered by Medicare, and 22 percent are covered by other payers or pay for the care themselves.

Nursing homes treat people with a wide range of clinical conditions. The mix and amount of resources nursing homes use determine the cost of the care they provide. These resources include the cost of direct care staff, such as nurses, nurse aides, and nurse aide training. In 2004, Senate Bill 1622 created the Oklahoma Nursing Facility Funding Advisory Committee. The purpose of the advisory committee was to develop a new methodology for calculating state Medicaid reimbursements to nursing homes by implementing facility specific rates based on expenditures related to direct care staffing.

SOONERCARE AND OUR PROVIDERS (CONTINUED)

NURSING HOMES (CONTINUED)

The committee recommended 70 percent of additional available funds for nursing homes be allocated annually for direct care staff. Based on the most recent data available, nursing homes spend approximately 37.5 percent of Medicaid reimbursement on direct care staffing. The committee also recommended further development of the methodology in future years, to strengthen incentives to provide improved quality care. One incentive to provide high quality nursing home care is the Focus on Excellence program.

Focus on Excellence will use regularly-collected nursing home performance data to accomplish three purposes:

- enable additional Medicaid payments to nursing homes that meet or exceed any of 10 separate performance targets;
- provide information to support a public star rating system for use by consumers in evaluating facilities; and
- give providers the technology and tools to set and meet their own quality improvement goals and compare their performance to facilities across the state and the nation.

A Web site will be available for providers and consumers to enter and view performance data and outcomes. Participating providers may receive a participation bonus if funds are available beginning July 1, 2007.

HOSPITALS

OHCA expects the inpatient and outpatient hospital payment rates to remain at 100 percent of the Medicaid costs of providing these services.

The SoonerCare hospital reimbursement system is based on Medicare's reimbursement model of Diagnostic Related Groups (DRG). A DRG payment methodology, which pays on a per discharge basis, encourages hospitals to operate more efficiently and matches payments to use of resources. For cases that are particularly costly, an additional outlier payment is made to help protect the hospital from large financial losses for unusually expensive cases. For inpatient stays in freestanding rehabilitation and behavioral health facilities, as well as long-term care sub-acute children's facilities, OHCA pays a per day rate.

FIGURE 16 SFY2007 HOSPITAL PAYMENTS

Types of Hospital Payments	SFY2006	SFY2007
Inpatient Services (Acute, Rehab & Children's)	$470,030,099	$559,561,584
Inpatient Psychiatric Services	$18,448,227	$19,437,150
Outpatient Services	$151,447,055	$188,691,195
Upper Payment Limit - Supplemental Payments	$10,666,000	$29,690,425
Indirect Medical Education (IME)	$25,077,370	$25,955,100
Graduate Medical Education (GME)	$26,056,562	$16,243,372
Disproportionate Share Hospitals (DSH)*	$31,190,420	$31,175,423
Total	**$732,915,733**	**$870,754,249**

*During SFY2007 Oklahoma adopted a new formula and methodology for allocating DSH funds. As a result, DSH payments that would have normally occurred in SFY2007 were delayed until July 2007 (SFY2008).

SoonerCare and Our Providers (continued)

Hospitals (continued)

Disproportionate Share Hospital (DSH) Payments

The DSH program was created in 1981 to address two main concerns identified by Congress at the time. The first concern was to address the needs of hospitals that served a high number of Medicaid and low-income, often uninsured, patients. The second concern was that there was the potential for a growing gap in 1981 between what Medicaid paid hospitals and what the cost of care was at the hospitals.

Congress left it up to each state to define and identify which hospitals were disproportionate share hospitals and also gave states broad latitude in how those hospitals were to be paid through the DSH program. 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.

During SFY2007 Oklahoma adopted a new formula and methodology for allocating DSH funds. The formula and methodology establishes three funding pools directed toward licensed hospitals located within the boundaries of the state provided that the hospitals meet certain federal requirements outlined by law.

The first pool is established by the federal government for Institutions for Mental Disease (IMD). The second pool is for High Disproportionate Share Public Hospital/Public - Private Major Teaching Hospital and is based on historic allocations. The third pool is for Private and Community or Public Hospitals which is further subdivided by hospital size for the purpose of allocating the DSH funds reserved for this pool.

Through the new formula OHCA will allocate $43,153,482 in federal fiscal year 2007 DSH funds to 68 licensed hospitals.

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.

SFY2007 IME Payments:

OU/OKC-Oklahoma Medical Center - $12,977,550
OU/Tulsa-Hillcrest Health Systems - $6,488,775
OSU/Tulsa-Hillcrest Health Systems - $6,488,775

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.

DME Qualified Hospitals	SFY2007
Baptist Medical Center	$977,078
Bone and Joint Hospital	$257
Comanche Co Memorial Hospital	$28,970
Deaconess Hospital	$35,492
Hillcrest Medical Center	$1,805,699
Jane Phillips Hospital	$6,901
Laureate Psych Hospital	$6,660
Medical Center of Southeastern OK	$40,225
Saint Francis	$889,676
Southwest Medical Center	$143,224
St. Anthony	$1,435,978
St. John	$623,861
Tulsa Regional Medical Center	$1,310,935
University Health Partners	$8,938,416
TOTAL	**$16,243,372**

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.

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.

SFY2007 GME Payments:

University of Oklahoma	*$41,964,444*
Oklahoma State University College of Osteopathic Medicine - Tulsa	*$15,746,589*

SoonerCare and Our Providers (continued)

Pharmacies

Providers for SoonerCare wrote almost 2 million prescriptions in the first six months of the fiscal year. Members get an average of almost four prescriptions per month. According to the Institute of Medicine, nationally each year more than 1.5 million patients are injured and more than 7,000 patients die from preventable medication errors linked to handwriting errors and other problems associated with writing prescriptions on paper.

In an effort to avoid these potentially harmful and costly mistakes, the Oklahoma Health Care Authority has partnered with Cerner Corp. to launch an electronic prescribing program for SoonerCare's more than 700,000 members across the state.

Cerner's e-prescribing solution provides two-way electronic communication between physicians and pharmacies. Health care providers can use the system to write new prescriptions, authorize refills, make changes, cancel prescriptions, and see if patients have had prescriptions filled. E-prescribing also has the potential for sharing information such as medication history with other health care organizations. The program will roll out to 500 SoonerCare providers toward the latter part of 2007.

In another effort to reduce medication errors and provide quicker transactions, OHCA contracts with EPOCRATES®, Inc. to provide pharmacy benefit information to prescribers and pharmacists using their desktop computer 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.

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. 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 of up to 20 percent of their annual capitation revenue. Out of 836 providers evaluated, 247 received a bonus for a total payout of $789,346. For more EPSDT information got to page 37 of this report.

UNDERSTANDING OHCA

OHCA and SoonerCare

Operating Principles

Administering the SoonerCare Program

Payment and Program Integrity

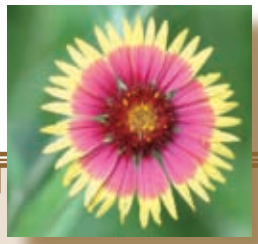
Organizational Chart

The Oklahoma Rose is a hybrid tea rose developed in 1964 at Oklahoma State University by Herbert C. Swim and O. L. Weeks. In 2004, the Oklahoma Rose became the official state flower of Oklahoma.

Retrieved from http://www.answers.com/topic/oklahoma?cat=travel

The Redbud (Cercis canadensis) has been Oklahoma's State Tree since 1937. The Redbud grows in the valleys and ravines of Oklahoma. In early spring, its reddish-pink blossoms brighten the landscape throughout the state.

Retrieved from http://www.answers.com/topic/oklahoma?cat=travel



Oklahoma's State Wildflower, the Indian Blanket (Gaillardia pulchella, Firewheel, or Sundance), is a hardy plant. It symbolizes Oklahoma's scenic beauty as well as the state's Native American heritage. Indian Blanket flowers bloom in June and July.

Retrieved from http://en.wikipedia.org/wiki/Indian_Blanket

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 12th year managing the now $3.3 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 $3.3 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 and 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.

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.

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, state Medicaid plans must meet 63 separate federal statutory requirements. About a third (19) of these relate directly to administration.

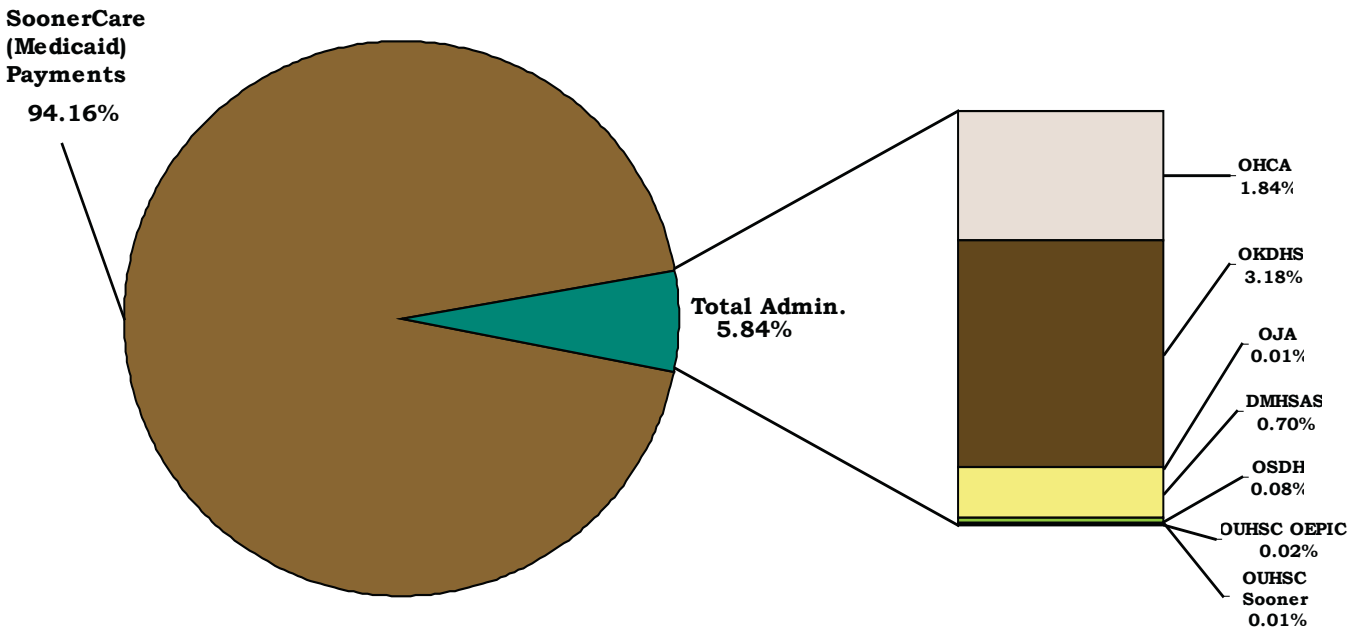
From an administrative perspective, SoonerCare can be viewed as a complex health insurance program: It purchases a broad range of acute and long-term care services on behalf of enrolled low-income individuals. Like private insurers, OHCA has to accomplish nine critical tasks. It must:

- 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 whom it will purchase covered benefits and enroll (or contract with) those who 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)

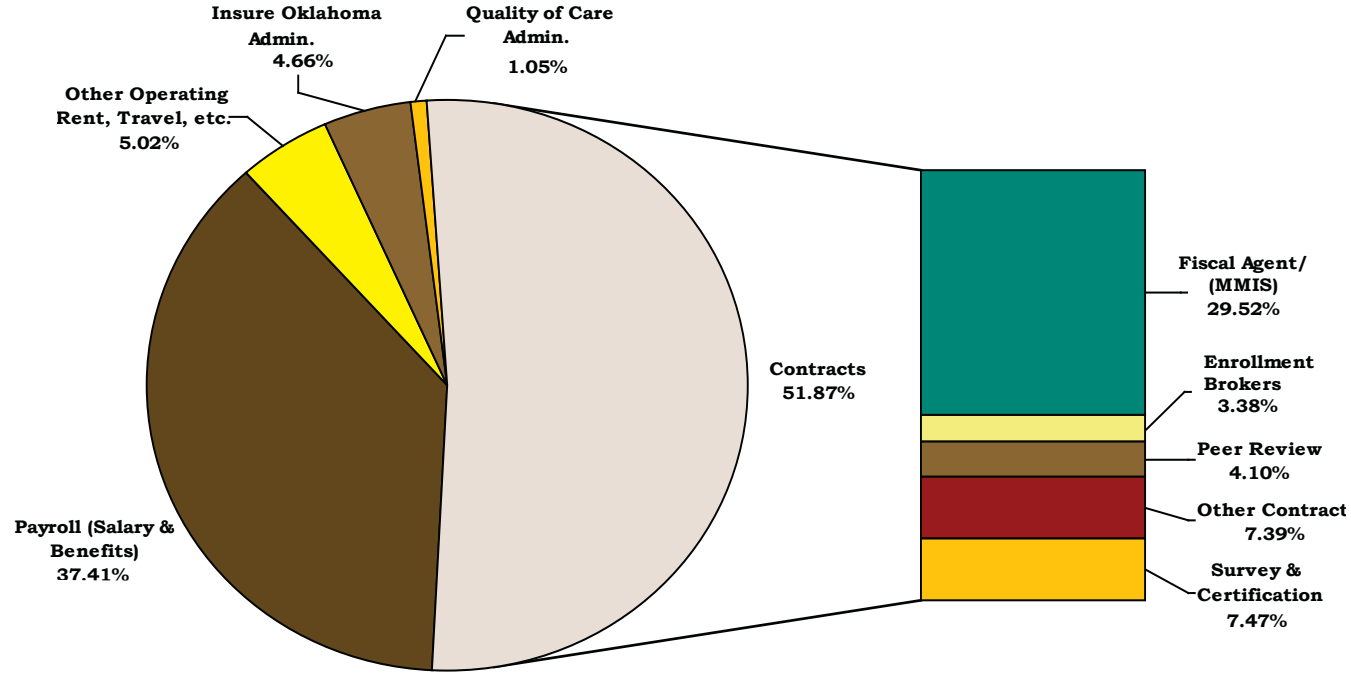
The administration of the SoonerCare program is divided among six different state agencies: the Oklahoma Health Care Authority (OHCA), the Oklahoma Department of Human Services (OKDHS), the Oklahoma State Department of Health (OSDH), the Office of Juvenile Affairs (OJA), the Department of Mental Health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

FIGURE 17 OHCA SOONERCARE EXPENDITURE PERCENTAGES—SFY2007



Finally, OHCA's administrative expenses are divided between direct operating expenses and vendor contracts. Of the $60 million spent by OHCA in SFY2007 on administration, 43 percent went to direct operation expenses, while 57 percent went toward vendor contracts.

FIGURE 18 OHCA ADMINISTRATIVE EXPENSES—SFY2007



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.

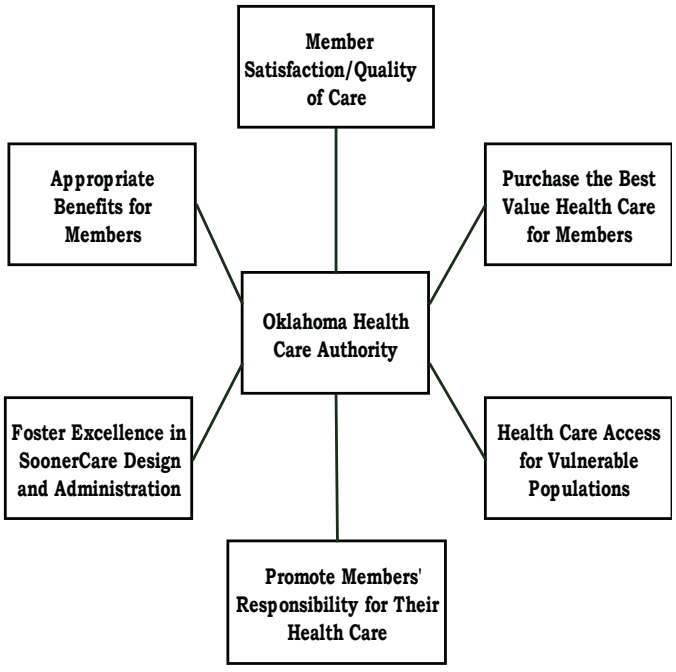
The OHCA, our health partners, advocacy groups, legislators and other stakeholders meet annually to discuss the agency's upcoming enhancements, goals and challenges. These meetings help guide and set the strategic plan for that specific year.

Broadly Stated Goals

The heart of our Strategic Plan is the statement of our primary strategic goals. 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.

The OHCA produces an award-winning Service Efforts and Accomplishments report every year. This report details the specific efforts of our agency and others to accomplish the above primary and yearly specific goals outlined in the agency's Strategic Plan. Both the Strategic Plan and the Service Efforts and Accomplishments reports can be found on OHCA's public Web site at www.okhca.org\Research\Reports.



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

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 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.

Additionally, the PRO performs on-site inspection of care reviews for licensed psychiatric inpatient and day treatment facilities that provide services to SoonerCare members under 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. APS Healthcare Inc. was the PRO under contract with OHCA during SFY2007. Additional information on APS Healthcare may be found at www.apshealthcare.com.

Figure 19 Post-Payment Review Recoveries—SFY2007

Provider Type	SFY2007
Behavioral Health	$1,234,826
Case Management	$21,808
Dental Services	$99,162
Durable Medical Equipment	$3,163,551
Hospital	$1,255,104
Nursing Facilities	$351,858
Personal Care/Habilitation Training Specialist	$29,862
Physician & Other Practitioners	$2,318,232
Pharmacy	$403,053
Private Duty Nursing	$950
School Corporation	$112,046
Therapy	$127,503
Vision	$36,966
Deceased Members - Various Provider Types	$78,154
Total - OHCA Recoveries	**$9,233,075**
MFCU - Other	$1,760
MFCU - National Settlements	$5,178,543
Total SoonerCare Recoveries	**$14,413,378**

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

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	*$2,613,940*
Other	*$9,903,706*

Cost Avoidance

Cost avoidance is the method of either finding alternate responsible payers, such as 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	*$707,237,909*
Private Insurance	*$269,020,905*

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—SFY2007	*$7,195,423*

Program and Payment Integrity Activities (continued)

State Maximum Allowable Cost Program

The State Maximum Allowable Cost (SMAC) program limits pharmacy reimbursement for generic products. SoonerCare has one of the highest generic utilization rates of any benefit plan in the nation, with an average of more than 68 percent of all prescriptions being dispensed as a generic drug. When the SMAC program was started in 2000, there were 400 products included. The most recent list includes more than 1,100 drug products.

By limiting the amount paid for generic drugs, OHCA was able to save more than $75.5 million in SFY2007.

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.

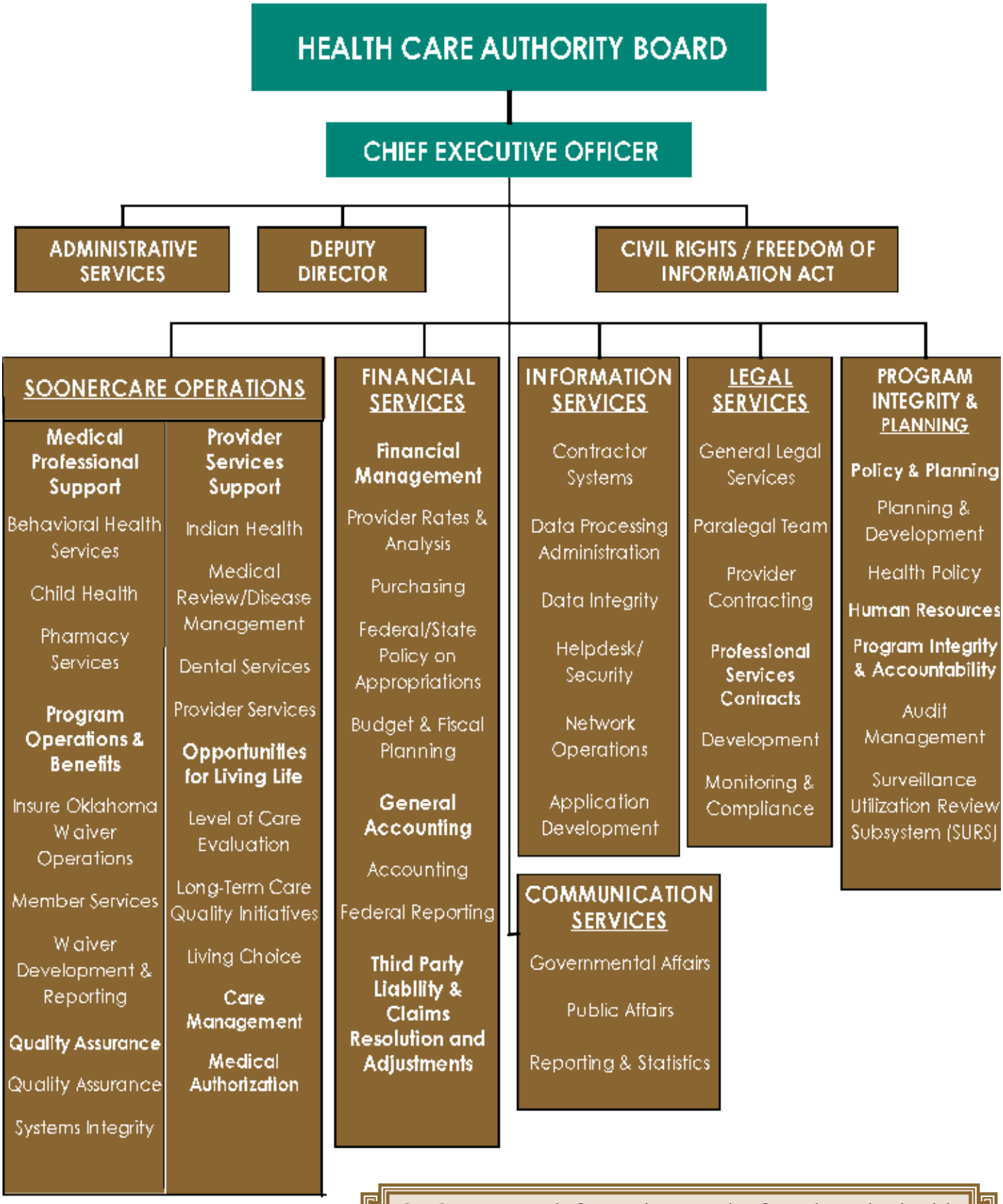
Rebates - Federal	*$81,398,186*
Rebates - State Supplemental	*$5,135,371*
Interest	*$133,846*

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. The fund is 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.

Total Quality of Care Program revenues were $54,277,601.

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.

FIGURE 20 OHCA'S ORGANIZATIONAL CHART



OHCA contact information can be found on the inside back cover or at www.okhca.org/contact us.

Appendix A Glossary of Terms

ABD - The Aged, Blind and Disabled SoonerCare population.

Member - A person enrolled in Oklahoma SoonerCare.

CMS - Centers for Medicare & Medicaid Services, formally known as Health Care Financing Administration (HCFA), federal agency that establishes and monitors Medicaid funding requirements.

EDS - Electronic Data Systems 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 - Federal Fiscal Year. The federal fiscal year starts on October 1 and ends September 30 each year.

FMAP - Federal Medical Assistance Percentage – The federal dollar match percentage.

ICF/MR - Intermediate Care Facility for the Mentally Retarded.

EPSDT - Early and Periodic Screening, Diagnosis and Treatment also known as "well child" screens.

MMIS - Medical Management Information System—the claims processing system.

SCHIP - State Children's Health Insurance Program for children age 19 and under who have no creditable insurance and meet come requirements. (Title XXI)

SFY - State Fiscal Year — starts on July 1 and ends June 30 each year.

SoonerCare Choice - Oklahoma's partially capitated managed care program.

TANF/AFDC - Temporary Assistance for Needy Families, formerly known as Aid to Families with Dependent Children. 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 time frame. 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 STATEWIDE SFY2007 FIGURES

FIGURE I SOONERCARE EXPENDITURES BY PAYOR

Category of Service	Total	Health Care Authority	Other State Agencies	Quality Care Fund	Medicaid Program Fund & HEEIA*	BCC Revolving Fund
ADvantage Waiver	$156,904,992	$0	$156,904,992	$0	$0	$0
Ambulatory Clinics	$27,604,021	$19,434,208	$7,733,787	$0	$0	$436,026
Behavioral Health - Case Mgmt	$31,608,209	$116,221	$31,376,523	$0	$0	$115,465
Behavioral Health - Clinic	$68,582,995	$68,577,533	$0	$0	$0	$5,462
Behavioral Health - Inpatient	$102,091,158	$96,472,408	$5,610,586	$0	$0	$8,164
Behavioral Health - Outpatient	$9,013,695	$9,013,695	$0	$0	$0	$0
CMS Payments	$160,946,485	$156,304,492	$0	$4,641,993	$0	$0
Dentists	$113,172,520	$107,693,319	$0	$0	$5,256,654	$222,547
Family Planning/ SoonerPlan	$7,194,109	$0	$7,194,109	$0	$0	$0
GME/IME/DME	$99,909,504	$0	$99,909,504	$0	$0	$0
Home & Community Based Waiver	$135,398,613	$0	$135,398,613	$0	$0	$0
Home Health Care	$17,860,158	$17,786,960	$0	$0	$0	$73,198
Homeward Bound Waiver	$94,984,612	$0	$94,984,612	$0	$0	$0
ICF/MR Private	$54,509,692	$35,060,591	$0	$18,562,205	$886,896	$0
ICF/MR Public	$72,339,210	$0	$72,339,210	$0	$0	$0
In-Home Support Waiver	$23,106,965	$0	$23,106,965	$0	$0	$0
Inpatient Acute Care	$577,074,290	$527,048,328	$744,348	$486,687	$42,979,488	$5,815,439
Lab & Radiology	$16,330,896	$15,597,751	$0	$0	$0	$733,145
Medical Supplies	$49,815,515	$47,020,326	$0	$2,708,208	$0	$86,981
Misc Medical Payments	$22,675,493	$22,582,875	$0	$0	$0	$92,618
Nursing Facilities	$489,707,271	$301,537,847	$0	$145,373,352	$42,778,841	$17,231
Other Practitioners	$33,646,552	$33,140,912	$0	$446,364	$0	$59,276
Outpatient Acute Care	$214,354,954	$209,305,408	$0	$41,604	$0	$5,007,942
Personal Care Services	$10,682,183	$0	$10,682,183	$0	$0	$0
Physicians	$298,407,904	$213,554,170	$22,132,559	$58,101	$49,402,324	$13,260,750
Premium Assistance*	$3,953,589	$0	$0	$0	$3,953,589	$0
Prescription Drugs	$300,169,210	$261,315,648	$0	$0	$36,713,568	$2,139,994
Residential Behavioral Management Services	$31,122,604	$0	$31,122,604	$0	$0	$0
SoonerCare Choice	$99,270,364	$87,018,708	$12,042,379	$0	$0	$209,277
Targeted Case Management	$43,439,141	$0	$43,439,141	$0	$0	$0
Transportation	$23,540,644	$22,745,783	$0	$701,226	$4,405	$89,230
Total SoonerCare Expenditures	**$3,389,417,548**	**$2,251,327,183**	**$754,722,115**	**$173,019,740**	**$181,975,765**	**$28,372,745**

Source: OHCA Financial Service Division, September 2007. *Medicaid Program Fund & HEEIA includes $3,953,589 Premium Assistance payments from HEEIA Fund. Financial statement data represents actual cash expenditures as reported to the Office of State Finance while MMIS data warehouse expenditure data is net of overpayments and adjustments. The Medicaid Program Fund, the HEEIA Fund and the BCC (Oklahoma Cares) Revolving Fund are all funded by tobacco tax collections.

Appendix B Statewide SFY2007 Figures (continued)

Figure II Statewide SoonerCare Figures

County	Population Proj. July 2006*	Rank	Unduplicated SoonerCare Enrollees**	Rank	Population Enrolled in SoonerCare	Rank
ADAIR	22,317	38	8,284	30	37%	1
ALFALFA	5,673	68	591	74	10%	76
ATOKA	14,340	47	3,751	46	26%	20
BEAVER	5,336	70	650	72	12%	75
BECKHAM	19,271	41	4,887	40	25%	29
BLAINE	12,734	51	2,434	56	19%	53
BRYAN	38,395	26	10,564	19	28%	19
CADDO	30,063	33	7,743	31	26%	24
CANADIAN	101,335	5	12,656	10	12%	74
CARTER	47,503	16	12,069	14	25%	28
CHEROKEE	44,910	20	11,386	17	25%	30
CHOCTAW	15,334	44	5,602	38	37%	2
CIMARRON	2,807	77	479	76	17%	61
CLEVELAND	228,594	3	32,624	3	14%	70
COAL	5,634	69	1,854	64	33%	5
COMANCHE	109,181	4	21,973	4	20%	49
COTTON	6,491	65	1,358	67	21%	48
CRAIG	15,046	45	4,342	42	29%	16
CREEK	69,146	9	15,415	7	22%	43
CUSTER	25,566	36	5,985	37	23%	39
DELAWARE	40,061	23	10,230	20	26%	25
DEWEY	4,475	72	719	71	16%	63
ELLIS	3,912	73	519	75	13%	72
GARFIELD	57,068	12	12,487	12	22%	45
GARVIN	27,375	34	6,734	34	25%	35
GRADY	50,490	13	9,894	23	20%	52
GRANT	4,653	71	722	70	16%	64
GREER	5,864	67	1,474	65	25%	31
HARMON	3,042	76	911	69	30%	14
HARPER	3,348	74	629	73	19%	55
HASKELL	12,155	52	3,787	44	31%	10
HUGHES	13,893	49	3,612	49	26%	21
JACKSON	26,042	35	6,120	36	24%	38
JEFFERSON	6,385	66	2,003	63	31%	8
JOHNSTON	10,436	59	3,237	52	31%	11
KAY	45,889	17	11,662	16	25%	27
KINGFISHER	14,316	48	2,199	61	15%	65
KIOWA	9,778	60	2,283	58	23%	40
LATIMER	10,562	58	2,610	55	25%	34
LEFLORE	50,079	14	14,083	8	28%	17

Appendix B Statewide SFY2007 Figures (continued)

Figure II Statewide SoonerCare Figures (continued)

County	Expenditures	Rank	Annual Per Capita	Rank	Monthly Per Enrollee	Rank
ADAIR	$28,182,110	31	$1,263	15	$283	65
ALFALFA	$2,282,345	74	$402	74	$322	45
ATOKA	$13,054,944	50	$910	40	$290	64
BEAVER	$1,811,789	75	$340	77	$232	76
BECKHAM	$21,414,422	41	$1,111	22	$365	20
BLAINE	$9,452,118	58	$742	54	$324	43
BRYAN	$42,088,178	22	$1,096	23	$332	38
CADDO	$25,736,472	34	$856	46	$277	69
CANADIAN	$45,748,367	18	$451	73	$301	57
CARTER	$48,792,860	13	$1,027	29	$337	33
CHEROKEE	$48,106,114	14	$1,071	26	$352	27
CHOCTAW	$24,393,759	36	$1,591	5	$363	22
CIMARRON	$1,421,321	76	$506	71	$247	75
CLEVELAND	$121,836,079	3	$533	69	$311	51
COAL	$7,966,252	60	$1,414	8	$358	24
COMANCHE	$66,070,928	7	$605	64	$251	74
COTTON	$5,689,642	66	$877	44	$349	28
CRAIG ‡	$25,413,736	35	$1,689	3	$488	4
CREEK	$68,174,521	6	$986	32	$369	18
CUSTER	$23,688,030	37	$927	38	$330	40
DELAWARE	$33,325,985	28	$832	47	$271	71
DEWEY	$3,456,734	70	$772	50	$401	11
ELLIS	$2,328,902	73	$595	65	$374	16
GARFIELD ‡	$90,044,693	4	$1,578	6	$601	2
GARVIN ‡	$59,019,542	9	$2,156	1	$730	1
GRADY	$33,217,331	29	$658	59	$280	67
GRANT	$3,432,897	71	$738	55	$396	13
GREER	$6,324,091	65	$1,078	24	$358	25
HARMON	$4,914,948	68	$1,616	4	$450	6
HARPER	$2,410,523	72	$720	57	$319	47
HASKELL	$14,503,169	47	$1,193	17	$319	48
HUGHES	$18,965,161	43	$1,365	10	$438	7
JACKSON	$20,531,799	42	$788	49	$280	68
JEFFERSON	$7,422,064	61	$1,162	18	$309	53
JOHNSTON	$13,682,002	49	$1,311	13	$352	26
KAY	$40,601,020	23	$885	42	$290	63
KINGFISHER	$7,206,941	62	$503	72	$273	70
KIOWA	$10,332,257	56	$1,057	27	$377	14
LATIMER	$10,483,707	55	$993	31	$335	35
LEFLORE	$52,408,253	11	$1,047	28	$310	52

Appendix B Statewide SFY2007 Figures (continued)

Figure II Statewide SoonerCare Figures (continued)

County	Population Proj. July 2006*	Rank	Unduplicated SoonerCare Enrollees**	Rank	Population Enrolled in SoonerCare	Rank
LINCOLN	32,645	31	6,513	35	20%	50
LOGAN	36,971	27	6,909	33	19%	56
LOVE	9,162	61	2,241	59	24%	36
MCCLAIN	31,038	32	4,408	41	14%	71
MCCURTAIN	34,018	29	11,898	15	35%	3
MCINTOSH	19,899	40	5,060	39	25%	26
MAJOR	7,329	64	957	68	13%	73
MARSHALL	14,558	46	3,773	45	26%	22
MAYES	39,774	24	9,900	22	25%	33
MURRAY	12,945	50	3,055	53	24%	37
MUSKOGEE	71,018	8	19,767	5	28%	18
NOBLE	11,152	56	2,201	60	20%	51
NOWATA	10,785	57	2,370	57	22%	44
OKFUSKEE	11,370	55	3,648	48	32%	6
OKLAHOMA	691,266	1	149,116	1	22%	46
OKMULGEE	39,670	25	12,199	13	31%	12
OSAGE	45,549	18	6,962	32	15%	66
OTTAWA	33,026	30	9,661	24	29%	15
PAWNEE	16,844	43	3,802	43	23%	42
PAYNE	73,818	7	11,257	18	15%	67
PITTSBURG	45,002	19	10,200	21	23%	41
PONTOTOC	35,350	28	9,159	26	26%	23
POTTAWATOMIE	68,638	10	17,174	6	25%	32
PUSHMATAHA	11,641	53	3,506	51	30%	13
ROGER MILLS	3,293	75	338	77	10%	77
ROGERS	82,435	6	12,545	11	15%	68
SEMINOLE	24,650	37	8,371	29	34%	4
SEQUOYAH	41,356	22	12,972	9	31%	9
STEPHENS	43,243	21	9,123	27	21%	47
TEXAS	20,238	39	3,581	50	18%	60
TILLMAN	8,482	62	2,686	54	32%	7
TULSA	577,795	2	107,632	2	19%	57
WAGONER	66,313	11	9,514	25	14%	69
WASHINGTON	49,241	15	8,757	28	18%	59
WASHITA	11,583	54	2,154	62	19%	58
WOODS	8,385	63	1,388	66	17%	62
WOODWARD	19,231	42	3,660	47	19%	54
Out of State	0		3			
Other ◊	0					
TOTAL	**3,579,212**		**763,565**	**21.33%**		

*Source: Population Division, U.S. 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 SFY2007 FIGURES (CONTINUED)

FIGURE II STATEWIDE SOONERCARE FIGURES (CONTINUED)

County	Expenditures	Rank	Annual Per Capita	Rank	Monthly Per Enrollee	Rank
LINCOLN	$23,089,242	39	$707	58	$295	60
LOGAN	$26,891,334	32	$727	56	$324	42
LOVE	$6,888,451	63	$752	52	$256	72
MCCLAIN	$15,864,453	45	$511	70	$300	59
MCCURTAIN	$47,196,850	16	$1,387	9	$331	39
MCINTOSH	$22,753,810	40	$1,143	20	$375	15
MAJOR	$4,573,418	69	$624	63	$398	12
MARSHALL	$14,272,050	48	$980	34	$315	50
MAYES	$39,975,315	24	$1,005	30	$336	34
MURRAY	$12,089,190	53	$934	37	$330	41
MUSKOGEE	$87,805,757	5	$1,236	16	$370	17
NOBLE	$12,552,434	51	$1,126	21	$475	5
NOWATA	$9,458,320	57	$877	43	$333	37
OKFUSKEE ‡	$23,305,673	38	$2,050	2	$532	3
OKLAHOMA	$547,417,577	1	$792	48	$306	54
OKMULGEE	$50,879,398	12	$1,283	14	$348	31
OSAGE	$26,875,882	33	$590	66	$322	46
OTTAWA	$35,443,980	26	$1,073	25	$306	56
PAWNEE	$16,605,944	44	$986	33	$364	21
PAYNE	$43,022,558	20	$583	67	$318	49
PITTSBURG	$43,949,048	19	$977	35	$359	23
PONTOTOC	$46,921,028	17	$1,327	11	$427	8
POTTAWATOMIE	$60,814,245	8	$886	41	$295	61
PUSHMATAHA	$15,398,458	46	$1,323	12	$366	19
ROGER MILLS	$1,219,179	77	$370	75	$301	58
ROGERS	$52,414,192	10	$636	62	$348	30
SEMINOLE	$34,993,027	27	$1,420	7	$348	29
SEQUOYAH	$47,620,056	15	$1,151	19	$306	55
STEPHENS	$32,164,227	30	$744	53	$294	62
TEXAS	$6,887,974	64	$340	76	$160	77
TILLMAN	$8,104,170	59	$955	36	$251	73
TULSA	$436,738,816	2	$756	51	$338	32
WAGONER	$38,127,570	25	$575	68	$334	36
WASHINGTON	$42,909,114	21	$871	45	$408	10
WASHITA	$10,691,555	54	$923	39	$414	9
WOODS	$5,375,500	67	$641	61	$323	44
WOODWARD	$12,408,768	52	$645	60	$283	66
Out of State	$17,173,310					
OTHER ◊	$330,277,443				$6,058	
TOTAL	**$3,377,085,329**		**$944**		**$369**	

‡Garfield & Garvin counties have public institutions and Okfuskee & Craig counties have private institutions for the developmentally disabled causing the average dollars per SoonerCare enrollee to be higher than the norm. ◊ Non-county specific payments include $107,753,230 in Medicare Part A & B (Buy-In) payments and $53,193,255 in Medicare Part D (claw-back) payments; $103,064,320 in Hospital Supplemental payments; $57,711,032 in GME payments to Medical schools; $4,560,481 in Public ICF/MR cost settlements; $3,732,228 in FQHC wrap-around payments; $3,614,205 in ESI premiums and $49,990 in ESI out-of-pocket payments; $1,466,136 in EPSDT bonus payments; and 1,477,761 in non-provider specific provider adjustments. Non-Emergency Transportation payments of $22,727,223 is also included in this category so as not to skew that provider county.

Appendix B Statewide SFY2007 Figures (continued)

Figure III Expenditures Paid to Providers and Members by County

County	Total Dollars Paid by Provider County	Total Dollars Paid by Member County	% of Dollars Staying in County
ADAIR	$12,172,963	$28,182,110	43%
ALFALFA	$1,378,053	$2,282,345	60%
ATOKA	$5,515,866	$13,054,944	42%
BEAVER	$1,224,437	$1,811,789	68%
BECKHAM	$16,042,688	$21,414,422	75%
BLAINE	$4,403,365	$9,452,118	47%
BRYAN	$49,577,207	$42,088,178	118%
CADDO	$15,499,580	$25,736,472	60%
CANADIAN	$22,135,885	$45,748,367	48%
CARTER	$41,877,632	$48,792,860	86%
CHEROKEE	$47,108,264	$48,106,114	98%
CHOCTAW	$14,343,271	$24,393,759	59%
CIMARRON	$707,746	$1,421,321	50%
CLEVELAND	$95,829,020	$121,836,079	79%
COAL	$3,380,086	$7,966,252	42%
COMANCHE	$64,840,270	$66,070,928	98%
COTTON	$2,727,946	$5,689,642	48%
CRAIG	$19,067,243	$25,413,736	75%
CREEK	$46,102,186	$68,174,521	68%
CUSTER	$18,767,672	$23,688,030	79%
DELAWARE	$18,048,360	$33,325,985	54%
DEWEY	$2,299,433	$3,456,734	67%
ELLIS	$1,758,921	$2,328,902	76%
GARFIELD	$83,781,952	$90,044,693	93%
GARVIN	$45,702,810	$59,019,542	77%
GRADY	$18,971,259	$33,217,331	57%
GRANT	$1,899,032	$3,432,897	55%
GREER	$3,367,046	$6,324,091	53%
HARMON	$3,512,092	$4,914,948	71%
HARPER	$1,542,683	$2,410,523	64%
HASKELL	$15,809,482	$14,503,169	109%
HUGHES	$8,956,866	$18,965,161	47%
JACKSON	$15,394,441	$20,531,799	75%
JEFFERSON	$3,466,485	$7,422,064	47%
JOHNSTON	$8,405,363	$13,682,002	61%
KAY	$29,343,616	$40,601,020	72%
KINGFISHER	$8,256,660	$7,206,941	115%
KIOWA	$9,136,749	$10,332,257	88%
LATIMER	$5,544,715	$10,483,707	53%
LEFLORE	$34,994,762	$52,408,253	67%
LINCOLN	$10,469,298	$23,089,242	45%

Appendix B Statewide SFY2007 Figures (continued)

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

County	Total Dollars Paid by Provider County	Total Dollars Paid by Member County	% of Dollars Staying in County
LOGAN	$14,664,219	$26,891,334	55%
LOVE	$2,973,270	$6,888,451	43%
MCCLAIN	$8,682,486	$15,864,453	55%
MCCURTAIN	$25,653,159	$47,196,850	54%
MCINTOSH	$24,329,315	$22,753,810	107%
MAJOR	$2,953,389	$4,573,418	65%
MARSHALL	$8,646,404	$14,272,050	61%
MAYES	$20,776,835	$39,975,315	52%
MURRAY	$5,770,155	$12,089,190	48%
MUSKOGEE	$84,596,529	$87,805,757	96%
NOBLE	$7,715,790	$12,552,434	61%
NOWATA	$5,378,555	$9,458,320	57%
OKFUSKEE	$15,344,933	$23,305,673	66%
OKLAHOMA	$798,583,659	$547,417,577	146%
OKMULGEE	$32,095,923	$50,879,398	63%
OSAGE	$6,991,613	$26,875,882	26%
OTTAWA	$31,815,578	$35,443,980	90%
PAWNEE	$9,825,972	$16,605,944	59%
PAYNE	$33,185,612	$43,022,558	77%
PITTSBURG	$37,696,325	$43,949,048	86%
PONTOTOC	$48,029,234	$46,921,028	102%
POTTAWATOMIE	$38,032,461	$60,814,245	63%
PUSHMATAHA	$17,579,981	$15,398,458	114%
ROGER MILLS	$274,422	$1,219,179	23%
ROGERS	$33,419,984	$52,414,192	64%
SEMINOLE	$22,496,562	$34,993,027	64%
SEQUOYAH	$45,833,957	$47,620,056	96%
STEPHENS	$24,346,974	$32,164,227	76%
TEXAS	$6,006,943	$6,887,974	87%
TILLMAN	$6,725,138	$8,104,170	83%
TULSA	$627,086,657	$436,738,816	144%
WAGONER	$9,570,800	$38,127,570	25%
WASHINGTON	$29,503,814	$42,909,114	69%
WASHITA	$5,340,853	$10,691,555	50%
WOODS	$3,778,487	$5,375,500	70%
WOODWARD	$10,364,355	$12,408,768	84%
Out of State	$98,331,721	$17,173,310	
Other ◊	$359,319,861	$330,277,443	109%
Total	**$3,377,085,329**	**$3,377,085,329**	**70%**

◊ Non-county specific payments include $107,753,230 in Medicare Part A & B (Buy-In) payments and $53,193,255 in Medicare Part D (clawback) payments; $103,064,320 in Hospital Supplemental payments; $57,711,032 in GME payments to Medical schools; $4,560,481 in Public ICF/MR cost settlements; $3,732,228 in FQHC wrap-around payments; $3,614,205 in ESI premiums and $49,990 in ESI out-of-pocket payments; $1,466,136 in EPSDT bonus payments; Member Other includes $4,867,434 in non-member specific adjustments and Provider Other includes $1,477,761 in non-provider specific provider adjustments. Non-Emergency Transportation payments of $22,727,223 is also included Other so as not to skew county figures.

Appendix B Statewide SFY2007 Figures (continued)

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

Type of Service	Total	ADvantage	Community	Homeward Bound	In Home Support
Adult Day Care Services	$3,035,678	$2,246,194	$484,542	$0	$304,942
Adv Comp Health Services	$83,442,983	$83,442,983	$0	$0	$0
ADvantage Home Delivered Meals	$10,291,489	$10,291,489	$0	$0	$0
Architectural Modification Services	$662,316	$119,611	$135,840	$168,471	$238,394
Audiology Services	$2,247	$0	$1,331	$798	$118
Behavioral Health Services	$3,292,103	$0	$2,219,191	$934,365	$138,547
Dental Services	$147,714	$0	$79,224	$60,493	$7,997
Direct Support Services	$181,361,549	$0	$83,190,236	$80,759,869	$17,411,443
Employee Training Specialist	$24,707,562	$0	$16,455,680	$5,127,425	$3,124,458
Eye Care and Exam Services	$133	$0	$133	$0	$0
Eyewear Services	$1,075	$0	$1,075	$0	$0
Group Home Services	$17,925,296	$0	$17,778,193	$147,103	$0
Home Health Services	$6,374	$266	$6,108	$0	$0
Homemaker Services	$672,439	$0	$511,183	$9,278	$151,979
Hospice Services	$1,093,319	$1,093,319	$0	$0	$0
Medical Supplies/Durable Goods	$17,159,090	$12,741,797	$2,396,019	$1,073,789	$947,484
Nursing Facility Services	$39,612	$39,612	$0	$0	$0
Nursing Services	$34,375,772	$30,290,091	$1,591,656	$2,494,024	$0
Nutritionist Services	$425,546	$0	$216,816	$206,749	$1,981
Personal Care Services	$980,641	$980,641	$0	$0	$0
Physician Services	$2,627,989	$0	$1,778,510	$726,020	$123,460
Prescribed Drugs Services	$4,323,011	$3,437,491	$453,227	$376,407	$55,887
Prosthetic/Orthotic Services	$2,100	$2,100	$0	$0	$0
Respite Care Services	$464,407	$394,745	$49,148	$0	$20,514
Specialized Foster Care/MR	$3,921,355	$0	$3,868,615	$52,740	$0
Targeted Case Manager (TCM)	$15,760,821	$15,760,821	$0	$0	$0
Therapy Services	$952,832	$0	$568,936	$291,404	$92,492
Transportation Services	$7,521,684	$0	$4,076,080	$2,917,328	$528,277
Total	**$415,197,138**	**$160,841,159**	**$135,861,743**	**$95,346,263**	**$23,147,973**
Unduplicated Members Served	**27,072**	**21,657**	**2,716**	**797**	**2,047**
Average Cost per Member	$15,337	$7,427	$50,023	$119,631	$11,308

Source: OHCA Financial Service Division, September 2007. 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.
* Unduplicated Member Served figures are the unduplicated counts of members that received a service.

APPENDIX B STATEWIDE SFY2007 FIGURES (CONTINUED)

FIGURE V BEHAVIORAL HEALTH EXPENDITURES BY TYPE OF SERVICE BY CHILD AND ADULT

BEHAVIORAL HEALTH SERVICES FOR CHILDREN UNDER 21

Type of Service	Expenditures	Members Served	Average per Member Served
Inpatient (Acute - General)	$10,146,226	1,591	$6,377
Inpatient (Acute - Freestanding)	$9,938,183	1,594	$6,235
Psychiatric Residential Treatment Facility (PRTF)	$71,751,563	3,400	$21,103
Outpatient (Private)	$39,964,827	24,782	$1,613
Outpatient - CMHC (Public)	$515,384	1,133	$455
Outpatient - CMHC (Contracted)	$11,301,420	11,308	$999
Psychologist	$4,356,285	5,724	$761
Psychiatrist	$1,765,981	4,763	$371
Residential Behavior Management Services (Group)	$10,308,980	1,353	$7,619
Residential Behavior Management Services (TFC)	$20,813,622	1,794	$11,602
Targeted Case Management (TCM)	$100,292	744	$135
Other Outpatient Behavioral Health Services	$345,379	191	$1,808
Total	**$181,308,140**	**41,799**	**$4,338**

BEHAVIORAL HEALTH SERVICES FOR ADULTS

Type of Service	Expenditures	Members Served	Average per Member Served
Inpatient (Acute - General)	$9,290,924	2,118	$4,387
Inpatient (Acute - Freestanding)	$916,047	123	$7,448
Psychiatric Residential Treatment Facility (PRTF)	-	-	-
Outpatient (Private)	$16,636,519	7,229	$2,301
Outpatient - CMHC (Public)	$3,699,781	3,475	$1,065
Outpatient - CMHC (Contracted)	$24,841,989	10,789	$2,303
Psychologist	$975,256	495	$1,970
Psychiatrist	$1,590,685	5,260	$302
Residential Behavior Management Services (Group)	-	-	-
Residential Behavior Management Services (TFC)	-	-	-
Targeted Case Management (TCM)	$686,354	3,540	$194
Other Outpatient Behavioral Health Services	$2,006,395	935	
Total	**$60,643,951**	**24,984**	**$2,427**

Total All Behavioral Health Services	**$241,952,090**	**66,619**	**$3,632**

Source: OHCA Financial Service Division, September 2007. Claim dollars were extracted from the MMIS claims history file for claims paid within the fiscal year. Financial statement data represents actual cash expenditures as reported to the Office of State Finance while MMIS data warehouse expenditure data is net of overpayments and adjustments. Member Served figures are the unduplicated counts of members that received a service. If a member received services from multiple service type providers, they would be counted once for each type of service; the total count is the unduplicated count overall.

Appendix B Statewide SFY2007 Figures (continued)

Figure VI Expenditures by Type of Service Totals

SFY2007	Totals		
Type of Service	Expenditures	Members Served	Avg per Member Served
Adult Day Care Services	$3,035,678	631	$4,811
Adv Comp Health Services	$83,442,983	14,270	$5,847
Advanced Practice Nurse (APN) Services	$1,887,336	16,459	$115
ADvantage Home Delivered Meals Services	$10,291,489	10,401	$989
Ambulatory Surgical Services	$5,609,177	13,245	$423
Architectural Modification Services	$662,316	284	$2,332
Audiology Services	$141,029	546	$258
Behavioral Health Services	$68,431,530	45,728	$1,496
Capitated (CAP) Services	$99,101,509	549,194	$180
Capitated (CAP) Services - GME to Med Schools	$57,711,032	-	$0
Chiropractic Services	$11,845	225	$53
Clinic Services	$11,305,656	42,385	$267
Clinics - OSA Services	$8,884,563	98,593	$90
Community Mental Health Services	$37,689,173	23,637	$1,594
Dental Services	$110,802,168	210,450	$527
Direct Support Services	$181,361,549	4,443	$40,820
Employee Training Specialist Services	$24,707,562	2,656	$9,303
End Stage Renal Disease (ESRD) Services	$11,107,324	1,764	$6,297
Eye Care and Exam Services	$5,370,675	65,239	$82
Eyewear Services	$5,927,041	52,232	$113
Free Standing Birthing Center Services	$23,891	34	$703
Group Home Services	$17,925,296	599	$29,925
Home Health (HH) Services	$16,285,275	7,660	$2,126
Homemaker Services	$672,439	261	$2,576
Hospice Services	$1,101,083	85	$12,954
HSP - Indirect Medical Education (IME)	$25,955,100	-	$0
HSP - Graduate Medical Education (GME)	$16,243,372	-	$0
HSP - Acute DSH	$31,175,423	-	$0
HSP - Upper Payment Limit	$29,690,425	-	$0
ICF-MR Services	$125,769,370	1,811	$69,447
Inpatient Hospital Services	$559,561,584	122,941	$4,551
Laboratory Services	$19,422,439	171,237	$113
Medicare Part A & B (Buy-In) Payments	$107,753,230	-	$0
Medicare Part D Payments	$53,193,255	-	$0
Mid Level Practitioner (MLP) Services	$178,592	2,397	$75
Medical Supplies/Durable Goods	$61,129,925	72,805	$840
Nursing Facility Services	$490,658,264	21,544	$22,775
Nursing Services	$34,375,772	7,188	$4,782
Nutritionist Services	$430,589	677	$636

Appendix B Statewide SFY2007 Figures (continued)

Figure VI Expenditures by Type of Service Totals (continued)

SFY2007	Totals		
Type of Service	**Expenditures**	**Members Served**	**Avg per Member Served**
Insure Oklahoma ESI Out-of-Pocket	$49,990	-	$0
Insure Oklahoma ESI Premium	$3,614,205	-	$0
Outpatient Hospital Services	$188,691,195	375,034	$503
Personal Care Services	$11,628,586	3,647	$3,189
Physician Services	$318,840,208	509,749	$625
Podiatry Services	$875,048	5,018	$174
Prescribed Drugs Services	$297,300,325	441,740	$673
Prosthetic/Orthotic Services	$912,769	927	$985
Psychiatric Services	$81,353,380	4,284	$18,990
Residential Behavior Management Services (RBMS)	$31,124,823	2,913	$10,685
Respite Care Services	$462,651	135	$3,427
Room and Board Services	$148,408	681	$218
School Based Services	$5,069,042	11,508	$440
Specialized Foster Care/MR Services	$3,921,355	257	$15,258
Targeted Case Manager (TCM) Services	$53,935,884	37,553	$1,436
Therapy Services	$2,148,389	1,337	$1,607
Transportation - Emergency	$30,730,923	62,871	$489
Transportation - Non-Emergency	$22,727,223	679,166	$33
X-Ray Services	$3,109,288	27,840	$112
Unknown Services by Service Type	$1,414,680	12,344	$115
Total	**$3,377,085,329**	**745,474**	**$4,530**

Source: OHCA Financial Service Division, September 2007. Claim dollars were extracted from the MMIS claims history file for claims paid within the fiscal year. Financial statement data represents actual cash expenditures as reported to the Office of State Finance while MMIS data warehouse expenditure data is net of overpayments and adjustments.
Member Served figures are the unduplicated counts of members that received a service. If a member received services from multiple service type providers, they would be counted once for each type of service; the total count is the unduplicated count overall.

Appendix B Statewide SFY2007 Figures (continued)

Figure VII Expenditures by Type of Service by Adult and Child

SFY2007 (Totals Pages 72 and 73)	Adult Totals			Children Totals		
Type of Service	Expenditures	Members Served	Avg. per Adult	Expenditures	Members Served	Avg. per Child
Adult Day Care Services	$3,000,659	624	$4,809	$35,019	12	$2,918
Adv Comp Health Services	$83,442,983	14,270	$5,847	$0	-	$0
Advanced Practice Nurse (APN)	$894,262	6,221	$144	$993,074	10,260	$97
ADvantage Home Delivered Meals	$10,291,489	10,401	$989	$0	-	$0
Ambulatory Surgical Services	$2,391,846	7,038	$340	$3,217,331	6,209	$518
Architectural Modification	$469,764	239	$1,966	$192,552	45	$4,279
Audiology Services	$3,211	58	$55	$137,818	488	$282
Behavioral Hlth Services	$22,724,927	211	$107,701	$45,706,603	29,882	$1,530
Capitated (CAP) Services	$21,178,796	105,625	$201	$77,925,185	446,498	$175
Capitated (CAP) Services - GME to Med Schools	$0	-	$0	$57,711,032	-	$0
Chiropractic Services	$11,771	224	$53	$74	1	$74
Clinic Services	$3,918,641	19,944	$196	$7,387,015	22,622	$327
Clinics - OSA Services	$2,486,655	25,331	$98	$6,397,907	74,044	$86
Community Mental Health	$26,401,969	14	$1,885,855	$11,287,203	1,050	$10,750
Dental Services	$8,050,987	16,447	$490	$102,751,181	194,085	$529
Direct Support Services	$164,220,814	3,435	$47,808	$17,140,734	1,122	$15,277
Employee Training Specialist	$23,849,180	2,551	$9,349	$858,382	159	$5,399
End Stage Renal Disease (ESRD)	$11,009,183	1,748	$6,298	$98,142	18	$5,452
Eye Care and Exam Services	$702,139	9,447	$74	$4,668,535	55,793	$84
Eyewear Services	$34,610	380	$91	$5,892,431	51,853	$114
Free Standing Birthing Center	$14,650	13	$1,127	$9,241	21	$440
Group Home Services	$16,266,110	562	$28,943	$1,659,186	49	$33,861
Home Health (HH) Services	$3,638,178	3,636	$1,001	$12,647,097	4,036	$3,134
Homemaker Services	$395,826	143	$2,768	$276,613	125	$2,213
Hospice Services	$1,101,083	85	$12,954	$0	-	$0
HSP - Indirect Medical Education (IME)	$25,955,100	-	$0	$0	-	$0
HSP - Graduate Medical Education (GME)	$8,121,686	-	$0	$8,121,686	-	$0
HSP - Acute DSH	$0	-	$0	$31,175,423	-	$0
HSP - Upper Payment Limit	$0	-	$0	$29,690,425	-	$0
ICF-MR Services	$122,059,018	1,758	$69,431	$3,710,352	78	$47,569
Inpatient Services	$310,540,238	65,813	$4,719	$249,021,346	57,247	$4,350
Laboratory Services	$9,915,609	69,647	$142	$9,506,830	103,008	$92
Medicare Part A & B (Buy-In) Payments	$107,753,230	1	$107,753,230	$0	-	$0
Medicare Part D Payments	$53,193,255	1	$53,193,255	$0	-	$0
Mid Level Practitioner (MLP) Services	$53,927	629	$86	$124,664	1,772	$70
Medical Supplies/Durable Goods	$42,323,644	49,479	$855	$18,806,280	23,455	$802
Nursing Facility Services	$489,809,989	21,509	$22,772	$848,275	42	$20,197
Nursing Services	$34,371,754	7,185	$4,784	$4,018	4	$1,004

APPENDIX B STATEWIDE SFY2007 FIGURES (CONTINUED)

FIGURE VII EXPENDITURES BY TYPE OF SERVICE BY ADULT AND CHILD (CONTINUED)

SFY2007 (Totals Pages 72 and 73)	Adult Totals			Children Totals		
Type of Service	Expenditures	Members Served	Avg. per Adult	Expenditures	Members Served	Avg. per Child
Nutritionist Services	$425,393	661	$644	$5,196	18	$289
ESI Out-of-Pocket	$49,990	-	$0	$0	-	$0
ESI Premium	$3,614,205	-	$0	$0	-	$0
Outpatient Hospital Services	$84,932,406	138,864	$612	$103,758,789	237,850	$436
Personal Care Services	$11,005,429	3,547	$3,103	$623,158	111	$5,614
Physician Services	$169,485,564	182,046	$931	$149,354,644	330,150	$452
Podiatry Services	$641,678	4,234	$152	$233,370	785	$297
Prescribed Drugs Services	$142,409,109	126,349	$1,127	$154,891,216	317,528	$488
Prosthetic/Orthotic Services	$409,877	556	$737	$502,892	371	$1,356
Psychiatric Services	$557,442	380	$1,467	$80,795,938	3,906	$20,685
Residential Behavior Management Services (RBMS)	$0	$0	$0	$31,124,823	2,913	$10,685
Respite Care Services	$405,553	115	$3,527	$57,098	20	$2,855
Room and Board Services	$36,954	172	$215	$111,454	509	$219
School Based Services	$40	1	$40	$5,069,002	11,507	$441
Specialized Foster Care/MR Services	$2,299,728	142	$16,195	$1,621,627	126	$12,870
Targeted Case Manager (TCM)	$34,532,115	12,335	$2,800	$19,403,769	25,373	$765
Therapy Services	$965,492	809	$1,193	$1,182,896	536	$2,207
Transportation - Emergency	$21,058,005	44,676	$471	$9,672,918	18,338	$527
Transportation - Non-Emergency	$6,326,179	200,756	$32	$16,401,044	481,693	$34
X-Ray Services	$2,320,029	14,324	$162	$789,259	13,533	$58
Unknown Services by Service Type	$688,065	564	$1,220	$724,143	10,638	$68
Total	**$2,092,760,441**	**246,786**	**$8,480**	**$1,284,324,887**	**505,100**	**$2,543**

Source: OHCA Financial Service Division, September 2007. Children are under age 21. Claim dollars were extracted from the MMIS claims history file for claims paid within the fiscal year. Financial statement data represents actual cash expenditures as reported to the Office of State Finance while MMIS data warehouse expenditure data is net of overpayments and adjustments.
Member Served figures are the unduplicated counts of members that received a service. If a member received services from multiple service type providers, they would be counted once for each type of service; the total count is the unduplicated count overall. A member may have claims under children and adult categories.

Appendix B Statewide SFY2007 Figures (continued)

Figure VIII Expenditures by Type of Service Percent of Change SFY2006 vs. SFY2007

Type of Service	SFY2006			SFY2007			Percent Change		
	Expenditures	Members	Avg Per Member	Expenditures	Members	Avg Per Member	Expend-itures	Mem-bers	Aver-age
Adult Day Care	$2,217,494	561	$3,953	$3,035,678	631	$4,811	37%	12%	22%
Adv Comp Health	$54,204,309	11,993	$4,520	$83,442,983	14,270	$5,847	54%	19%	29%
Advanced Practice Nurse	$2,078,426	16,621	$125	$1,887,336	16,459	$115	-9%	-1%	-8%
ADvantage Home Delivered Meals	$6,006,560	8,447	$711	$10,291,489	10,401	$989	71%	23%	39%
Ambulatory Surgery	$4,167,091	11,124	$375	$5,609,177	13,245	$423	35%	19%	13%
Architectural Modification	$519,551	246	$2,112	$662,316	284	$2,332	27%	15%	10%
Audiology	$102,897	1,085	$95	$141,029	546	$258	37%	-50%	172%
Behavioral Health	$52,468,558	39,098	$1,342	$68,431,530	45,728	$1,496	30%	17%	12%
Capitated (CAP)	$84,444,262	546,518	$155	$99,103,939	549,194	$180	17%	0%	17%
Capitated (CAP) - GME	$55,717,767	-		$57,711,032	-	$0	4%	0%	0%
Chiropractic	$14,298	219	$65	$11,845	225	$53	-17%	3%	-19%
Clinic	$10,870,003	37,010	$294	$11,305,656	42,385	$267	4%	15%	-9%
Clinics - OSA	$7,085,395	81,703	$87	$8,884,563	98,593	$90	25%	21%	4%
Comm Mntl Hth Svcs	$37,288,535	18,539	$2,011	$37,689,173	23,637	$1,594	1%	27%	-21%
Dental	$98,993,524	192,355	$515	$110,802,168	210,450	$527	12%	9%	2%
Direct Support	$167,316,149	4,233	$39,527	$181,361,549	4,443	$40,820	8%	5%	3%
Employee Training Specialist	$22,744,649	2,572	$8,843	$24,707,562	2,656	$9,303	9%	3%	5%
End Stage Renal Disease (ESRD)	$11,493,132	1,700	$6,761	$11,107,324	1,764	$6,297	-3%	4%	-7%
Eye Care and Exam	$5,303,315	69,355	$76	$5,370,675	65,239	$82	1%	-6%	8%
Eyewear	$6,035,979	53,564	$113	$5,927,041	52,232	$113	-2%	-2%	1%
Free Standing Birthing Center	$51,839	63	$823	$23,891	34	$703	-54%	-46%	-15%
Group Home	$14,359,180	578	$24,843	$17,925,296	599	$29,925	25%	4%	20%
Home Health	$12,459,055	6,600	$1,888	$16,285,275	7,660	$2,126	31%	16%	13%
Homemaker	$757,752	286	$2,649	$672,439	261	$2,576	-11%	-9%	-3%
Hospice	$604,058	52	$11,616	$1,101,083	85	$12,954	82%	63%	12%
HSP - Indirect Medical Education (IME)	$25,077,370	-	$0	$25,955,100	-	$0	4%	0%	0%
HSP - Graduate Medical Education	$26,056,562	-	$0	$16,243,372	-	$0	-38%	0%	0%
HSP - Acute DSH	$31,190,420	-	$0	$31,175,423	-	$0	-0%	0%	0%
HSP - Upper Payment Limit	$10,666,000	-	$0	$29,690,425	-	$0	178%	0%	0%
ICF-MR	$123,970,611	1,857	$66,759	$125,769,370	1,811	$69,447	1%	-2%	4%
Inpatient	$470,030,099	118,701	$3,960	$559,561,584	122,941	$4,551	19%	4%	15%
Laboratory	$14,790,367	149,920	$99	$19,422,439	171,237	$113	31%	14%	15%

Appendix B Statewide SFY2007 Figures (continued)

Figure VIII Expenditures by Type of Service Percent of Change SFY2006 vs. SFY2007 (continued)

Type of Service	SFY2006			SFY2007			Percent Change		
	Expenditures	Members	Avg Per Member	Expenditures	Members	Avg Per Member	Expend-itures	Mem-bers	Aver-age
Medicare Part A & B (Buy-In) Payments	$96,692,889	-	$0	$107,753,230	-	$0	11%	0%	0%
Medicare Part D Payments	$20,493,119	-	$0	$53,193,255	-	$0	0%	0%	0%
Mid Level Practitioner	$232,131	3,154	$74	$178,592	2,397	$75	-23%	-24%	1%
Medical Supplies/ Durable Goods	$62,160,996	66,123	$940	$61,129,925	72,805	$840	-2%	10%	-11%
Nursing Facility	$438,498,446	22,280	$19,681	$490,658,264	21,544	$22,775	12%	-3%	16%
Nursing	$25,443,483	6,928	$3,673	$34,375,772	7,188	$4,782	35%	4%	30%
Nutritionist	$390,952	676	$578	$430,589	677	$636	10%	0%	10%
ESI Out-of-Pocket	$6,481	-	$0	$49,990	-	$0	0%	0%	0%
ESI Premium	$610,180	-	$0	$3,614,205	-	$0	0%	0%	0%
Outpatient Hospital	$151,447,055	359,107	$422	$188,691,195	375,034	$503	25%	4%	19%
Personal Care	$35,316,690	18,462	$1,913	$11,628,586	3,647	$3,189	-67%	-80%	67%
Physician Services	$281,227,252	491,900	$572	$318,840,208	509,749	$625	13%	4%	9%
Podiatry	$689,912	4,597	$150	$875,048	5,018	$174	27%	9%	16%
Prescribed Drugs	$392,853,727	473,455	$830	$297,300,325	441,740	$673	-24%	-7%	-19%
Prosthetic/Orthotic	$1,009,782	1,014	$996	$912,769	927	$985	-10%	-9%	-1%
Psychiatric	$67,493,452	4,266	$15,821	$81,353,380	4,284	$18,990	21%	0%	20%
Residential Behavior Management Services	$31,763,812	3,074	$10,333	$31,124,823	2,913	$10,685	-2%	-5%	0%
Respite Care	$374,142	116	$3,225	$462,651	135	$3,427	24%	16%	6%
Room and Board	$158,290	679	$233	$148,408	681	$218	-6%	0%	-7%
School Based	$5,695,341	13,817	$412	$5,069,042	11,508	$440	-11%	-17%	7%
Specialized Foster Care/MR	$3,227,797	273	$11,823	$3,921,355	257	$15,258	21%	-6%	29%
Targeted Case Manager	$51,970,544	37,290	$1,394	$53,935,884	37,553	$1,436	4%	1%	3%
Therapy	$1,951,564	1,320	$1,478	$2,148,389	1,337	$1,607	10%	1%	9%
Transportation - Emergency	$24,149,209	58,429	$413	$30,730,923	62,871	$489	27%	8%	18%
Transportation - Non-Emergency	$17,054,758	665,304	$26	$22,727,223	679,166	$33	33%	2%	31%
X-Ray	$2,326,995	31,919	$73	$3,109,288	27,840	$112	34%	-13%	53%
Unknown Services by Service Type	$5,456,442	20,532	$266	$1,412,250	12,344	$114	-74%	-40%	-57%
TOTAL	$3,077,780,653	727,224	$4,232	$3,377,085,329	745,474	$4,530	10%	3%	7%

Source: OHCA Financial Service Division, September 2007. Claim dollars were extracted from the MMIS claims history file for claims paid within the fiscal year. Financial statement data represents actual cash expenditures as reported to the Office of State Finance while MMIS data warehouse expenditure data is net of overpayments and adjustments. Member Served figures are the unduplicated counts of members that received a service. If a member received services from multiple service type providers, they would be counted once for each type of service; the total count is the unduplicated count overall.

Appendix B Statewide SFY2007 Figures (continued)

Figure IX Expenditures by Type of Service by Aid Category

Type of Service	Aged	Blind / Disabled	TANF / Parents & Children	Oklahoma-Cares	Sooner-Plan	TEFRA	Other Total*
Adult Day Care	$1,857,937	$1,177,741	$0	$0	$0	$0	$0
Adv Comp Health	$50,929,523	$32,513,460	$0	$0	$0	$0	$0
Advanced Practice Nurse	$36,621	$259,340	$1,535,419	$30,061	$24,550	$438	$908
ADvantage Home Delivered Meals	$6,064,352	$4,227,137	$0	$0	$0	$0	$0
Ambulatory Surgical	$637,730	$1,229,269	$3,574,719	$103,231	$60,608	$2,989	$630
Architectural Modification	$77,923	$584,394	$0	$0	$0	$0	$0
Audiology	$671	$33,854	$106,423	$0	$0	$82	$0
Behavioral Health	$1,188,435	$24,308,891	$42,868,407	$42,232	$0	$4,223	$19,343
Capitated (CAP)	$124,433	$12,114,903	$86,618,818	$207,571	$0	$28,971	$9,242
Capitated (CAP) - GME to Med Schools	$0	$0	$0	$0	$0	$0	$57,711,032
Chiropractic	$7,057	$4,788	$0	$0	$0	$0	$0
Clinic	$429,127	$1,872,503	$8,493,059	$154,812	$354,727	$93	$1,334
Clinics - OSA	$7,529	$792,459	$5,771,861	$169,054	$2,056,050	$86,147	$1,462
Comm Mntl Hth Svcs	$1,127,514	$24,673,773	$11,806,718	$76,020	$25	$862	$4,260
Dental	$686,752	$8,196,329	$101,641,592	$222,258	$0	$15,239	$39,999
Direct Support	$2,407,138	$179,110,093	-$127,292	$0	$0	$0	-$28,390
Employee Training Specialist	$305,322	$24,402,240	$0	$0	$0	$0	$0
End Stage Renal Disease	$2,126,379	$8,813,478	$167,113	$355	$0	$0	$0
Eye Care and Exam	$241,685	$598,200	$4,518,546	$9,526	$293	$447	$1,978
Eyewear	$18,268	$389,067	$5,509,939	$3,460	$0	$3,743	$2,565
Free Standing Birthing Center	$0	$0	$23,891	$0	$0	$0	$0
Group Home	$503,620	$17,421,676	$0	$0	$0	$0	$0
Home Health	$350,734	$11,241,119	$4,063,289	$72,620	$0	$556,541	$972
Homemaker	$1,742	$682,464	-$11,767	$0	$0	$0	$0
Hospice	$20,604	$1,080,186	$0	$293	$0	$0	$0
HSP - Indirect Medical Education (IME)	$0	$0	$0	$0	$0	$0	$25,955,100
HSP - Graduate Medical Education	$0	$0	$0	$0	$0	$0	$16,243,372
HSP - Acute DSH	$0	$0	$0	$0	$0	$0	$31,175,423
HSP - Upper Payment Limit	$0	$0	$0	$0	$0	$0	$29,690,425
ICF-MR	$6,041,067	$119,344,895	$383,408	$0	$0	$0	$0
Inpatient	$23,894,456	$213,047,540	$316,669,445	$5,666,487	$2,273	$162,787	$118,596
Laboratory	$217,539	$2,857,991	$14,896,934	$566,636	$869,637	$532	$13,171
Medicare Part A & B (Buy-In) Payments	$107,753,230	$0	$0	$0	$0	$0	$0
Medicare Part D Payments	$53,193,255	$0	$0	$0	$0	$0	$0

APPENDIX B STATEWIDE SFY2007 FIGURES (CONTINUED)

FIGURE IX EXPENDITURES BY TYPE OF SERVICE BY AID CATEGORY (CONTINUED)

Type of Service	Aged	Blind / Disabled	TANF / Parents & Children	Oklahoma-Cares	Sooner-Plan	TEFRA	Other Total*
Mid Level Practitioner	$466	$27,594	$147,033	$2,599	$756	$0	$144
Medical Supplies/ Durable Goods	$15,195,401	$35,157,843	$10,473,099	$84,723	-$252	$216,125	$2,984
Nursing Facility	$383,723,289	$106,456,628	$461,115	$17,231	$0	$0	$0
Nursing	$17,823,292	$16,552,480	$0	$0	$0	$0	$0
Nutritionist	$11,392	$419,197	$0	$0	$0	$0	$0
ESI Out-of-Pocket	$0	$0	$0	$0	$0	$0	$49,990
ESI Premium	$0	$0	$0	$0	$0	$0	$3,614,205
Outpatient Hospital	$10,588,164	$46,840,469	$125,761,816	$4,837,437	$546,403	$47,641	$69,264
Personal Care	$4,872,237	$6,703,965	$45,874	$0	$0	$6,511	$0
Physician	$19,619,316	$89,982,299	$195,050,770	$13,149,336	$819,734	$134,258	$84,497
Podiatry	$131,043	$423,882	$307,522	$12,574	$0	$0	$26
Prescribed Drugs	$4,484,495	$148,496,447	$140,788,905	$2,581,848	$616,796	$252,693	$79,141
Prosthetic/Orthotic	$119,692	$567,532	$222,709	$306	$0	$2,485	$45
Psychiatric	$423,225	$15,810,421	$64,912,678	$8,164	$0	$91,094	$107,798
Residential Behavior Management Services	$11,923	$926,079	$30,174,765	$0	$0	$0	$12,055
Respite Care	$139,939	$322,712	$0	$0	$0	$0	$0
Room and Board	$1,460	$20,885	$124,223	$1,820	$0	$20	$0
School Based	$563	$2,191,190	$2,845,919	$0	$0	$31,370	$0
Specialized Foster Care/MR	$0	$3,921,355	$0	$0	$0	$0	$0
Targeted Case Manager	$9,683,066	$28,106,683	$16,136,104	$597	-$1,029	$1,789	$8,675
Therapy	$14,479	$1,660,173	$462,876	$0	$0	$10,360	$500
Transportation - Emergency	$2,436,314	$17,009,032	$11,182,378	$90,017	$0	$5,432	$7,750
Transportation - Non-Emergency	$1,941,138	$3,325,251	$17,358,174	$94,113	$0	$4,576	$3,972
X-Ray	$351,524	$1,159,180	$1,432,199	$165,581	$0	$136	$669
Unknown Services by Service Type	$168,880	$39,139	$540,679	$610	$0	$64	$662,878
Total	**$731,991,939**	**$1,217,098,225**	**$1,226,939,361**	**$28,371,570**	**$5,350,571**	**$1,667,647**	**$165,666,015**
Unduplicated Members Served	**58,470**	**101,388**	**566,299**	**8,385**	**27,726**	**175**	-
Average Cost Per Member Served	**$12,519**	**$12,004**	**$2,167**	**$3,384**	**$193**	**$9,529**	-

Source: OHCA Financial Service Division, September 2007. *Other includes $160,775,352 in Hospital Supplemental (IME/GME/DSH and UPL) payments; $49,990 in Insure Oklahoma ESI Out-of-Pocket and $3,614,205 ESI Premium payments; and $135,400 in Insure Oklahoma IP payments. Claim dollars were extracted from the MMIS claims history file for claims paid within the fiscal year. Financial statement data represents actual cash expenditures as reported to the Office of State Finance while MMIS data warehouse expenditure data is net of overpayments and adjustments.
Member Served figures are the unduplicated counts of members per aid category that received a service. A member may be counted in more than one aid category.

Appendix B Statewide SFY2007 Figures (continued)

Figure X Expenditures by Type of Service by Benefit Type

Type of Service	SoonerCare Traditional	SoonerCare Choice	Insure Oklahoma IP & ESI*	Sooner-Plan	SoonerCare Supplemental	HCBS Waivers
Adult Day Care	$0	$0	$0	$0	$0	$3,035,678
Adv Comp Health	$0	$0	$0	$0	$0	$83,442,983
Advanced Practice Nurse	$462,819	$1,348,595	$368	$24,550	$51,005	$0
ADvantage Home Delivered Meals	$0	$0	$0	$0	$0	$10,291,489
Ambulatory Surgical	$902,533	$3,751,617	$630	$60,608	$893,788	$0
Architectural Modification	$0	$0	$0	$0	$0	$662,316
Audiology	$37,496	$100,749	$0	$0	$537	$2,247
Behavioral Health	$25,227,404	$39,445,984	$0	$0	$466,039	$3,292,103
Capitated (CAP)	$0	$99,099,079	$2,430	$0	$0	$0
Capitated (CAP) - GME to Med Schools	$0	$57,711,032	$0	$0	$0	$0
Chiropractic	$0	$0	$0	$0	$11,845	$0
Clinic	$2,950,607	$7,286,917	$85	$354,727	$713,320	$0
Clinics - OSA	$2,062,592	$4,765,857	$62	$2,056,050	$2	$0
Comm Mental Health	$17,787,962	$19,872,049	$110	$25	$29,028	$0
Dental	$16,600,335	$91,355,169	$212	$0	$2,698,738	$147,714
Direct Support	$0	$0	$0	$0	$0	$181,361,549
Employee Training Specialist	$0	$0	$0	$0	$0	$24,707,562
End Stage Renal Disease	$3,711,202	$680,526	$0	$0	$6,715,596	$0
Eye Care and Exam	$1,071,845	$4,009,593	$65	$293	$288,745	$133
Eyewear	$1,109,099	$4,815,187	$0	$0	$1,680	$1,075
Free Standing Birthing Center	$7,048	$16,844	$0	$0	$0	$0
Group Home	$0	$0	$0	$0	$0	$17,925,296
Home Health	$8,142,348	$8,131,919	$0	$0	$4,633	$6,374
Homemaker	$0	$0	$0	$0	$0	$672,439
Hospice	$7,325	$440	$0	$0	$0	$1,093,319
HSP - Indirect Medical Education (IME)	$13,756,203	$12,198,897	$0	$0	$0	$0
HSP - Graduate Medical Education (GME)	$8,608,987	$7,634,385	$0	$0	$0	$0
HSP - Acute DSH	$16,522,974	$14,652,449	$0	$0	$0	$0
HSP - Upper Payment Limit	$15,735,925	$13,954,500	$0	$0	$0	$0
ICF-MR	$125,680,167	$89,128	$0	$0	$75	$0
Inpatient	$272,872,405	$254,071,923	$60,623	$2,273	$32,554,361	$0
Laboratory	$8,664,060	$9,664,429	$5,727	$869,637	$218,587	$0
Medicare Part A & B (Buy-In) Payments	$0	$0	$0	$0	$107,753,230	$0
Medicare Part D Payments	$0	$0	$0	$0	$53,193,255	$0

Appendix B Statewide SFY2007 Figures (continued)

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

Type of Service	SoonerCare Traditional	SoonerCare Choice	Insure Oklahoma IP & ESI*	Sooner-Plan	SoonerCare Supplemental	HCBS Waivers
Mid Level Practitioner	$71,236	$105,971	$126	$756	$503	$0
Medical Supplies/Durable Goods	$13,136,849	$21,107,159	$515	-$252	$9,726,564	$17,159,090
Nursing Facility	$471,576,642	$331,780	$0	$0	$18,710,230	$39,612
Nursing	$0	$0	$0	$0	$0	$34,375,772
Nutritionist	$2,339	$0	$0	$0	$2,704	$425,546
ESI Out-of-Pocket*	$0	$0	$49,990	$0	$0	$0
ESI Premium*	$0	$0	$3,614,205	$0	$0	$0
Outpatient Hospital	$92,173,387	$75,256,593	$9,725	$546,403	$20,705,086	$0
Personal Care	$39,051	$2,025,763	$0	$0	$8,583,131	$980,641
Physician	$99,867,468	$183,036,594	$23,546	$819,734	$32,464,877	$2,627,989
Podiatry	$138,921	$505,429	$0	$0	$230,697	$0
Prescribed Drugs	$70,902,565	$214,105,833	$31,073	$616,796	$7,321,046	$4,323,011
Prosthetic/Orthotic	$76,734	$427,254	$0	$0	$406,681	$2,100
Psychiatric	$41,666,036	$39,475,689	$0	$0	$211,655	$0
Residential Behavior Management Services (RBMS)	$31,021,881	$102,942	$0	$0	$0	$0
Respite Care	-$1,756	$0	$0	$0	$0	$464,407
Room and Board	$63,409	$84,999	$0	$0	$0	$0
School Based	$1,117,270	$3,951,772	$0	$0	$0	$0
Specialized Foster Care/MR	$0	$0	$0	$0	$0	$3,921,355
Targeted Case Manager	$35,623,971	$2,552,121	$0	-$1,029	$0	$15,760,821
Therapy	$571,459	$622,948	$0	$0	$1,150	$952,832
Transportation - Emergency	$8,455,551	$11,389,291	$0	$0	$3,364,397	$7,521,684
Transportation - Non-Emergency	$7,523,994	$15,203,229	$0	$0	$0	$0
X-Ray	$596,114	$2,007,753	$126	$0	$505,295	$0
Unknown Services by Service Type	$944,539	$467,741	-$22	$0	$2,421	$0
Grand Total	**$1,417,488,997**	**$1,227,418,125**	**$3,799,595**	**$5,350,571**	**$307,830,902**	**$415,197,138**
Members Served	**709,783**	**498,680**	**426**	**27,726**	**109,492**	**27,072**
Average Per Member Cost	**$1,997**	**$2,461**	**$318**	**$193**	**$2,811**	**$15,337**

Source: OHCA Financial Service Division, September 2007. *Insure Oklahoma IP and ESI includes $49,990 in Insure Oklahoma ESI Out-of-Pocket and $3,614,205 ESI Premium payments; and $135,400 in Insure Oklahoma IP payments. Claim dollars were extracted from the MMIS claims history file for claims paid within the fiscal year. Financial statement data represents actual cash expenditures as reported to the Office of State Finance while MMIS data warehouse expenditure data is net of overpayments and adjustments. Member Served figures are the unduplicated counts of members per benefit plan that received a service. A member may be counted in more than one benefit plan.

Appendix B Statewide SFY2007 Figures (continued)

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

Type of Service	Blind/ Disabled/ TEFRA	State Custody	SCHIP	TANF	Other Aid Categories*
Adult Day Care	$23,248	$11,770	$0	$0	$0
Adv Comp Health	-$1,539	$1,539	$0	$0	$0
Advanced Practice Nurse (APN)	$38,611	$119,615	$133,944	$698,796	$2,107
ADvantage Home Delivered Meals	-$1,065	$1,065	$0	$0	$0
Ambulatory Surgical	$136,875	$258,622	$526,478	$2,289,431	$5,926
Architectural Modification	$136,373	$56,179	$0	$0	$0
Audiology	$28,575	$23,688	$36,552	$49,003	$0
Behavioral Health	$4,457,973	$13,894,048	$5,327,672	$22,005,922	$20,989
Capitated (CAP)	$3,437,875	$56,472	$11,125,202	$63,292,628	$13,008
Capitated (CAP) - GME to Med Schools	$0	$0	$0	$0	$57,711,032*
Chiropractic	$68	$6	$0	$0	$0
Clinic	$187,593	$509,574	$442,677	$6,190,880	$56,290
Clinics - OSA	$789,561	$741,323	$500,564	$3,941,690	$424,769
Community Mental Health	$1,290,025	$2,775,319	$1,494,154	$5,722,399	$5,306
Dental	$3,695,496	$8,009,032	$20,737,558	$70,184,974	$124,121
Direct Support	$8,279,942	$8,860,792	$0	$0	$0
Employee Training Specialist	$363,175	$495,207	$0	$0	$0
End Stage Renal Disease	$32,110	$83,194	$0	-$17,162	$0
Eye Care and Exam	$205,273	$422,745	$1,005,281	$3,030,136	$5,100
Eyewear	$343,759	$570,566	$1,191,423	$3,780,977	$5,706
Free Standing Birthing Center	$0	$0	$0	$9,241	$0
Group Home	$826,804	$832,382	$0	$0	$0
Home Health (HH)	$8,312,904	$1,516,059	$169,929	$2,647,233	$972
Homemaker	$66,177	$210,436	$0	$0	$0
Hospice	$0	$0	$0	$0	$0
HSP - Indirect Medical Education (IME)	$0	$0	$0	$0	$0
HSP - Graduate Medical Education (GME)	$0	$0	$0	$0	$8,121,686*
HSP - Acute DSH	$0	$0	$0	$0	$31,175,423*
HSP - Upper Payment Limit	$0	$0	$0	$0	$29,690,425*
ICF-MR	$2,226,105	$1,391,291	$0	$92,956	$0
Inpatient	$30,736,934	$22,867,479	$14,976,379	$180,335,197	$105,356
Laboratory	$338,021	$573,959	$761,406	$7,559,087	$274,357
Medicare Part A & B (Buy-In) Payments	$0	$0	$0	$0	$0
Medicare Part D Payments	$0	$0	$0	$0	-$1,296,253

APPENDIX B STATEWIDE SFY2007 FIGURES (CONTINUED)

FIGURE XI CHILDREN (UNDER 21) EXPENDITURES BY TYPE OF SERVICE BY AID CATEGORY (CONTINUED)

Type of Service	Blind/ Disabled/ TEFRA	State Custody	SCHIP	TANF	Other Aid Categories*
Mid Level Practitioner (MLP)	$3,297	$13,730	$16,042	$91,132	$464
Medical Supplies/Durable Goods	$8,572,091	$2,903,727	$1,769,065	$5,559,837	$1,559
Nursing Facility	$547,991	$300,284	$0	$0	$0
Nursing	-$19,420	$23,437	$0	$0	$0
Nutritionist	$1,380	$3,816	$0	$0	$0
ESI Out-of-Pocket	$0	$0	$0	$0	$0
ESI Premium	$0	$0	$0	$0	$0
Outpatient Hospital	$6,094,849	$6,283,111	$14,005,211	$77,164,116	$211,502
Personal Care	$532,866	$81,202	$0	$9,090	$0
Physician	$13,637,068	$16,301,499	$15,548,290	$103,531,041	$336,746
Podiatry	$18,552	$18,207	$54,534	$142,051	$26
Prescribed Drugs	$36,848,699	$20,018,831	$21,811,634	$76,022,816	$189,235
Prosthetic/Orthotic	$268,700	$29,303	$83,335	$121,509	$45
Psychiatric	$12,984,695	$35,022,512	$8,235,900	$24,439,860	$112,970
Residential Behavior Management Services (RBMS)	$33,807	$30,479,537	-$1,616	$602,138	$10,956
Respite Care	$18,714	$38,384	$0	$0	$0
Room and Board	$16,964	$4,319	$2,434	$87,737	$0
School Based	$2,029,271	$712,215	$638,420	$1,689,097	$0
Specialized Foster Care/MR	$175,260	$1,446,367	$0	$0	$0
Targeted Case Manager (TCM)	$1,767,961	$14,850,826	$412,734	$2,365,403	$6,844
Therapy	$635,515	$243,795	$69,767	$233,319	$500
Transportation - Emergency	$1,044,460	$899,573	$820,707	$6,897,329	$10,849
Transportation - Non-Emergency	$568,667	$1,166,952	$2,622,368	$12,032,641	$10,416
X-Ray	$43,589	$44,669	$160,403	$539,677	$920
Unknown Services by Service Type	$185,481	$49,659	$56,404	$421,237	$11,363
Grand Total	**$151,961,332**	**$195,218,317**	**$124,734,851**	**$683,763,417**	**$128,646,968**
Unduplicated Members Served	**17,260**	**36,755**	**117,062**	**437,323**	**3,938**
Average Per Member Served Cost	**$8,804**	**$5,347**	**$1,066**	**$1,564**	

Source: OHCA Financial Service Division, September 2007. Child figures are for individuals under the age of 21.

*Other Aid Categories include SoonerPlan, TEFRA, O-EPIC and Oklahoma Cares members. Other Aid Categories expenditures include $126,698,566 in Hospital Supplemental (GME/DSH and UPL) payments. Claim dollars were extracted from the MMIS claims history file for claims paid within the fiscal year. Financial statement data represents actual cash expenditures as reported to the Office of State Finance while MMIS data warehouse expenditure data is net of overpayments and adjustments.
Member Served figures are the unduplicated counts of members per aid category that received a service. A member may be counted in more than one aid category.

Appendix C SoonerCare Benefits Overview

Please note: All covered services must be	***SoonerCare* Traditional**		***SoonerCare* Choice**		**SoonerPlan**
medically necessary	***Children Under 21***	***Adults 21 and Over***	***Children Under 21***	***Adults 21 and Over***	
Behavior 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. Basic coverage may be available to pregnant women	Preventive, restoration, and maintenance	Emergency extractions only. Basic coverage may be available to pregnant women	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
Inpatient hospital services (acute care only)	Covered medically necessary	Covered medically necessary	Covered medically necessary	Covered medically necessary	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***	
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, 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. For Insure Oklahoma IP benefits go to www.insureoklahoma.net.

Appendix D SFY2007 Board Approved Rules

Board Approval Date	Rule Description	Savings/Total Cost/State Share	Effective Date
July 13, 2006	Issuing program rules to implement the O-EPIC Individual Plan and revising O-EPIC Premium Assistance (PA) rules to: (1) allow employees with multiple employers to qualify for inclusion in the PA program if their primary employer meets eligibility guidelines, (2) add multiple definitions, and (3) remove unnecessary requirements not in use in the current program. APA WF#06-08	Annual State Share $924,000	September 1, 2006
August 16, 2006	Revising O-EPIC PA rules to increase the maximum number of employees an employer may have to participate in the O-EPIC program from 25 to 50. APA WF#06-20	Annual State Share $924,000	October 8, 2006
August 16, 2006	Establishing criteria for coverage of bariatric surgery. APA WF#06-29	Annual State Share $325,500	October 8, 2006
August 16, 2006	Revising rules to clarify payment exclusions regarding services provided prior to and in conjunction with surgery. APA WF#06-12	Budget neutral	October 8, 2006
August 16, 2006	Revising Breast and Cervical Cancer rules to provide members a specific time frame after deemed eligibility in which to seek diagnostic testing and treatment. APA WF#06-21	Budget neutral	October 8, 2006
September 14, 2006	Revising rules to allow coverage for a first trimester ultrasound and additional ultrasounds in high risk pregnancies. APA WF#06-28	Annual State Share $622,808	November 1, 2006
October 12, 2006	Revising rules to delete one panel review for members after an agency decision regarding an adverse determination. APA WF#06-34	Budget neutral	December 1, 2006
October 12, 2006	Revising rules to remove the limitation of gender and number of mammograms a member can have. Changes also reflect organ transplant clarifications. APA WF#06-22	Annual State Share $700,000	December 1, 2006
October 12, 2006	Revising rules to utilize other accrediting agencies pursuant to Medicare practices and guidelines. APA WF#06-27	Budget neutral	December 1, 2006
October 12, 2006	Revising rules regarding Private Duty Nursing in-home treatment plan and to allow private duty nurses to accompany children to ER and doctor visits. APA WF#06-25 & 06-26	Budget neutral	December 1, 2006
October 12, 2006	Revising rules to reflect recent changes to outpatient hospital pricing. Changes also reflect organ transplant clarifications. APA WF#06-33	Annual State Share $17.2 million	December 1, 2006
August 16, 2006	Revising rules to include coverage for adult immunizations under the Center for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practice's (ACIP) guidelines and revisions are made to clarify the accreditation requirements to be eligible to perform organ transplants and define appropriate transplants that are reimbursable by the Oklahoma Health Care Authority. APA WF#06-38	Annual State Share $900,000	December 1, 2006
November 9, 2006	Revising rules to establish a payment and billing method for OHCA contracted air ambulance providers that transport SoonerCare members out-of-state and provide ground transportation from the airport to the admitting hospital. APA WF#06-32	Budget neutral	December 21, 2006
December 14, 2006	Revising resource eligibility rules for individuals related to aged, blind and disabled to increase the maximum monthly income for Medicaid Income Pension Trust, also known as a Miller Trust, from $2,500 to $3,000. APA WF#06-47	Annual State Share $4,959,869	February 1, 2007

APPENDIX D SFY2007 BOARD APPROVED RULES (CONTINUED)

Board Approval Date	Rule Description	Savings/Total Cost/State Share	Effective Date
December 14, 2006	Revising Dental rules to: (i) establish a limited dental benefit for pregnant women; (ii) allow coverage of sealants for children up to 18 years of age; (iii) allow stainless steel crowns for children with 70 percent or more of the root structure regardless of the child's age; and (iv) add language under Smoking Cessation to agree with changes being made in other rule sections. APA WF#06-42	Annual State Share $2,040,762.65	February 1, 2007
December 14, 2006	Revising SoonerPlan rules to comply with CMS clarifications to exclude family planning services to individuals with Medicare or other creditable health insurance coverage. APA WF#06-43	Budget Neutral	February 1, 2007
December 14, 2006	Revising eligibility rules to allow a $240 work related expense deduction from each adult member's earned income in the Low Income Families with Children, Pregnancy Related, SoonerPlan, O-EPIC Premium Assistance and O-EPIC Individual Plan programs. APA WF#06-53	Annual State Share $2,180,300	February 1, 2007
December 14, 2006	Revising Long Term Care rules to allow nursing facility reimbursement for nurse aide training as an administrative claim instead of being included in the facility's per diem. APA WF#06-46	Budget neutral	February 1, 2007
December 14, 2006	Revising rules reflecting that the transportation a recipient's family member needs to participate in family counseling is the responsibility of the psychiatric residential treatment center. APA WF#06-35	Budget neutral	February 1, 2007
December 14, 2006	Revising rules to add coverage of external breast prosthesis and support garments for women who have had a mastectomy.	Annual State Share $12,784	February 1, 2007
December 14, 2006	Revising Nutrition Service rules to increase the maximum number of medically necessary nutritional counseling hours by a licensed registered dietician from two to six hours per year. APA WF#06-54	Annual State Share $39,506	February 1, 2007
December 14, 2006	Revising O-EPIC rules to: (i) update the Individual Plan benefit package by reducing unnecessary duplication and referencing other sections where the same benefit is located; and (ii) clarify employer eligibility procedures for the O-EPIC Premium Assistance program. APA WF#06-55	Annual State Share $924,000	February 1, 2007
December 14, 2006	Issuing rules to establish the Oklahoma Prescription Drug discount Program (OPDDP) that allows certain Oklahomans to purchase prescription drugs at the lowest possible out-of-pocket cost through the OPDDP's pharmacy network. APA WF#06-41	Annual Cost to the State (state-funded) $1,400,000	February 1, 2007
December 14, 2006	Revising surgery rules to comply with current agency protocol regarding the prior authorization process for breast reduction mammoplasty. APA WF#06-40	Budget neutral	February 1, 2007
February 8, 2007	Revising O-EPIC Individual Plan rules to add perinatal dental coverage for pregnant women to the benefit package.	Annual State Share $924,000	April 1, 2007
February 8, 2007	Revising Developmental Disabilities Services rules to: (1) clarify DDSD Home and Community Based Services Waiver program provisions; (2) clarify habilitation services; (3) delineate levels of support criteria in agency companion services; (4) reflect current group home provisions and requirements; and (5) provide contracting guidelines for HCBS Waiver service employment. APA WF#06-48A and 06-48E	Budget neutral	May 11, 2007
March 8, 2007	Revising Physicians rules to clarify terminology for cataract surgery and claims' processing with modifiers. APA WF#07-08	Budget neutral	June 25, 2007

Appendix D SFY2007 Board Approved Rules (continued)

Board Approval Date	Rule Description	Savings/Total Cost/State Share	Effective Date
March 8, 2007	Revising rules to require documentary evidence of citizenship or naturalization and identity in compliance with the Deficit Reduction Act of 2005. APA WF#06-15A and 06-15E	Budget neutral	June 25, 2007
March 8, 2007	Revising rules to add coverage for donor expenses for organ transplants for SoonerCare members. APA WF#06-30	State Share $79,620	June 25, 2007
March 8, 2007	Revising rules to clarify availability of non-emergency transportation for SoonerCare members. APA WF#06-45	Budget neutral	June 25, 2007
March 8, 2007	Revising rules to require providers to bill their usual and customary charges. APA WF#06-57	Budget neutral	June 25, 2007
March 8, 2007	Revising rules to remove procedure codes and allowable amounts for escort and lodging expenses.	Budget neutral	June 25, 2007
March 8, 2007	Revising rules to reflect newly CMS approved 115 Waiver protocols including: (1) direct access to women's health care specialists; (2) removal of the guarantee of six month eligibility for SoonerCare members; and (3) deletion of language requiring a provider to be board eligible or certified to engage in the practice of family medicine. APA WF#06-59	Budget neutral	June 25, 2007
March 8, 2007	Revising rules to consolidate all services provided by the Oklahoma State Department of Health, County Health Departments, and City-County Health Departments. APA WF#06-60	Budget neutral	June 25, 2007
March 8, 2007	Revising Advanced Practice Nurse rules to correct an inaccurate citation. APA WF#06-62	Budget neutral	June 25, 2007
March 8, 2007	Revising rules to clarify billing procedures for newborn care. APA WF#06-63	Budget neutral	June 25, 2007
March 8, 2007	Revising Long Term Care eligibility rules to comply with Section 6011 of the Deficit Reduction Act of 2005 to: (1) lengthen the look back period for transfer of assets; (2) calculate penalty periods; and (3) specify the condition under which an undue hardship exists. APA WF#06-64	Budget neutral	June 25, 2007
April 12, 2007	Revising Long Term Care rules to remove the nursing facility payment methodology from rules and referencing the Medicaid State Plan. APA WF#07-17	Budget neutral	June 1, 2007
April 12, 2007	Revising rules to change the due date for the payment of the Quality of Care Fee from the 10th to the 15th of the month following the assessment. APA WF#07-16	Budget neutral	June 1, 2007
April 12, 2007	Revising PASRR rules to reflect the new required PASRR form and new submission deadline requirements. APA WF#07-07A and 07-07B	Budget neutral	June 1, 2007
April 12, 2007	Revising Residential Behavioral Management Services (RBMS) in Group Settings and Non-Secure Diagnostic and Evaluation Centers rules to: (1) allow Licensed Alcohol and Drug Counselors to provide RBMS services; (2) add trauma informed methodology as an option to staff training requirements; and, (3) update terminology as recommended by the Behavioral Health Collaborative. APA WF#07-10	Budget neutral	June 1, 2007
April 12, 2007	Revising Residential Behavioral Management Services (RBMS) in Foster Care Settings to: (1) allow Licensed Alcohol and Drug Counselors to provide RBMS services; (2) and trauma informed methodology as an option to staff training requirements; (3) update terminology as recommended by the Behavioral Health Collaborative; and (4) add language to the inspection of care section to describe actions on contract deficiencies. APA WF#07-12	Budget neutral	June 1, 2007
April 12, 2007	Revising Adult Case Management Services rules regarding provider requirements to concur with recommendations of the Behavioral Health Collaborative. APA WF#07-13	Budget neutral	June 1, 2007

Appendix D SFY2007 Board Approved Rules (continued)

Board Approval Date	Rule Description	Savings/Total Cost/State Share	Effective Date
April 12, 2007	Revising Children's Case Management Services rules regarding provider requirements to concur with recommendations of the Behavioral Health Collaborative. APA WF#07-09	Budget neutral	June 1, 2007
April 12, 2007	Revising outpatient Behavioral Health Services rules to: (1) streamline documentation; (2) broaden accessibility to providers; (3) develop consistency among state agencies that deal with mental health services; and (4) eliminate coverage of Clubhouse services. APA WF#07-14	Budget neutral	June 1, 2007
May 10, 2007	Revising inpatient psychiatric hospital rules to establish criteria for newly defined levels of Psychiatric Residential Treatment Facilities. APA WF#07-11	Budget neutral	July 1, 2007
May 10, 2007	Revising and relocating Disease Management rules from Pharmacy specific to general coverage rules and to allow the expansion of Disease Management services to all provider types. APA WF#07-01	Budget neutral	July 1, 2007
May 10, 2007	Revising Medical Supplies rules to: (1) reorganize and be more user friendly by adding definitions and separating services; (2) include supplier accreditation, medical necessity, prescription, documentation, and prior authorization requirements; (3) address rental, purchase, repairs, maintenance, replacement, and delivery of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS); (4) allow SoonerCare members freedom of provider choice; and (5) provide guidelines for new billing and reimbursement requirements. APA WF#07-22	Budget neutral	July 1, 2007
June 14, 2007	Revising pharmacy rules to: (1) allow for coverage of certain over-the-counter products if the particular product is both cost-effective and clinically appropriate; (2) remove specific drug names from policy; and (3) clean up outdated terminology. APA WF#07-06	Savings in State Share $270,000	Pending Governor's approval
June 14, 2007	Revising rules to: (1) remove the prior authorization requirement for the initial evaluation of physical therapy services for children; and (2) issue provider specific rules for outpatient occupational therapy services. APA WF#07-23	Budget neutral	Pending Governor's approval
June 14, 2007	Revising Physicians rules to clarify payment for venipuncture and catheterization services. APA WF#07-15	Budget neutral	Pending Governor's approval
June 14, 2007	Revising Dental rules to allow prior authorization information for periodontal scaling and root planning to be submitted after the services have been provided in certain situations. APA WF#07-18	Budget neutral	Pending Governor's approval
June 14, 2007	Revising O-EPIC Individual Plan (IP) rules to allow 12 months of Sooner Care eligibility to the newborn of an O-EPIC IP member. APA WF#07-19	Budget neutral	Pending Governor's approval
June 14, 2007	Issuing rules to establish guidelines for ICF/MR level of care medical eligibility determination for TEFRA children. APA WF#07-21	Budget neutral	Pending Governor's approval
June 14, 2007	Revising eligibility rules for long term services to comply with provisions of the Deficit Reduction Act of 2005 which: (1) requires a change in the disclosure and treatment of annuities purchased on or after 2/8/06; (2) establishes an upper limit for the excluded value of a home; (3) requires that included in the definition of "assets" are funds used to purchase a promissory note, loan, or mortgage, unless certain circumstances exist; and (4) redefines "assets" to include the purchase of a life estate interest in another individual's home. APA WF#07-24	Budget neutral	Pending Governor's approval

Appendix E SFY2007 Contracted SoonerCare Providers

Provider Type	SFY2007
Adult Day Care	36
Advance Practice Nurse	655
Advantage Comprehensive Health Care	15
Advantage Home Delivered Meal	20
Ambulatory Surgical Center (ASC)	63
Audiologist	83
Capitation Provider - IHS Case Manager	25
Case Manager (Targeted)	109
Certified Registered Nurse Anesthetist (CRNA)	676
Chiropractor	48
Clinic - Family Planning Clinic	6
Clinic - Federally Qualified Health Clinic (FQHC)	13
Clinic - Group	2262
Clinic - Rural Health	65
Clinic - Speech/Hearing Clinic	4
DDSD - Architectural Modification	62
DDSD - Employee Training Specialist	108
DDSD - Homemaker Services	248
DDSD - Non-Federal Medical	182
DDSD - Supportive Living Arrangements	49
DDSD - Volunteer Transportation Provider	432
Dentist	686
Direct Support Services	282
DME/Medical Supply Dealer	1490
End-Stage Renal Disease Clinic	40
Extended Care Facility - Facility Based Respite Care	79
Extended Care Facility - ICF/MR	68
Extended Care/Skilled Nursing Facilities	340
Free Standing Birthing Center	2
Home Health Agency	170
Hospital - Acute Care	723
Hospital - Critical Access	63
Hospital - Psychiatric	22
Hospital - Residential Treatment Center	42
Laboratory	153
Long Term Care Authority Hospice	40
Mental Health Provider - Counselor	65
Mental Health Provider - Psychologist	348
Mental Health Provider - Social Worker	164
Mid-Level Practitioner	624
Nutritionist	135
Optometrist	476
Outpatient Mental Health Clinic	209
Personal Care Services	35
Pharmacy	933
Physician - Allergist	44
Physician - Anesthesiologist	1001
Physician - Cardiologist	607
Physician - General Pediatrician	1670
Physician - General Practitioner	2361
Physician - General Surgeon	684
Physician - Internist	1852
Physician - Obstetrician/Gynecologist	585
Physician - Other Specialist	4002
Physician - Radiologist	1139
Residential Behavior Management Services (RBMS)	17
Respite Care	248
School Corporation	226
Specialized Foster Care/MR	236
Therapist - Physical	366
Therapist - Occupational	170
Therapist - Speech/Hearing	368
Transportation Provider	213
X-Ray Clinic	60
TOTAL	**28,199**

The term "contracted" is defined as a provider that was enrolled with Oklahoma SoonerCare within SFY2007, 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.

Important Telephone Numbers

OHCA Main Number	405-522-7300
SoonerCare Helpline	1-800-987-7767

Member Services	405-522-7171 or 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

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

OHCA Internet Resources

Oklahoma Health Care Authority	www.okhca.org
Insure Oklahoma	www.insureoklahoma.net
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

Oklahoma Health Care Authority

Pioneering Health Care Coverage in Oklahoma