SOLUTIONS

CARE

PREVENTION

HOPE

RESULTS

OKLAHOMA HEALTH CARE AUTHORITY

WELLNESS

COMMUNITY

QUALITY

SERVICE

RELIEF

oklahoma health care authority

OUR MISSION STATEMENT

Our mission is 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

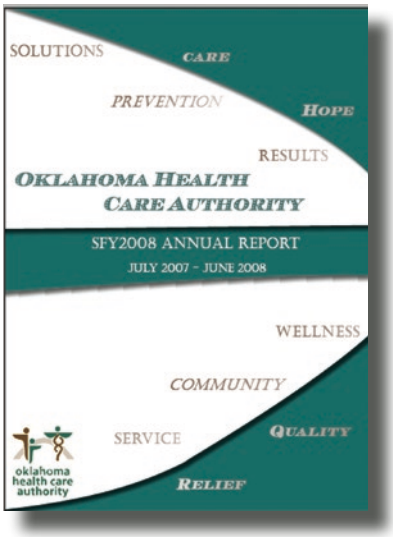
Our vision at the Oklahoma Health Care Authority (OHCA) is for Oklahomans to enjoy optimal health status through having access to quality health care regardless of their ability to pay.

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.



On the cover: Just words? Included in this report are the words we as an agency live by every day. These words, like road signs, guide us in our daily tasks as public servants working to provide health care coverage to Oklahomans.

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Governor

State of Oklahoma

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Health Cabinet Secretary

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2nd Session of the 51st Legislature

Mike Morgan
President Pro Tempore, State Senate

Glenn Coffee
Co-President Pro Tempore, State Senate

Chris Benge
Speaker, House of Representatives

OHCA Board Members

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

Message from the Chief Executive Officer

I hope as you read this report you come away with a sense of the innovative spirit that is characteristic of the Oklahoma Health Care Authority. We try not to be just "purchasers" of health care. Rather, we strive to improve the value of the services we buy.

Soaring costs coupled with the growing number of uninsured Americans have pushed health care reform to the top of domestic public policy challenges. The federal government has been slow to change health policy and programs and as a result states are undertaking some impressive initiatives to try to improve the system.

The federal Medicaid program dates back more than 40 years; it was created as part of the welfare system in the 1960s. It was originally designed to assist the poor, mainly children and elderly or disabled adults. However, today one out of five Oklahomans has no health insurance, and most of these are working adults, a trend occurring across the country.

Such a large number of uninsured people has a huge impact on the health care system as a whole. Recognizing this, leaders of at least nine states have implemented premium assistance programs where they help residents of their states buy into private market health coverage through their employer. In Oklahoma, our leaders authorized the Insure Oklahoma/O-EPIC program to help small businesses and their employees with this expense. You can read more about this program and its growth during the past year in this report.

States are also looking at quality initiatives to improve value and contain cost. The OHCA has implemented very successful projects for appropriate emergency room utilization and effective health management. The ER utilization project targets frequent users of the emergency room and directs them to care that is more appropriate. The health management project works with our members who have chronic diseases and serious health problems to teach them to better manage their conditions.

An excellent example of a pay-for-performance initiative is featured in the Focus on Excellence section. This program recognizes nursing homes that make extra effort to provide quality patient care and directs public funds spent on nursing home care to be related to quality performance. Focus on Excellence quality performance results are also posted on the Internet providing timely and helpful information to the general public.

Advances in technology are being tapped by many states to help improve their programs. This report contains sections about the OHCA's use of emerging technology. Examples include the agency's new process to immediately enroll newborns into the SoonerCare program and the growing use of electronic prescribing. These and other electronic advances help ease the paperwork burden, reduce human error, support high quality care delivery and coordination, and speed along the processing of claims.

I've mentioned just a few of the ways we are trying to transform our program and in turn help improve the overall health care system in our state and the health status of all Oklahomans.

It has been said that you can't make a silk purse out of a sow's ear. We say, making a modern health care system out of the antiquated policies of federal Medicaid laws and regulations can also seem impossible. However, on a daily basis I personally observe some beautiful purses leave this agency and some proud people carrying them. It is my privilege to work beside the OHCA staff and volunteers who make it possible.

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SFY2008 Highlights

Members

- There were 797,556 unduplicated members enrolled in either SoonerCare (Oklahoma Medicaid) or Insure Oklahoma during SFY2008 (July 2007 through June 2008).
- A total of 771,105 Oklahoma SoonerCare members received services during SFY2008.
- Overall SoonerCare enrollees increased by 4.5 percent and the number served increased 3.4 percent from SFY2007 (July 2006 through June 2007).
- Enrollment in the Insure Oklahoma program has increased 314 percent since June 2007. As of June 2008, 11,684 enrollees and 2,742 businesses were participating.
- During SFY2008, Oklahoma provided coverage to 34,260 SoonerPlan enrollees and 7,541 women needing further diagnosis or treatment for breast and/or cervical cancer through the Oklahoma Cares program.
- SoonerCare covers more than 55 percent of the births in Oklahoma. (Calendar year 2007, there were 32,888 SoonerCare births compared with 54,946 total statewide, according to the Oklahoma State Department of Health preliminary 2007 data.)

Expenditures

- Fifty-eight percent of SoonerCare expenditures were made for services provided to the aged, blind and disabled enrollees, who made up an average of 18 percent of SoonerCare members for SFY2008.
- SoonerCare funded 70 percent of Oklahoma's total long-term care actual bed days.
- OHCA expended $27.5 million on behalf of the Breast and Cervical Cancer enrollees and more than $5.3 million on SoonerPlan enrollees.
- Quality of Care revenues totaled $52,291,769.
- Dollars recovered by OHCA through post-payment reviews totaled $6,394,754.
- Drug rebate collections totaled $102,864,768.
- By limiting the amount paid for generic drugs, OHCA saved more than $62.3 million through the State Maximum Allowable Cost (SMAC) program.

Administration

- The OHCA processed 34 emergency rules, 45 permanent rules and 23 State Plan amendments.
- There were 85 group provider training sessions attended by more than 8,500 providers. OHCA and EDS held 3,961 individual on-site provider training sessions during SFY2008.
- OHCA received and investigated 7,820 SoonerCare member complaints. This represents less than 1 percent of the 797,556 SoonerCare enrollees.
- There were 38 provider and 46 member formal appeals filed. This is less than one quarter of 1 percent of both populations.
- OHCA administrative costs comprised 2 percent of the total SoonerCare expenditures. OHCA operating costs represent 46 percent of OHCA administrative costs, and the other 54 percent are contract costs.

SFY2008 Year in Review

Insure Oklahoma Enrollment Increases - Income Guidelines Raised

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 comes 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 200 percent of federal poverty level).

In November 2007, the number of employees a qualifying small business can have was raised from 25 to 50 and the income guidelines for employees and individuals were raised from 185 to 200 percent of federal poverty level. As of June 2008, 2,742 businesses were participating in the plan.

Total enrollment in the Insure Oklahoma health coverage program grew substantially during a statewide media campaign launched in mid-October 2007. There were 4,349 Oklahomans enrolled before the media blitz; as of June 2008, 11,684 were enrolled, or an increase of 169 percent!

Covering Out-of-State Children in Oklahoma's Indian Boarding Schools

Oklahoma is home to five American Indian boarding schools with a total enrollment of approximately 1,142 students. About a third of the American Indian children attending the boarding schools lacked comprehensive health care coverage. Although many of them live in dormitories or residential facilities in Oklahoma for most of the year, they had been considered out-of-state residents and thus ineligible for SoonerCare.

On December 1, 2007, OHCA became the first state to formally extend coverage to students living in Indian Health Services, Bureau of Indian Affairs or tribal-controlled peripheral dormitories and schools. The amended rule change allowed for more than 300 uninsured Indian boarding school students to qualify for SoonerCare. At the end of the 2008 school year, approximately 135 students had enrolled in SoonerCare as a result of the new rule.

SFY2008 Year in Review (continued)

Perinatal Benefits Expand

The Oklahoma Health Care Authority has long been committed to providing optimal health care for mothers and newborns. Nearly three years ago, the OHCA initiated a partnership with the Oklahoma State Department of Health to develop a statewide Perinatal Advisory Task Force (PATF). The PATF is composed of more than 20 agencies and organizations involved with perinatal care. It serves to provide expertise regarding perinatal health care and to make recommendations regarding program modifications that may contribute to improving perinatal outcomes in Oklahoma.

As of December 2007, pregnant/postpartum SoonerCare members now have benefits that cover the care provided by maternal and infant health social workers, lactation consultants and genetic counselors. These services were added to allow increased access to services that have been shown to help improve pregnancy outcomes and infant health.

Pregnant women with certain medical conditions often require an increased level of care and specialized testing to properly manage their pregnancies. Last December, expansions were made to cover additional services for pregnant SoonerCare members with certain high-risk pregnancy conditions. Providers of obstetrical care may obtain prior authorization for reimbursement of care for medically high-risk pregnant women when co-managing care in consultation with a maternal fetal medicine specialist. Several critical diagnostic tests needed in high-risk pregnancies, including fetal non-stress tests, biophysical profiles and additional ultrasounds, are now separately covered when provided to SoonerCare members who meet the established criteria and receive prior authorization.

OHCA Implements Soon-to-be Sooners (Pregnancy-Related Benefits for Unborn Citizens)

Each year, in accordance with federal law, SoonerCare pays for emergency labor and delivery services for women who are not eligible for SoonerCare benefits due to their immigration status. Although these newborn babies will be citizens of both Oklahoma and the United States at the time of their birth, they often have not had the benefit of prenatal care services. Prenatal care has long been shown to contribute toward positive birth outcomes; a lack of prenatal care may contribute to poor birth outcomes.

Poor birth outcomes not only negatively affect the child and family but society as well, in the form of increased health care costs. Studies have shown that each dollar spent on prenatal care can save from one to three dollars in the first year of life. In April 2008, SoonerCare implemented the “Soon-to-be Sooners” (STBS) program which helps Oklahoma babies to start out as healthy as possible by providing for health care coverage before they are born.

The STBS program is federally approved through Title 21 of the Social Security Act and makes SoonerCare coverage of pregnancy-related medical services available to pregnant women who, prior to this benefit, would not have otherwise qualified for benefits due to citizenship status. STBS benefits are more limited than SoonerCare full scope benefits and cover only those medical services related to the well-being of the pregnancy.

SFY2008 YEAR IN REVIEW (CONTINUED)

NEW STATE WEB SITE HELPS OKLAHOMANS CHOOSE NURSING FACILITIES

With a click of the mouse, consumers can visit a new Web site, www.oknursinghomeratings.com, to access current information about nursing facilities that contract with the SoonerCare (Medicaid) program. Called Focus on Excellence, the program is designed to encourage quality improvements in long-term care services through public accountability. The Web site is available for providers and consumers to enter and view performance data and outcomes. The Web site receives approximately 1,866 page views per week and 88.89 percent new visits.
The OHCA contracts with a national health care data management firm, My InnerView Inc., to provide independent validation of each nursing home's performance under the program. Using this information, the facilities are awarded a "star rating" based on their scores on these factors with one star being the lowest and five the highest.

Two hundred and eighty-eight facilities have joined the program which represents a 93 percent participation rate. Enrollment in this program is not mandatory, but was strongly incentivized. Providers began receiving quarterly bonuses of up to 4 percent of their normal daily rate October 1, 2007. To date, as many as 24 facilities has received a 5 star rating. As always, the added payments are dependent on sufficient annual legislative appropriations.

The Focus on Excellence Program received a Governor's Commendation for Excellence Award as well as nominations for the Red Tape Reduction and Quality Crown awards at the annual Quality Oklahoma Team Day awards ceremony.

APPROVAL RATING HIGH FOR OKLAHOMA CARES PROGRAM

Oklahoma Cares, SoonerCare's breast and cervical cancer treatment program, received high marks on a 2007 survey measuring member satisfaction.

In the survey, members were asked about the services they received and what improvements, if any, could be made to the care they received through the program. Members were pleased with the prompt service they received when being enrolled. More than 90 percent of the members indicated that they especially appreciated the follow-up telephone calls made by the program staff. In addition, 98 percent of those members participating in the survey ranked the staff as being courteous and respectful. The survey results also showed an overall satisfaction with the process for screenings and information on performing breast self-exams.

SFY2008 Year in Review (continued)

SoonerCare Member Outreach Continues

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.

SoonerCare OB Outreach Lessons Learned

In 2008, OHCA staff began a pilot project to determine an effective way to be able to speak directly with pregnant members to ensure they are linked with an obstetric provider and know and understand their pregnancy benefits, It also allows staff to identify members who may be classified as at-risk pregnancies.

The first pilot was conducted in March and April 2008. Three groups of 300 pregnant members were targeted with three different outreach approaches. The first group was telephoned, the second group received a short letter asking them to call the Helpline, and the third group received a longer letter explaining pregnancy benefits and also asking the member to call the Helpline. Results for groups II and III were very disappointing. The first group's telephone results were better but were determined to be inefficient. However, when letters were mailed to the portion of group I staff had been unable to reach by phone, the call-back rate was greater than 40 percent. A second pilot was then ordered using letters styled after the group I call-back letter.

The second pilot was conducted in May and June 2008. A letter similar to the successful group I call-back letter of the first pilot was mailed to 450 pregnant women. Two weeks after the mailing, responses from 42 percent of the members had been recorded, duplicating the results of group I in the first pilot. As a result, the outreach for pregnant members will go into production beginning the first week of July. Responses will be recorded in an electronic database, and care management and administration staff will be able to view the results.

Out-of-State Care Coordination Provided

SoonerCare members are very fortunate to have quality medical care available to them, including specialty care. However, sometimes a SoonerCare member needs specialty care that is not available in Oklahoma. In this event, the SoonerCare member gets a team of OHCA staff working in collaboration with their local physician to identify and coordinate care with medical providers located all over the United States.

This highly specialized care was coordinated for 34 members with at least 22 facilities and 41 physicians. This also included a variety of emergency air transports in 12 other states through the efforts of our OHCA staff in these often critical, time-sensitive situations. OHCA manually processed just over $4.5 million in claims related to these specialty contracts.

SFY2008 Year in Review (continued)

SoonerCare Continues to Face Federal Funding Challenges

The federal and state governments share Medicaid costs. Each year the federal matching rate for medical services, known as the "federal medical assistance percentage" (FMAP), is adjusted. Reductions in federal matching rates for the past five years have cost the state an additional $141.8 million.

In the last five years, OHCA has lost nearly $37 million in state dollars due to Medicare Part A and Part B premium increases. The OHCA pays the premiums and deductibles for Medicare Part A and Part B coverage for those people who are both eligible for Medicaid and Medicare. Medicare increases the premiums annually.

Additionally, OHCA is required to pay back the estimated Medicaid prescription cost savings for seniors eligible for both Medicaid and Medicare. Dual eligibles now receive most of their prescription drug benefits from Medicare Part D. This prescription savings amount is referred to as a "clawback." The OHCA paid $57.7 million in Medicare Part D "clawback" in SFY2008.

OHCA Awarded Grant to Streamline Enrollment

The goal of providing 24-hour-a-day, seven-day-a-week access to SoonerCare enrollment via a Web-based application became a step closer in October 2007 with the announcement that Oklahoma was awarded a $6.1 million federal grant to create the process.

The proposed project would create an alternative to the current paper application by providing a Web-based online enrollment process that would quickly determine if Oklahomans qualify for any of the state's SoonerCare health coverage programs. It will also inform the applicant of other health services that may be available.

The agency will receive the federal funds over the next two years to support the planning, design, development, testing, implementation and evaluation of this project. The online enrollment process would encompass creation and programming of a Web-based online application and eligibility determination system, development of the necessary detailed policies and procedures, and technical support resources, including a help-desk system.

Online enrollment would significantly reduce the need for face-to-face interviewing and data entry to enroll potential members, reduce the margin of error and streamline the enrollment process to accomplish much more with less.

Electronic Enrollment for Newborns Becomes a Reality

After much planning, development and testing, OHCA implemented a Web-based SoonerCare application to add newborns to existing SoonerCare cases in April 2008. As a result of this project, called E-NB1, newborns can now be enrolled in SoonerCare before they leave the hospital. Babies successfully enrolled are assigned a primary care provider, have a SoonerCare identification number and can have claims processed for their services immediately. Prior to implementation less than 69 percent of newborns were added within 10 days of birth; now 94 percent are added within 10 days.

SFY2008 Year in Review (continued)

SoonerCare Health Management Program Begins

The SoonerCare Health Management Program (HMP) was developed to address the needs of SoonerCare members who are chronically ill and the increasing concerns of rising health care costs in Oklahoma. This program, which began in February 2008, is currently serving more than 2,000 SoonerCare Choice members. The HMP is a dual-armed approach to health management that focuses on nurse care management as well as provider activation through practice facilitation.

Identified members receive care management from nurses who provide education and support specific to the member's chronic condition. They also help coordinate care and improve self-management skills. Each member receives a behavioral health screening, health literacy and health status assessments, and an in-depth pharmacological review. The HMP has a built-in behavioral health referral process and a community resource referral system, both of which have been highly successful.

SoonerCare Choice primary care providers also benefit from HMP. Providers have the opportunity to participate in practice facilitation. A professional, highly-trained practice facilitator assists participating practices for one to two months in applying quality improvement techniques, redesigning office systems to improve efficiency and implementing CareMeasures, a free Web-based health information registry tool. This registry tool identifies unmet clinical measures to help the practice prioritize clinical services to be offered during the next patient encounter. CareMeasures is also equipped with a data measurement component for ongoing evaluation and performance tracking. Financial and non-financial incentives are presented to the practice based on program participation.

NPI Implemented Successfully

In May 2008, OHCA successfully implemented the federally-mandated single National Provider Identification (NPI) number that providers use with Medicare, Medicaid, and all private payers. Our challenge was to add the new identifying numbers to the files of over 22,000 enrolled providers and change our claims system to process payments with the NPI.

OHCA generally followed the same phased-in approach as Medicare but with slightly more flexibility as needed for our Oklahoma providers. New and renewal contracts required NPIs starting in late 2006. Providers received letters and training on how to obtain and use the NPI. By the time implementation began in February 2008, over 85 percent of providers had an NPI on the system.

Full implementation took place on May 22, 2008. Both OHCA and EDS had extra staff available to help providers with the inevitable questions and glitches of the transition process. Within a few weeks, claim denials and call volume had subsided to normal levels and providers were receiving payment without delay.

SFY2008 YEAR IN REVIEW (CONTINUED)

SOONERCARE PROVIDER SERVICES CONTINUES TO PROVIDE SERVICES

The Provider Services unit continues to make strides to better serve our SoonerCare provider networks. Currently, 22 dedicated and professional provider representatives are available to assist providers with program, policy and claims issues. Staff provides on-site support in the provider's office upon request. They continue to work 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 educational assistance to providers concerning ER utilization. Provider representatives are also responsible for the recruitment and retention of in-state and out-of-state providers.

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).

A direct, toll-free number is available for providers who have detailed and complex questions. This phone number is staffed from 8 a.m. to 5 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 37,565 calls were received by Provider Services in SFY2008.

Providers still have the capabilities 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. Provider Services staff received and answered more than 900 secure e-mails in SFY2008.

New in SFY2008 is a SoonerCare training request form developed for providers to submit requests for training visits. This new form is the SC-12 and can be found on the OHCA public Web site in the Provider section under Forms.

2ND ANNUAL TRIBAL CONSULTATION HELD

OHCA's second SoonerCare Tribal Consultation was held in June 2008 at the Citizen Pottawatomi Heritage Center in Shawnee. More than 150 tribal leaders and state and federal government representatives attended. The goal of the consultation meeting is to maximize partnerships with sovereign tribal governments through discussions of SoonerCare issues affecting their service delivery such as program development, strategic planning and legislative mandates.

SFY2008 Year in Review (continued)

Data Match Project with Child Support Enforcement

In 2008, the OHCA Third-Party Liability unit began a collaborative effort with the Child Support Enforcement Division (CSED). After much time spent designing and planning an effective means of data sharing, OHCA, OKDHS Family Support and CSED have implemented this worthwhile process.

The OHCA now gets information from CSED when a medical support order is enforced, which gives OHCA accurate and timely information on members who are covered by private insurance. This results in not only cost avoidance savings but also post-payment recovery collections. In exchange, OHCA sends private insurance information obtained through contractors and data matches to CSED on our SoonerCare members. This information is used to help enhance their federal funds and prevent administrative time spent searching for employers and enforcing medical support orders. As a result of this project, the first file transfer resulted in over 10,000 updated private insurance policies, and CSED sends OHCA approximately 200 new private insurance verifications weekly.

Oklahoma Hosts National Medicaid Meeting

Issues facing Medicaid programs nationwide were discussed as the Oklahoma Health Care Authority hosted the spring meeting of the National Association of State Medicaid Directors (NASMD) in June 2008.

Representatives from 41 states, the District of Columbia and three territories, Saipan, Guam and the Virgin Islands, gathered in downtown Oklahoma City to discuss issues such as targeted case management, program integrity and health care reform.

Oklahoma's Medicaid Director Lynn Mitchell, M.D., serves as a member of the NASMD Executive Committee. The association serves as a focal point of communication between the states and the federal government and provides an information network among the states on Medicaid issues.

SFY2008 Year in Review (continued)

OHCA Garners International Service Award

The Oklahoma Health Care Authority garnered international accolades from their partner in technology, EDS, by winning the company's 2007 Service Excellence Cup. The award was presented to the agency during its February 2008 board meeting.

The Service Excellence Cup is an award designed to recognize EDS' clients and their respective EDS support teams that most clearly demonstrate excellence in creating and maintaining mutually valuable relationships. The award is open to all of EDS' more than 10,000 clients worldwide.

The OHCA, which has been nominated for the award the past three years, joins the ranks of previous winners that include Western Union, Motorizzazione Civile (Europe, Middle East, Africa), Mexicana de Aviación (Latin America) and Blue Cross Blue Shield of Massachusetts.

An excerpt from the agency's award nomination notes, "Health care innovation enabled through technology has become the trademark of the OHCA with 2007 far exceeding previous outstanding years." Specific projects listed on the nomination include the OHCA/EDS team's development of a Web-based enrollment system for hospitals to enroll newborns into SoonerCare ensuring immediate assignment of the child to a physician, the migration of a paper-based nursing home preadmission and evaluation system to a Web-based system and automation of the labor-intensive prior authorization process.

OHCA Staff Receive Recognition

Often OHCA staff efforts are heralded through calls and letters. Occasionally, outstanding efforts are recognized through awards. That is the case for Maria Ordonez and Maria Arroyo. Both received an Award of Excellence and Appreciation from Integris Southwest Medical group for their participation and planning of Integris' 20th Annual Hispanic Health Fair. Both women have given their time and served on the planning committee for 18 years combined. The awards were given at a dinner and award ceremony in April 2008. Maria Arroyo and the OHCA also received a certificate of appreciation from Disney Elementary School for the Tulsa Hispanic Health Fair.

Terrie Fritz received the Maternal and Child Health Achievement of Excellence Award given by the Oklahoma Public Health Association. The Maternal and Child Health Achievement of Excellence award recognizes special contributions to improving the lives and health of mothers, infants and children in Oklahoma. Ms. Fritz received the award for her professionalism, caring and diligence to do an excellent job serving the citizens of Oklahoma.

Also receiving an award were Debbie Spaeth and Leah Taylor. Both received the "Advocacy for Progress" award from the Oklahoma Association for Marriage & Family Therapy at their 2008 Spring Conference. The award is in recognition of their efforts to advance solutions for Oklahomans facing mental health and substance abuse issues.

SFY2008 Year in Review (continued)

OHCA 2008 Quality Oklahoma Team Day Awards

OHCA highlighted 7 projects at the 2008 Quality Oklahoma Team Day held at the state capitol.

Projects receiving a Governor's Commendation for Excellence award are included below.

Certified Nurse Aide Training

The Certified Nurse Aide (CNA) training 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. This project was also nominated for the Extra Mile and Quality Crown awards.

Educating Persistent Users Regarding the Use of Emergency Room Services

Intervention teams conduct face-to-face meetings with persistent members (using ER services more than 30 times in three consecutive quarters) to provide education on appropriate ER utilization and information on community resources and continue to work with members to ensure receipt of needed 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. This project was also nominated for the Red Tape Reduction and Extra Mile awards.

Eliminating Roadblocks to Access Behavioral Health Care

Automatic approval of prior authorization requests for outpatient behavioral health care for one month of services when providers agree to begin treatment within seven days of members' discharge from residential facilities.

Focus on Excellence

OHCA, with input from the nursing home community, consumers, advocates and industry experts, has developed a quality measurement system designed to inform stakeholders of nursing homes' quality efforts and recognize those which ensure high quality services are provided to Oklahoma's long-term care residents. The Focus on Excellence Web site is detailed on page 11. This project was also nominated for the Red Tape Reduction and Quality Crown awards.

Web-Based SoonerCare Enrollment for Newborns (NB-1)

OHCA, OKDHS and EDS collaboration to create an online process that eliminates manual enrollment for newborns, ensuring that babies have SoonerCare health benefits before leaving the hospital and allowing attending physicians and hospitals to submit claims for reimbursement more quickly. For more detail go to page 13 of this report.

WHAT IS MEDICAID?

WHO QUALIFIES FOR MEDICAID?

WHAT IS SOONERCARE?

WHO ARE THE MEMBERS OF SOONERCARE?

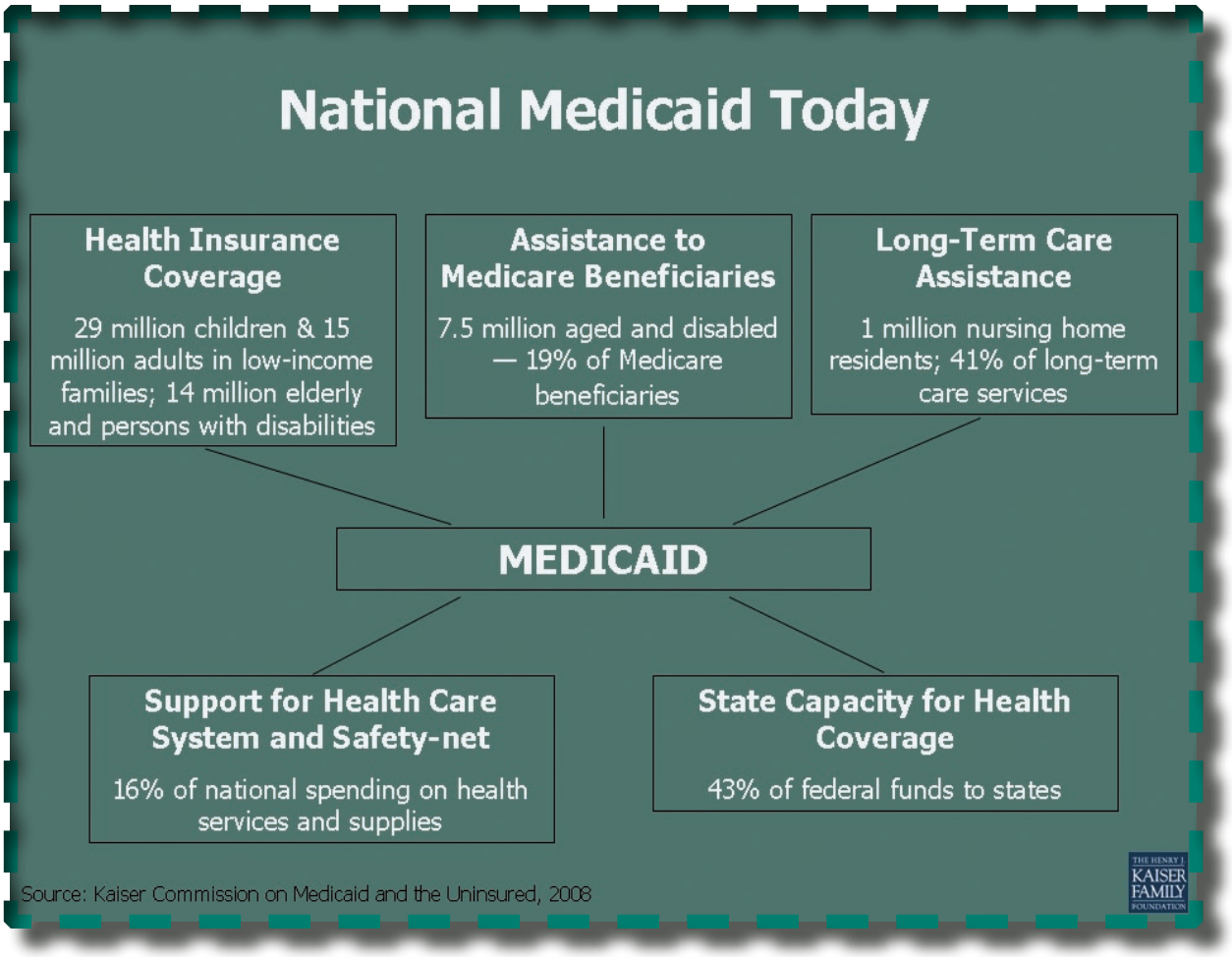
HOW IS SOONERCARE FINANCED?

WHERE ARE THE SOONERCARE DOLLARS GOING?

OKLAHOMA'S UNINSURED

OKLAHOMA'S RESPONSE TO THE UNINSURED

SOONERCARE AND THE ECONOMY



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 known as 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 2008 Federal Poverty Guidelines (FPL)

Family Size	Annual (Monthly) Income			
	100%	185%	250%	300%
1	$10,400 ($867)	$19,240 ($1,603)	$26,000 ($2,167)	$31,200 ($2,600)
2	$14,000 ($1,167)	$25,900 ($2,158)	$35,000 ($2,917)	$42,000 ($3,500)
3	$17,600 ($1,467)	$32,560 ($2,713)	$44,000 ($3,667)	$52,800 ($4,400)
4	$21,200 ($1,767)	$39,220 ($3,268)	$53,000 ($4,417)	$63,600 ($5,300)
5	$24,800 ($2,067)	$45,880 ($3,823)	$62,000 ($5,167)	$74,400 ($6,200)
6	$28,400 ($2,367)	$52,540 ($4,378)	$71,000 ($5,917)	$85,200 ($7,100)
7	$32,000 ($2,667)	$59,200 ($4,933)	$80,000 ($6,667)	$96,000 ($8,000)
8	$35,600 ($2,967)	$65,860 ($5,488)	$89,000 ($7,417)	$106,800 ($8,900)

SOURCE: Federal Register, Vol. 73, No. 15, January 23, 2008, pp. 3971–3972; http://aspe.hhs.gov/poverty/08poverty.shtml
For family units with more than eight members, add $3,600 for each additional member.

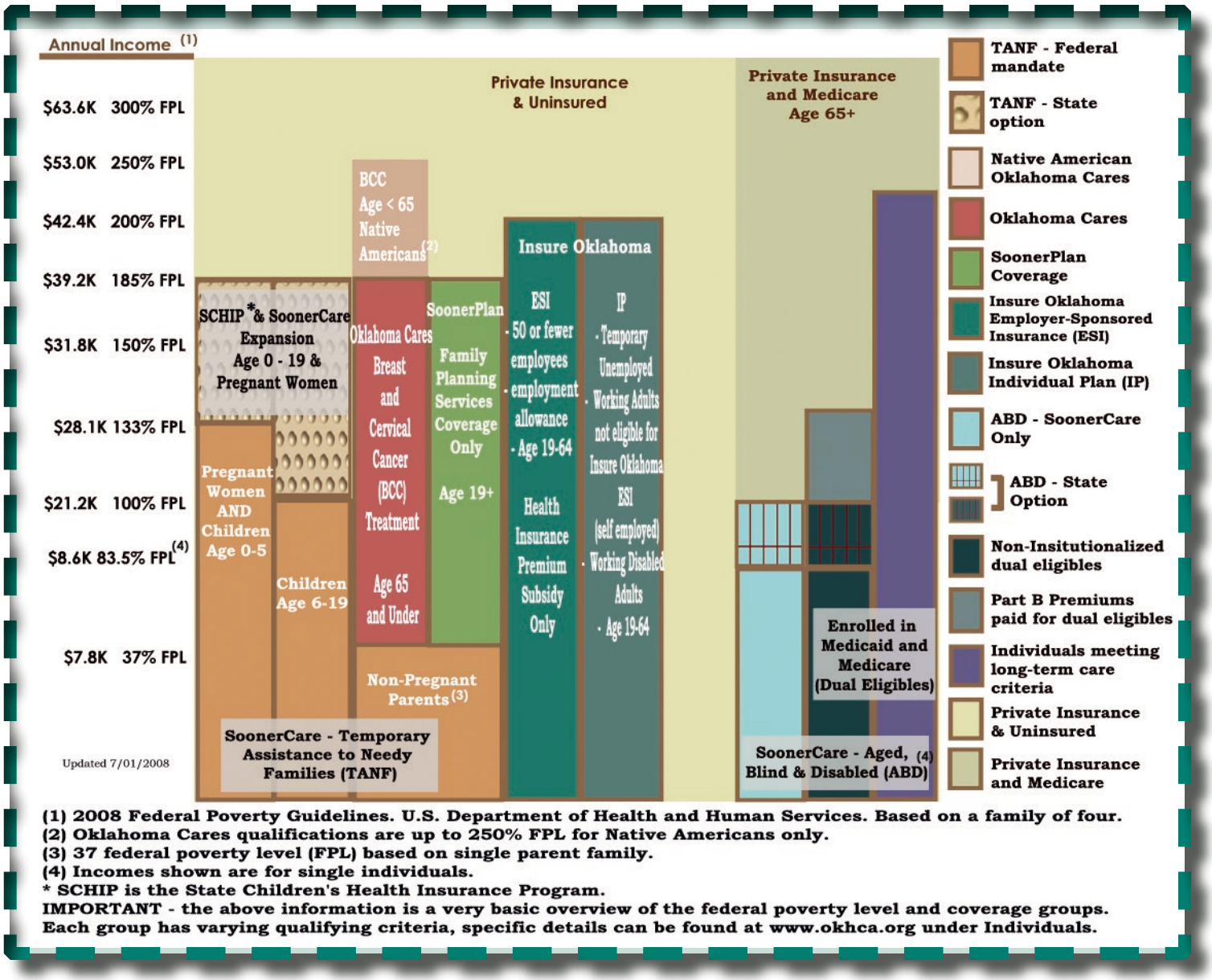
The designation of some groups as mandatory and others as optional is an artifact of Medicaid's origins as a health care provider for traditional welfare populations. Through laws enacted over the past 40 years, eligibility has been extended to include not only people who are receiving cash-assistance 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) to determine SoonerCare eligibility. This means that applications for 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 2008 Federal Poverty Guidelines (FPL) and Coverage



(1) 2008 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. SoonerCare offers varying health benefit packages, 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, covered under a health maintenance organization (HMO) or enrolled under one of the Home and Community-Based Services waiver programs.

SoonerCare Supplemental is a plan that pays the Medicare 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, who are unemployed or who are working disabled individuals.

For more information about Insure Oklahoma, go to page 33 of this report or 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, 47 percent of SoonerCare enrollees do not receive any type of cash assistance.

Children and Parents. 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 91,000 low-income pregnant women or adults in families with children were enrolled under TANF guidelines. The majority of these members receive the SoonerCare Choice benefit package.

FIGURE 3 SFY2008 SOONERCARE CHILDREN UNDER 21

Total Unduplicated Children under 21	519,880
Children Qualified under TANF	450,527
Children Qualified under Blind and Disabled	18,078
Children Qualified under TEFRA	229
Children Qualified under SCHIP	115,433

Children above may be counted in multiple qualifying groups.

Aged. Nearly 61,000 adults age 65 and older, excluding people who are blind or disabled, were covered by SoonerCare in SFY2008. Twenty-seven 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 SFY2008, more than 91,500 Oklahomans who are blind or have chronic conditions and disabilities were enrolled in SoonerCare. Sixty nine 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 just over 111,000* dually eligible enrollees at some point during SFY2008. 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. Calculation methodology has changed since SFY2007. Updated methodology SFY2007 figure restated as 112,317 dual enrollees.

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. During SFY2008 a monthly average of 65,000 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 Children/Parents in this report.

SoonerCare expansion. Also in 1997, legislation raised the optional SoonerCare eligibility level to 185 percent of the federal poverty level for children 18 and under as well as pregnant women regardless of their age. The SoonerCare expansion also includes these qualifying individuals even if they have other types of insurance coverage (third-party liabilities). In SFY2008, 9,609 children and or pregnant women qualified through this expansion. These enrollees receive SoonerCare Choice benefits and are categorized under Children/Parents.

Since the implementation of the SoonerCare eligibility expansion programs in 1997, the number of children enrolled in SoonerCare has increased more than 150 percent.

TEFRA. The Tax Equity and Fiscal Responsibility Act (TEFRA) gives Oklahoma the option to make SoonerCare benefits available to children age 18 and under 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 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 as Aged, Blind and Disabled.

260 children have qualified through the TEFRA program since its inception in October 2005.

Oklahoma Cares. Implemented in January 2005, OHCA's breast and cervical cancer treatment program, Oklahoma Cares, provides SoonerCare health care benefits to women under age 65 found to need 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 Children/Parents category in this report.

There have been 16,144 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 age 20 and over with income below 185 percent of federal poverty level and who do not have family planning coverage from any other source. SoonerPlan member benefits are limited to family planning services from any SoonerCare provider who offers family planning.

Since inception, there have been 56,469 men and women enrolled through 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:

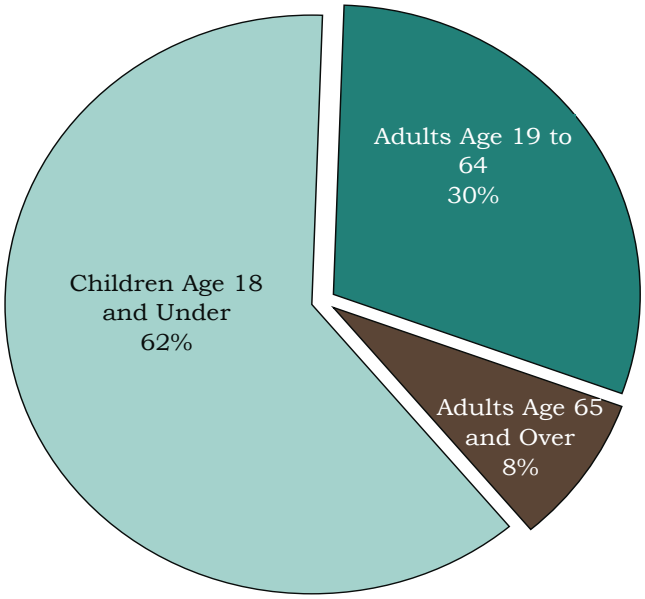
- *ADvanatge Waiver:* Serves the "frail elderly" (age 65 years and older) and adults over age 21 with physical disabilities that qualify for placement in a nursing facility. Approximately 26,000 members receive services through this waiver program.
- *Community Waiver:* Serves approximately 2,900 members 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 providing adults (ages 18 and older) with mental retardation access to waiver services. This waiver serves more than 1,600 adults who would otherwise qualify for placement in an ICF/MR.
- *In-Home Supports Waiver for Children:* Designed to provide waiver services to children ages 3 through 17 years with mental retardation. During SFY2008, this waiver served 718 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



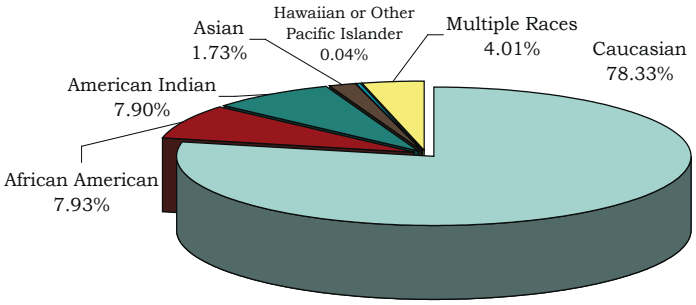
Approximately 1 in 5 Oklahomans Enrolled in SoonerCare

There were 797,556 unduplicated members enrolled in the SoonerCare program during SFY2008. On average, 606,681 members were enrolled each month of the state fiscal year. Females comprised 58 percent of the unduplicated enrollees.

Figure 5 SoonerCare Population by Race

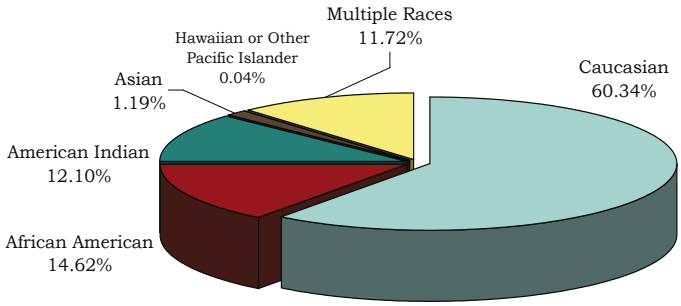
Oklahomans can declare any combination of five races. The pie charts below represent the counts of races reported alone. The bar chart below is the total SoonerCare count of each race for every reported occurrence either alone or in combination with another race.

State of Oklahoma Population 2007

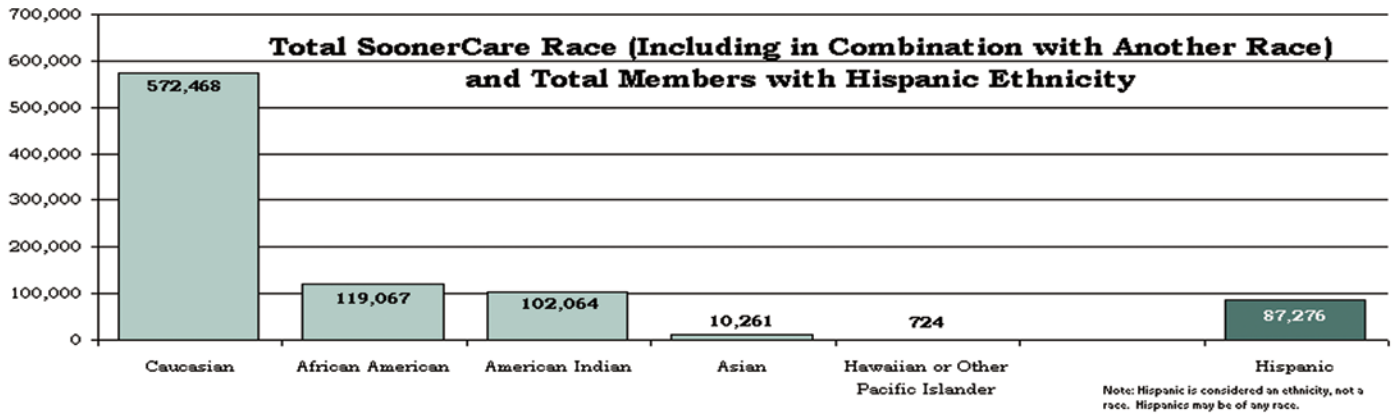


Total Estimated Population 2007 - 3,617,316

Oklahoma SoonerCare Population SFY2008



Total Enrolled SFY2008 - 797,556



Oklahoma state totals based upon US Bureau of the Census Oklahoma State Data Center 2007 Population - single race reported alone counts. Oklahoma SoonerCare unduplicated single race reported alone counts based upon data extracted from member eligibility files on July 14, 2008. The multiple race group has two or more races reported. 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%	FFY09	65.90%	76.13%

‡ 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 more than 40 percent of all federal funds flowing into Oklahoma. Federal Medicaid dollars received for SFY2008 totaled more than $2.4 billion.

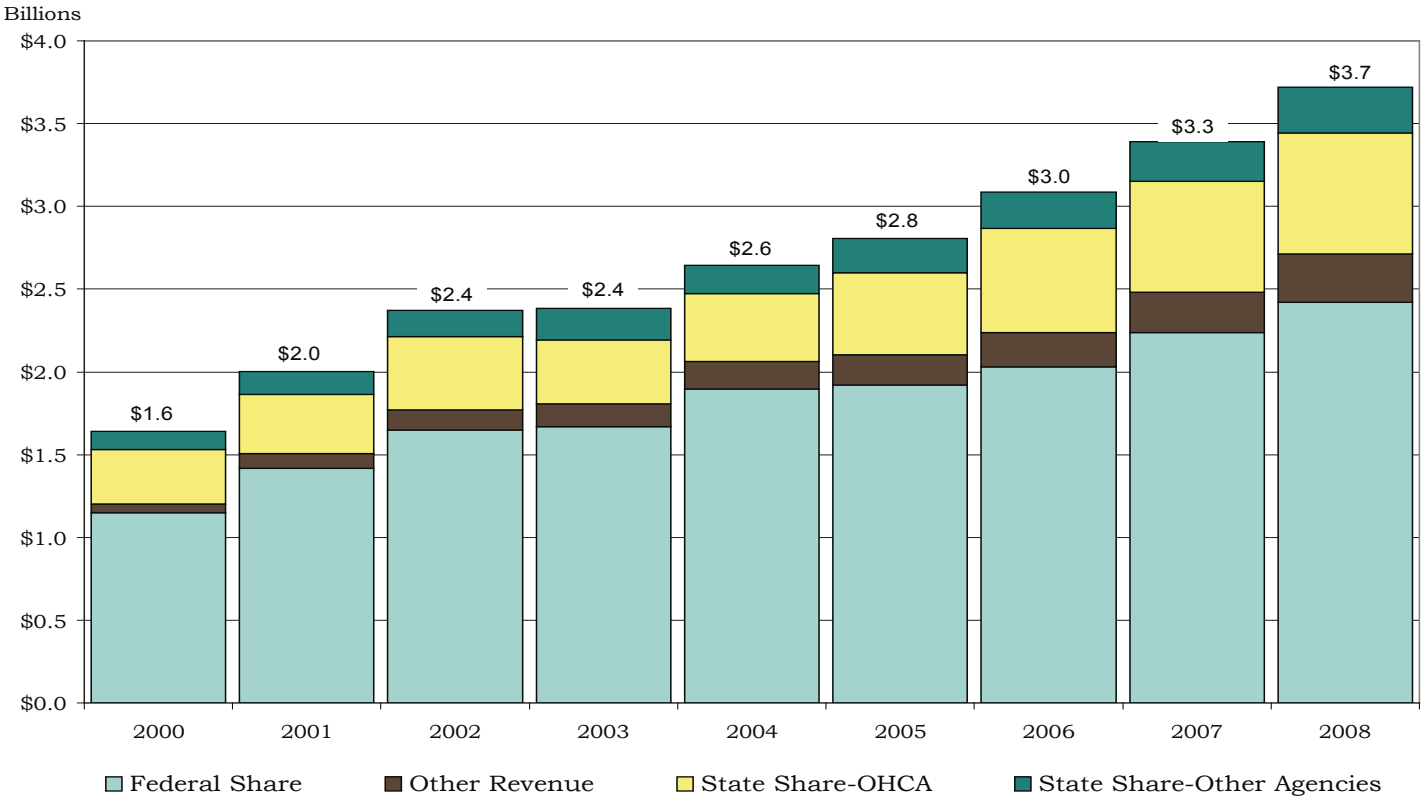
FIGURE 7 SFY2008 CONDENSED SUMMARY OF OHCA REVENUES

Revenue Source	Actual Revenues
State Appropriations	$771,709,298
Federal Funds—OHCA	$1,914,907,648
Federal Funds for Other State Agencies	$568,722,333
Refunds from Other State Agencies	$273,538,408
Tobacco Tax Funds	$94,948,681
Drug Rebate	$102,864,240
Medical Refunds	$20,198,362
Quality of Care Fees	$52,291,769
Prior Year Carryover	$64,287,695
Other Revenue	$19,564,768
Total Revenue	$3,883,033,202

Source: OHCA Financial Services Division, September 2008. 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 2000-2008



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
2008	$3,719,999,267	$2,419,909,782	$290,956,731	$734,195,329	$274,937,424

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

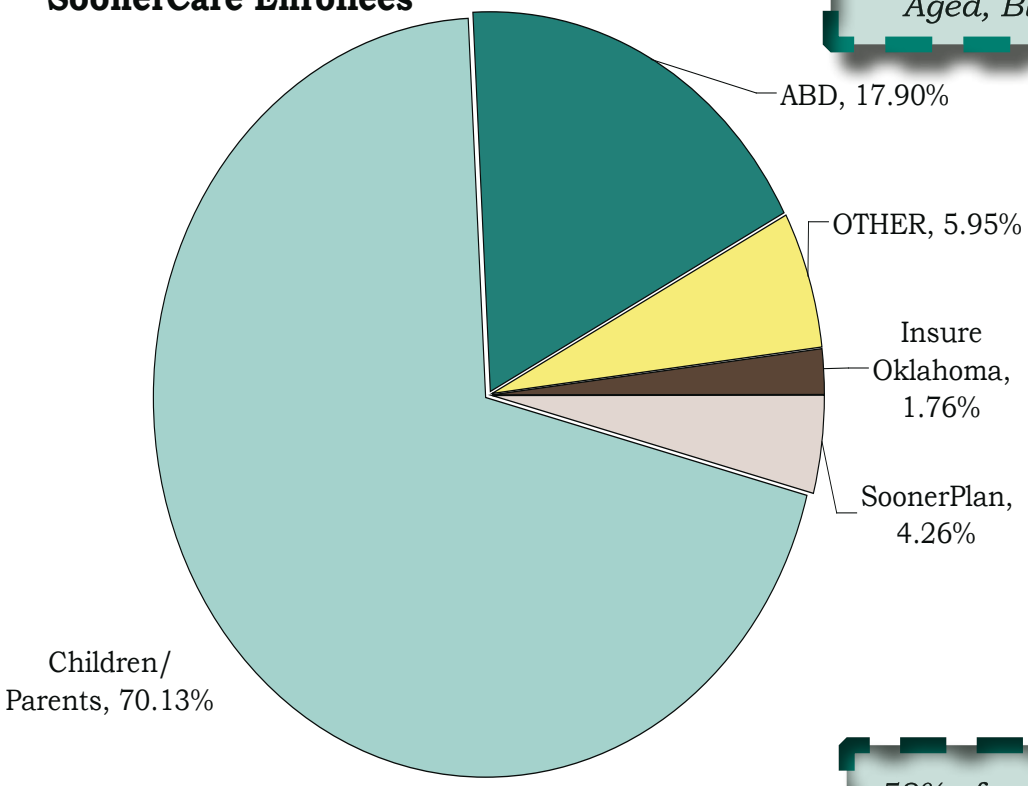
More than five of every 10 SoonerCare dollars were paid for services rendered to the Aged, Blind and Disabled (ABD) population. This group includes dual eligibles, people with chronic medical conditions or residents of long-term care facilities.

WHERE ARE THE SOONERCARE DOLLARS GOING?

FIGURE 9 SOONERCARE ENROLLEES AND EXPENDITURES BY AID CATEGORY PERCENTAGES

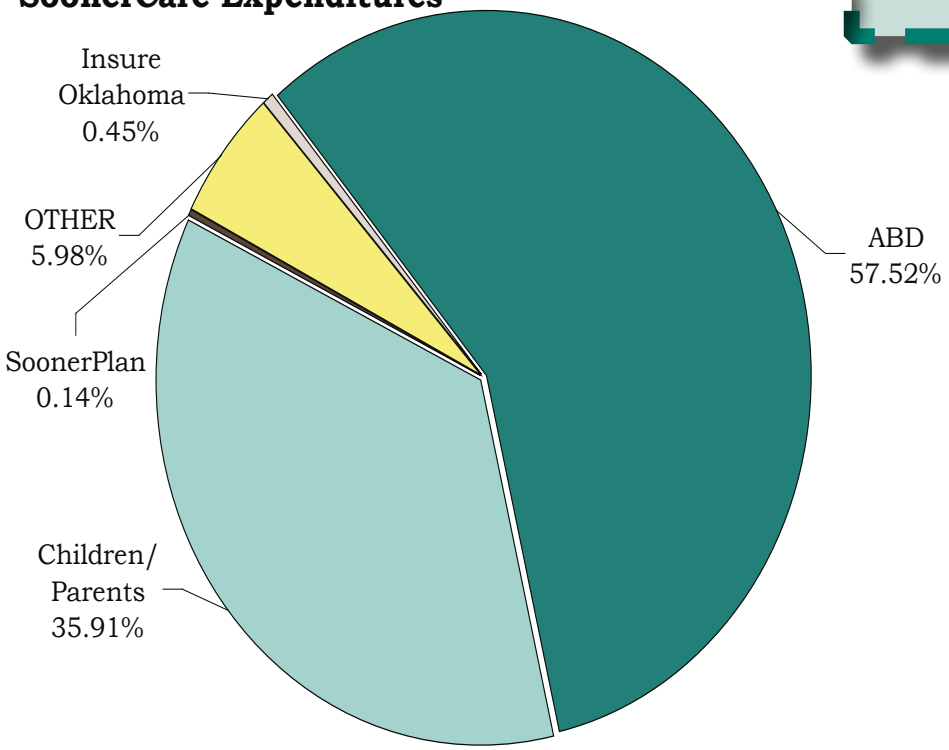
Only 18% of enrollees were Aged, Blind and Disabled.

SoonerCare Enrollees



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

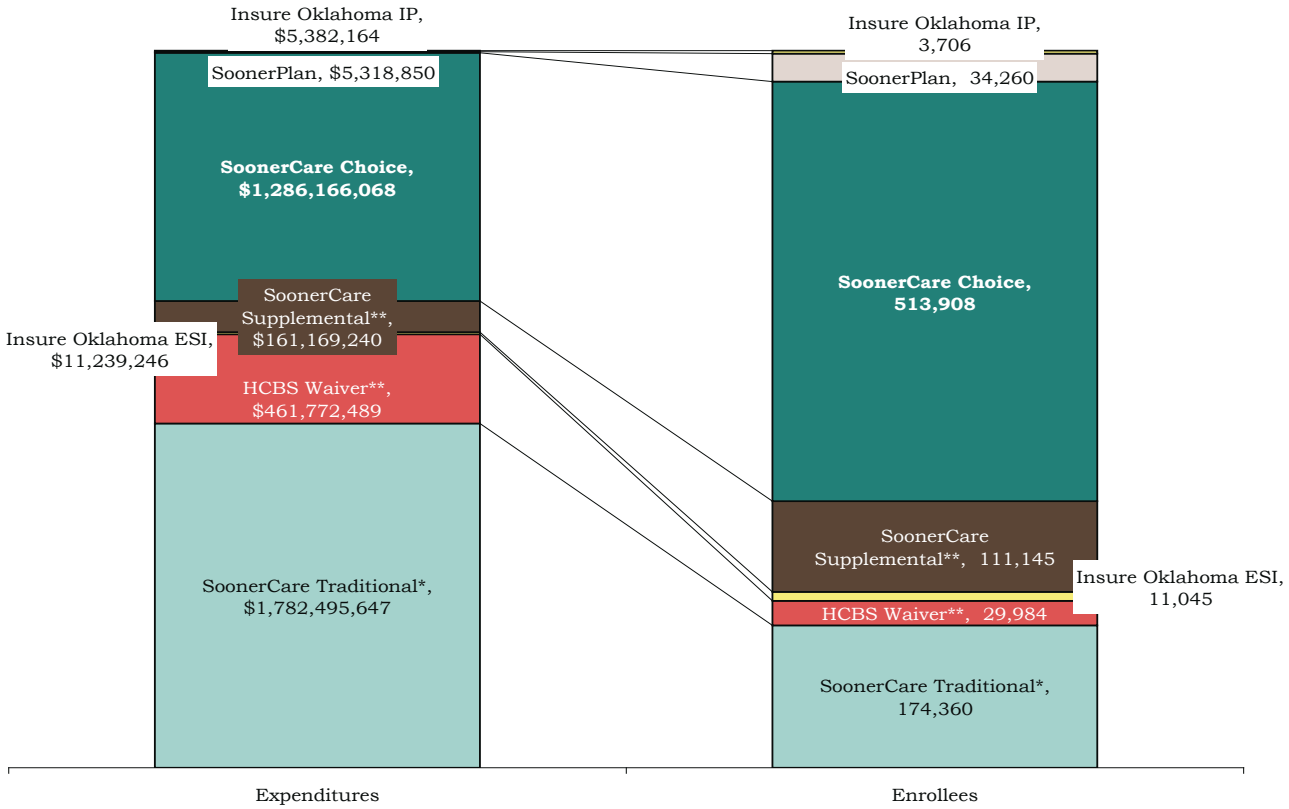
SoonerCare Expenditures



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.

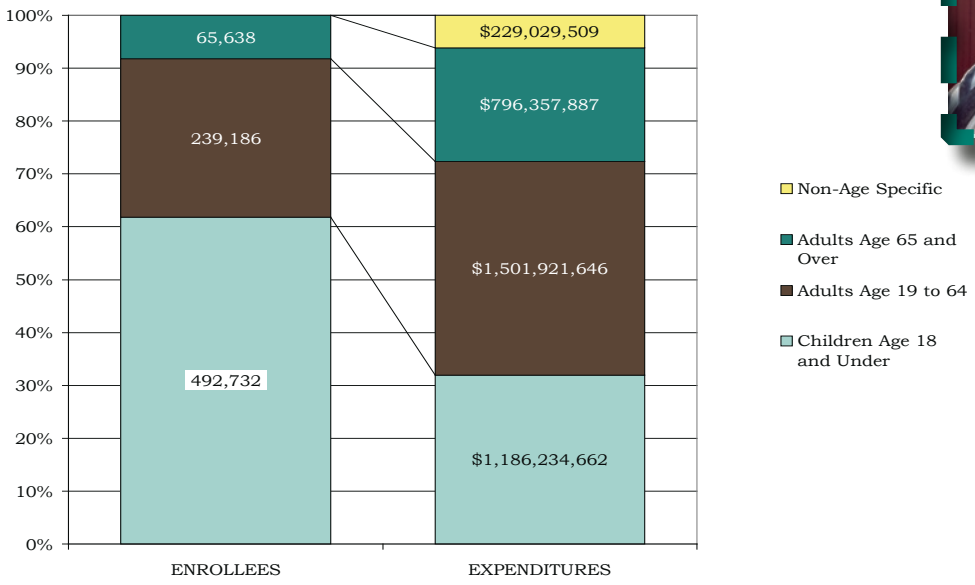
Where are the SoonerCare Dollars Going? (continued)

Figure 10 Oklahoma SoonerCare Enrollees and Expenditures by Benefit Plan—SFY2008



*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. HCBS Waiver expenditures are for all services to waiver members, including services not paid with waiver funds.

Figure 11 Oklahoma SoonerCare Enrollees and Expenditures by Age—SFY2008



*Non-age specific payments include $150,046,103 in Hospital Supplemental payments; $70,246,418 in GME payments to Medical schools; $6,945,335 in Public ICF/MR cost settlements; $1,641,506 in FQHC wrap-around payments; $116,435 in RHC cost settlement payments and $33,712 in non-member specific provider adjustments. $113,272,212 in Medicare Part A & B (Buy-In) payments and $57,701,257 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—SFY2008

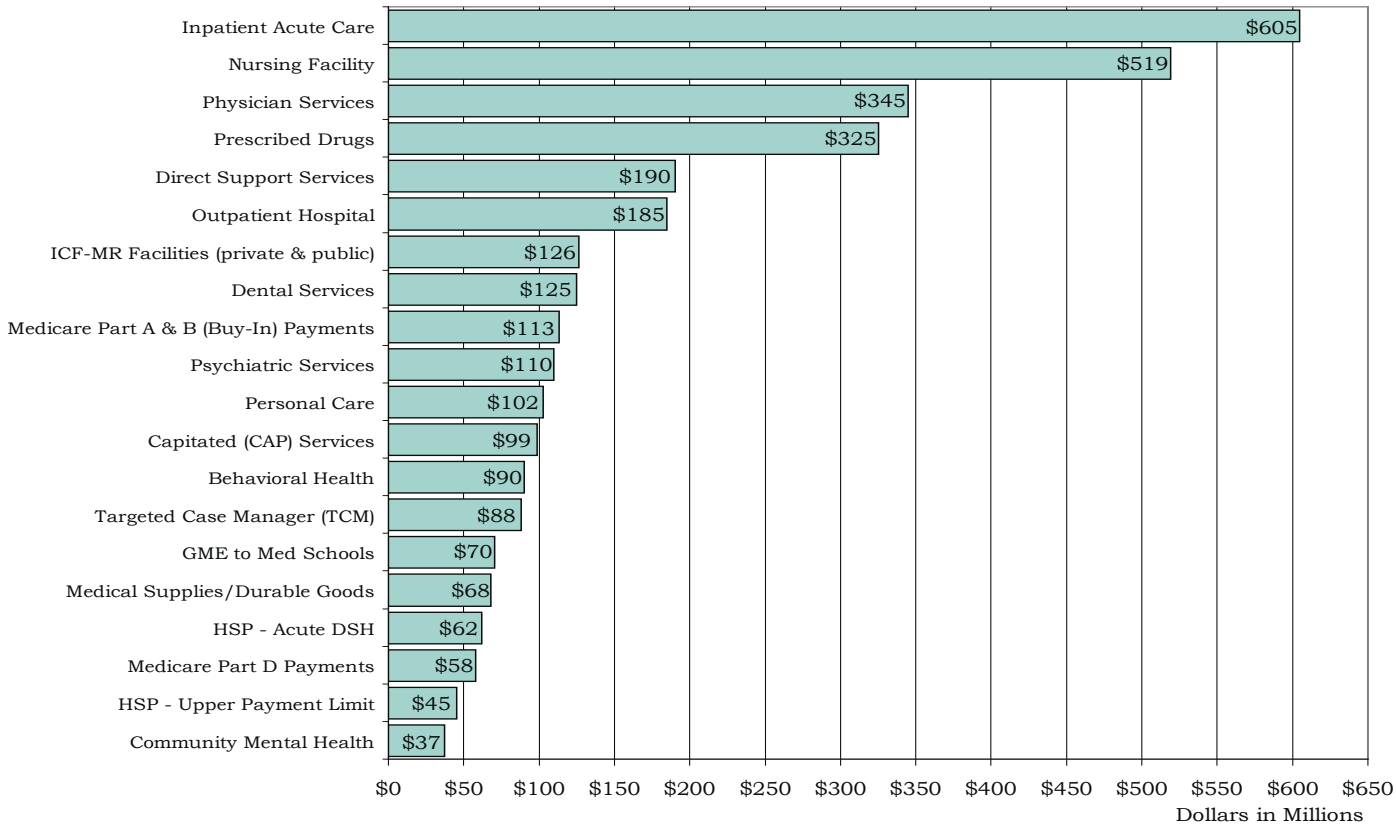


FIGURE 13 SOONERCARE CHOICE CAPITATION PAYMENTS—SFY2008

Aged, Blind and Disabled (ABD)	Member Months	Capitation Payments
ABD Adults	324,693	$9,282,296
ABD Children	151,338	$3,624,664
IHS ABD Adults	7,641	$22,923
IHS ABD Children	4,031	$12,093
Children/Parents (TANF)*	**Member Months**	**Capitation Payments**
TANF Adults	365,561	$9,612,764
TANF Children	3,825,011	$75,347,896
IHS TANF Adults	7,491	$14,982
IHS TANF Children	106,935	$224,832
Miscellaneous Capitation (not limited to SoonerCare Choice)	**Member Months**	**Capitation Payments**
Insure Oklahoma - IP	17,598	$52,794
Non-Emergency Transportation (ABD)	1,489,027	$21,293,086
Non-Emergency Transportation (TANF)	4,729,928	$3,689,344

*Temporary Assistance to Needy Families (TANF) is referred to as Children/Parents in this report. IHS indicates Indian Health Services members.

Oklahoma's Uninsured

According to the Census Bureau's 2008 Current Population Survey (CPS), more than 630,000 Oklahomans were uninsured in 2007. Approximately 116,000 of the uninsured Oklahomans were children under age 18.

Uninsured children are 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.

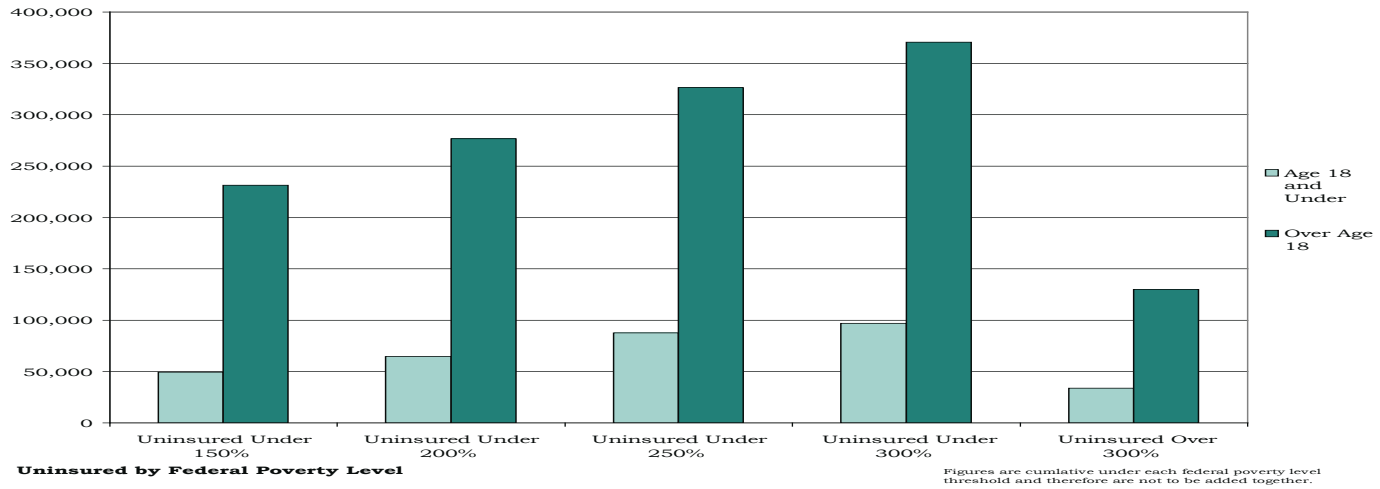
For adults, being uninsured even on a temporary basis can have serious implications for state economies. Uninsured workers are less likely to receive adequate and timely health care and, as a result, suffer more serious illnesses that often threaten their work productivity and job retention.

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 2007 Single Year Oklahoma Uninsured Estimates by Federal Poverty Level



Source: U.S. Census, Current Population Survey (CPS) 2007 Poverty universe data collected 2008.

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 15,000 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 200 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

Expansions approved by the Oklahoma legislature 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 federal poverty level (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 federal poverty level.

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 200 percent of federal poverty level (after income disregards);
- 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:

- must 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 include the basic for individuals above, plus:

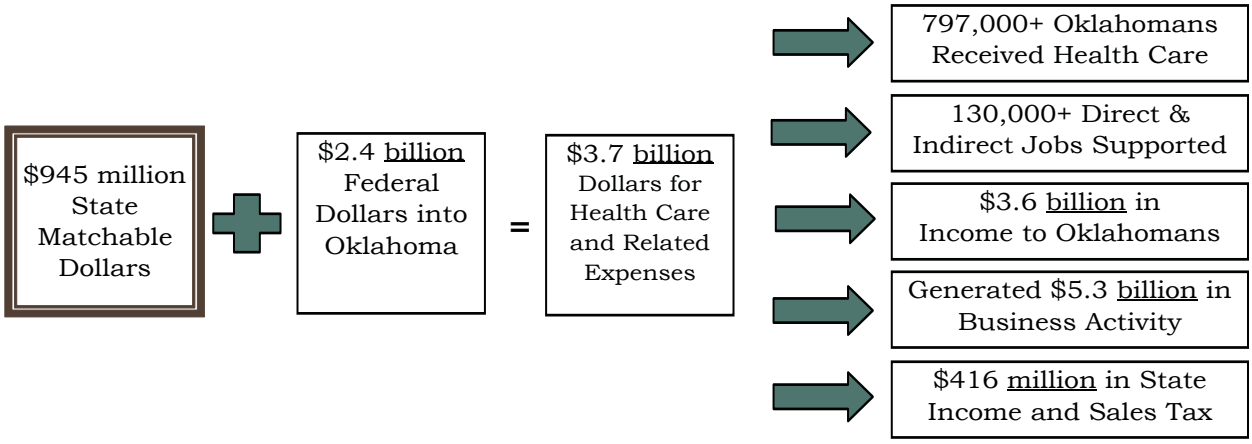
- not be eligible for ESI and work for an Oklahoma business with 50 or fewer employees; or
- temporarily unemployed and eligible to receive unemployment benefits; or
- working disabled who works for any size employer and has a ticket to work.

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 under served Oklahomans. The health care sector affects the economy in much the same way a manufacturing plant does by bringing in money, providing jobs and wages to residents and providing an opportunity to keep health care dollars circulating within the state economy. Health care businesses, in turn, have an additional impact through the purchases of utility services and cleaning supplies, as well as the payment of property taxes. Just like the changes in a manufacturing plant or farm operation, changes in the health care sector influence the rest of the Oklahoma economy.

Figure 15 Economic Impact of SoonerCare on the Oklahoma Economy



RELIEF

HOPE

HEALTH

WELLNESS

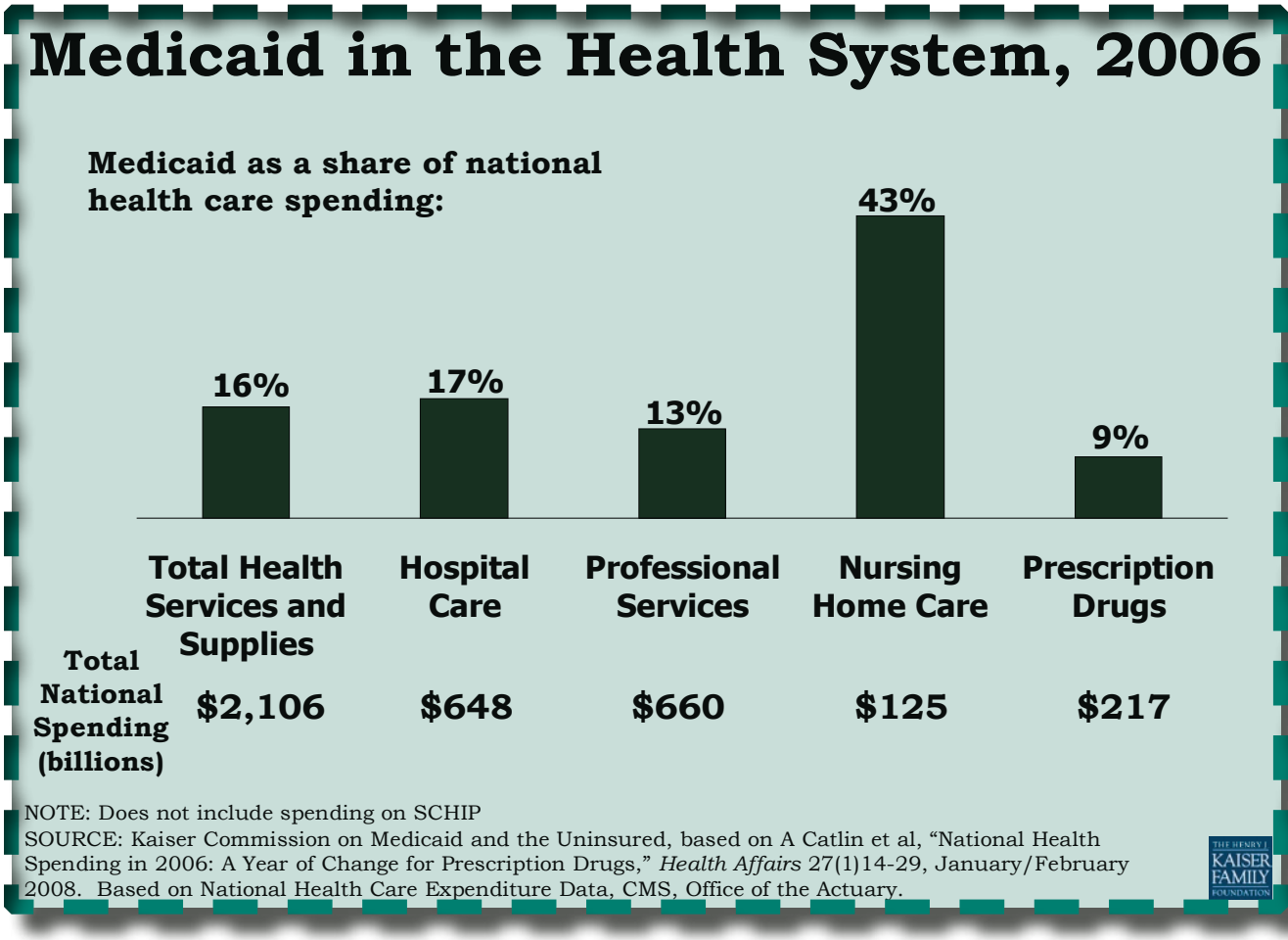
WHAT BENEFITS DOES SOONERCARE COVER?

OKLAHOMA SOONERCARE BENEFITS

SOONERCARE AND NATIVE AMERICANS

SOONERCARE AND OUR PROVIDERS

Medicaid in the Health System, 2006



NOTE: Does not include spending on SCHIP
SOURCE: Kaiser Commission on Medicaid and the Uninsured, based on A Catlin et al, "National Health Spending in 2006: A Year of Change for Prescription Drugs," *Health Affairs* 27(1)14-29, January/February 2008. Based on National Health Care Expenditure Data, CMS, Office of the Actuary.

THE HENRY J. KAISER FAMILY FOUNDATION

What Benefits Does SoonerCare Cover?

Title XIX of the Social Security Act requires certain basic services be offered to the categorically needy population in order to receive federal matching funds. 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. States may place appropriate limits on a Medicaid service based on such criteria as medical necessity or utilization control.

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.

The Insure Oklahoma Individual Plan has a separate set of covered services and applicable co-pays. To view the details, go to www.insureoklahoma.org.

$1 Co-Pay

Physicians (not PCP/CM)
Certified Registered Nurse Anesthetists
Home Health Agencies
Rural Health Clinics
Federally Qualified Health Centers
Optometrists

Prescription Co-Pay

$1 for each prescription under $30
$2 for each prescription $30 and over

$3 Co-Pay

*Inpatient Hospital**
Outpatient Hospital
Ambulatory Surgical Services

*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 and treatment planning,
  - individual, family and/or group psychotherapy,
  - rehabilitative and life skills redevelopment,
  - case management,
  - medication management, training and support,
  - program for assertive community treatment, and
  - behavioral health aide services.

Children under age 21 accounted for 63 percent of the members receiving behavioral health services and 77 percent of the expenditures.

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

All children require basic preventive and early intervention health care in order to optimize their capacity to grow, learn and develop. In SFY2008, 519,880 children in Oklahoma were enrolled in SoonerCare. This means that 49 percent of Oklahoma's children were enrolled in SoonerCare at some point during the year. Child health services offered under SoonerCare represent a comprehensive array of screening, diagnosis and treatment services designed to ensure the health care needs of this vulnerable population.

FY2008 saw a 2 percent increase in the screening rate (percentage of screens per the periodicity schedule) of child health checkups in Oklahoma. This was in part due to the implementation and outreach of the revised periodicity schedule.

Child health checkups should be performed at certain ages as set out in the State's periodicity schedule and should include, at a minimum:

- comprehensive health history;
- thorough examination;
- age-appropriate immunizations;
- laboratory tests;
- vision and hearing screens;
- dental screening services;
- lead toxicity screen (12 and 24 months of age);
- health education; and
- other necessary health care of conditions discovered as part of a checkup.

Oklahoma SoonerCare Benefits (continued)

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 caregivers 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 or EPSDT); this program covers dentistry for children based on medical necessity. Dental care includes emergency care, preventive services and therapeutic services for dental diseases that may cause damage to the supporting oral structures and loss of teeth.

Dental services have 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.

233,726 children received dental services and accounted for 91 percent of the dental expenditures in SFY2008.

SoonerCare contracted with 804 dental providers in SFY2008.

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 21 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 coinsurance and deductible fees for hospital services and skilled nursing services for Medicare and Medicaid (dual eligibles) qualified persons. The deductible and coinsurance 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:

SFY2008 "buy-in" expenditures totaled $113,272,212.

An average of 2,735 Part A premiums and 81,596 Part B premiums were paid each month during SFY2008.

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. While Medicare Part D pays for the majority of Medicare beneficiaries' prescriptions, the federal government requires states to pay back an estimated Medicaid prescription cost savings amount. This amount is referred to as "clawback." The OHCA paid $57,701,257 in Medicare Part D "clawback" payments in SFY2008.

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 66.9 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. 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 5,056,970 nursing facility bed days for SFY2008; this represents 69.5 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 Facilities *	21,606	5,056,970	$508,070,821	$23,515	$100
ICFs/MR (Private)	1,427	488,843	$57,252,811	$40,121	$117
ICFs/MR (Public)	387	132,488	$66,585,527	$172,056	$503
ICFs/MR (ALL)	1,814	621,331	$123,838,338	$68,268	$199

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 nursing facility (avg $22/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 71 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 has one of the highest generic utilization rates of any pharmacy benefit plan in the nation with an average of more than 71 percent of all prescriptions being dispensed as a generic drug.

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 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.

Opportunities for Living Life members residing in long-term care facilities receive prescriptions as shown for SoonerCare Choice, but do not have a limitation on the number of prescriptions covered each month.

Home and Community-Based Services enrollees receive a pharmacy benefit equal to that of SoonerCare Choice, plus members who are not Medicare eligible receive up to an additional seven generic prescriptions per month.

The federal Medicare prescription plan (Part D) now pays for a majority of Medicare beneficiaries' prescriptions. A few of the drugs not covered by Part D can be covered for members also enrolled under SoonerCare Traditional.

The federal government requires states to pay back an estimated prescription cost savings amount. This amount is referred to as a "clawback."

Insure Oklahoma - Individual Plan provides prescription coverage similar to SoonerCare Choice above with different co-payment requirements. Access www.insureoklahoma.org for additional information.

SoonerPlan provides prescription coverage for family planning products only.

The average cost per prescription funded by SoonerCare was $68 and the average monthly prescription cost per patient was $165 for SFY2008.

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 patient 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 checkups;
- 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 total of 10,259 members used the SoonerRide services for a total of more than 664,000 transports in SFY2008.

In January 2008, stretcher services were added as an allowable charge under SoonerRide.

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 federally recognized tribal governments and, according to the 2006 Census estimates, nearly 400,000 Native Americans live here. During SFY2008, more than 102,000 Native Americans were enrolled in SoonerCare. This represents approximately 13 percent of the average monthly enrollment.

Native American SoonerCare members select where they access services including culturally sensitive health care services from three types of health care systems specifically for Native Americans: Indian Health Services (IHS) facilities, Tribal health facilities, or urban Indian clinics (I/T/U). There are more than 50 contracted I/T/U facilities in Oklahoma. 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 need 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.

SoonerCare covers more than 75,000 Native American children under the age of 21.

During SFY2008, OHCA had more than 3,000 pregnant Native American women enrolled.

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

The OHCA and the Cherokee Nation of Oklahoma will implement the Program for All Inclusive Care for the Elderly (PACE) project in August 2008. This program, called Cherokee Elder Care, is the first tribally owned and first rural PACE program in the United States.

The goal for the PACE program is to manage care through an interdisciplinary approach with participation by the PACE team and the both the member and family or other care givers. As a home and community based program, members live in the community, but attend the PACE center 1 or 2 times per week for primary care services, to meet with their case manager and to engage in social activities with other PACE members.

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.

SoonerCare has contracts with more than 10,000 physicians.

During SFY2008, 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 play an essential role in Oklahoma's health care system, caring for approximately 30,000 elderly and disabled people 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. 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 uses 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 (www.oknursinghomeratings.com) is available for providers and consumers to enter and view performance data and outcomes. Participating providers began receiving a participation bonus July 2007.

HOSPITALS

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 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 SFY2008 HOSPITAL PAYMENTS

Types of Hospital Payments	SFY2007	SFY2008
Inpatient - Acute and Critical Access	480,199,507	527,150,404
Inpatient Rehabilitation - Freestanding	9,732,959	11,782,653
Inpatient - Indian Health Services	16,000,490	14,944,659
Inpatient - LTAC Children's	14,149,511	14,265,643
Inpatient Behavioral Health - Freestanding	10,854,229	10,448,872
Psychiatric Residential Treatment Facilities*	77,020,480	99,142,247
Outpatient Services^	168,073,827	161,265,658
Medicare Crossovers	53,575,156	60,081,501
Upper Payment Limit - Supplemental Payments	29,690,425	45,131,919
Indirect Medical Education (IME)	25,955,100	26,811,620
Graduate Medical Education (GME)	16,243,372	16,243,331
Disproportionate Share Hospitals**	31,175,423	61,859,233
Total	**932,670,479**	**1,049,127,740**

*Effective October 2006 PRTF expenditures include all ancillary services. ^Reclassified approximately $13 million in IHS outpatient clinic services from outpatient hospital to clinic services. **DSH payments scheduled for 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.

The Oklahoma DSH formula and methodology adopted in SFY2007 established 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 more than $50 million in federal fiscal year 2008 DSH funds to 56 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.

SFY2008 IME Payments:

OU/OKC-Oklahoma Medical Center – $13,405,810
OU/Tulsa-Hillcrest Health Systems – $6,702,905
OSU/Tulsa-Hillcrest Health Systems – $6,702,905

SoonerCare and Our Providers (continued)

Hospitals (continued)

Direct Medical Education (DME)

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

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

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

These payments are made by allocating a pool of funds made available from state matching funds transferred to the OHCA from the University Hospital Authority. The amounts for each hospital are determined by their relative number of residents and interns weighted by Medicaid days and acuity of service.

DME Qualified Hospitals	SFY2008
Baptist Medical Center	$1,347,334
Baptist Medical Center/Southwest	$152,419
Bone and Joint Hospital	$87
Comanche Co. Memorial Hospital	$28,224
Deaconess Hospital	$27,368
Hillcrest Medical Center	$1,593,165
Jackson County Memorial	$386
Jane Phillips Hospital	$7,659
Laureate Psych Hospital	$4,298
Medical Center of Southeastern OK	$45,865
Midwest City Regional	$11,298
Saint Francis	$744,673
St. Anthony	$1,268,188
St. John	$579,672
Tulsa Regional Medical Center	$1,494,279
University Health Partners	$8,938,416
TOTAL	**$16,243,331**

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.

SFY2008 GME Payments:

University of Oklahoma OKC and Tulsa $51,134,177

Oklahoma State University College of Osteopathic Medicine - Tulsa $19,112,241

Payments are made to the major colleges of medicine on a predetermined and contracted amount with contracted levels of residents and interns as well as levels of specialty services to SoonerCare members that are required. The state funds are transferred to the OHCA from the University Hospital Authority.

SoonerCare and Our Providers (continued)

Pharmacies

Providers for SoonerCare wrote almost 5 million prescriptions during the fiscal year. Members who use the pharmacy benefit get an average of just over two 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 early in SFY2009.

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 2007 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 899 providers evaluated, 316 received a bonus for a total payout of $878,986. For more EPSDT information, got to page 37 of this report.

SOLUTIONS

OHCA AND SOONERCARE

OPERATING PRINCIPLES

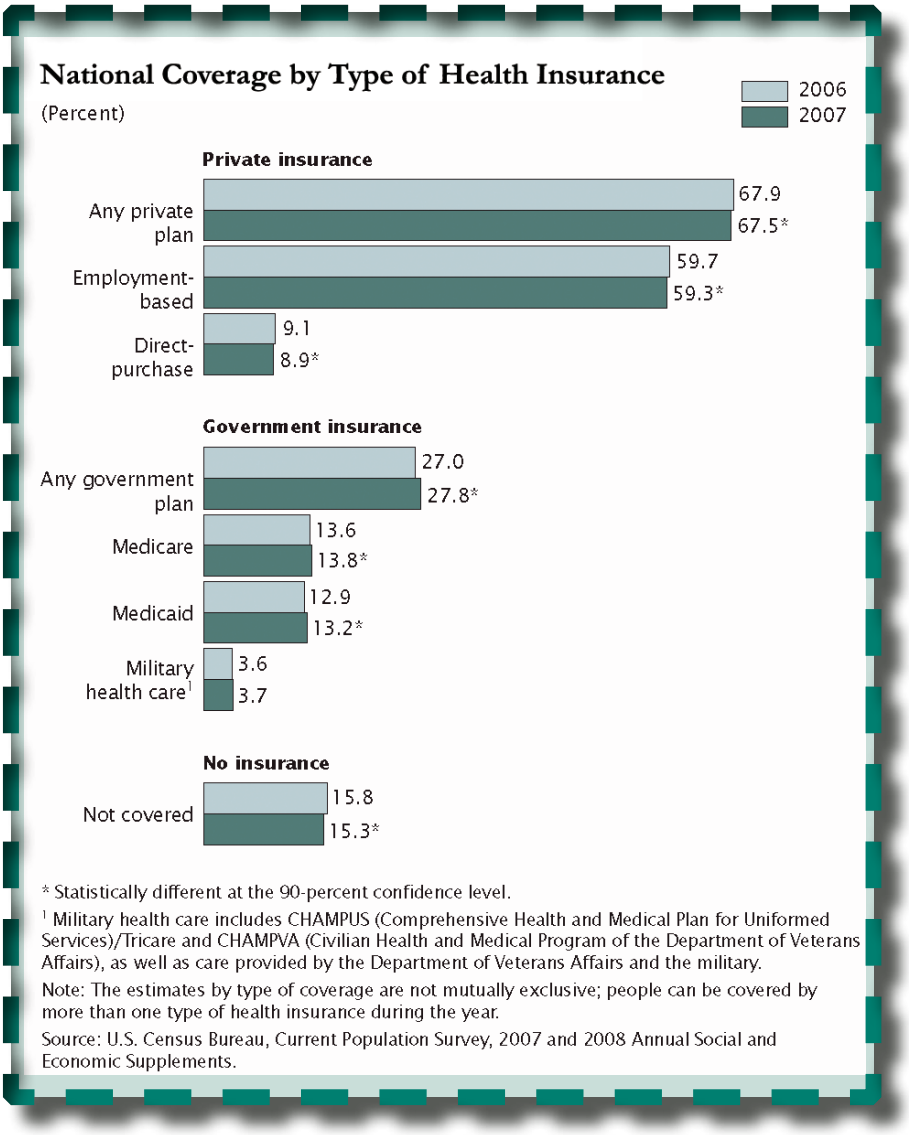
ADMINISTERING THE SOONERCARE PROGRAM

PAYMENT AND PROGRAM INTEGRITY

ORGANIZATIONAL CHART

SERVICE

QUALITY



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 13th year managing the now $3.7 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 $3.7 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), a Medical Advisory Task Force (MAT) 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.

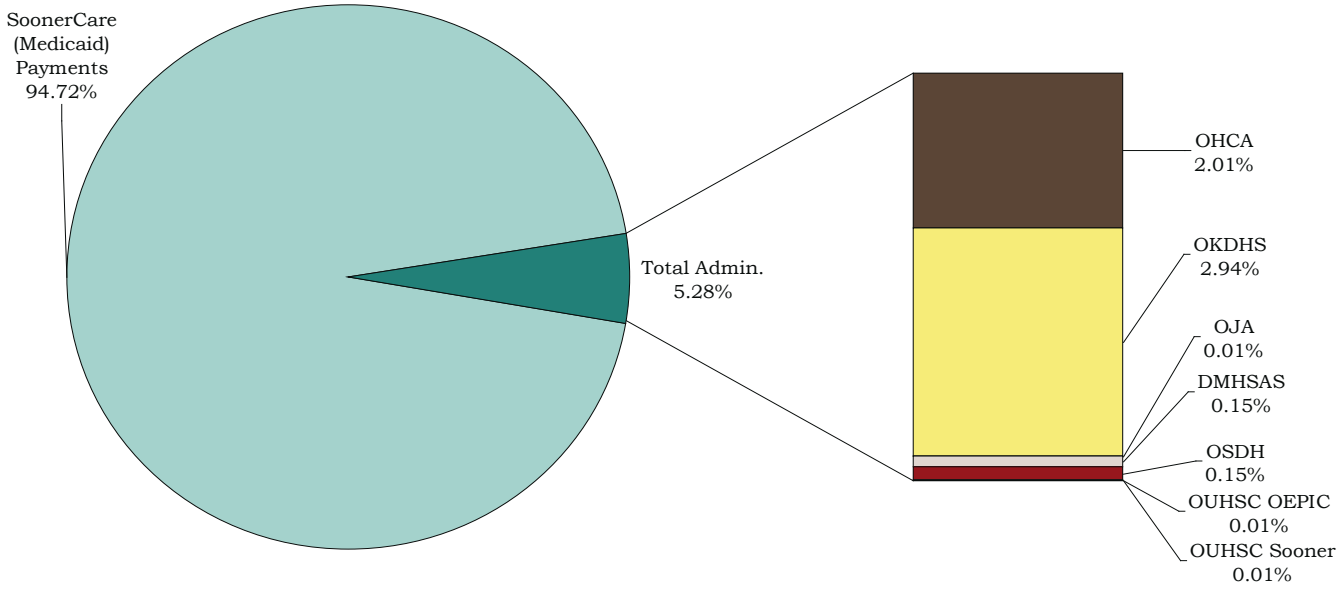
From an administrative perspective, SoonerCare can be viewed as a complex health insurance program: It purchases a broad range of acute and long-term care services on behalf of enrolled low-income individuals. Like private insurers, OHCA has to accomplish nine critical tasks. It must:

- 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)

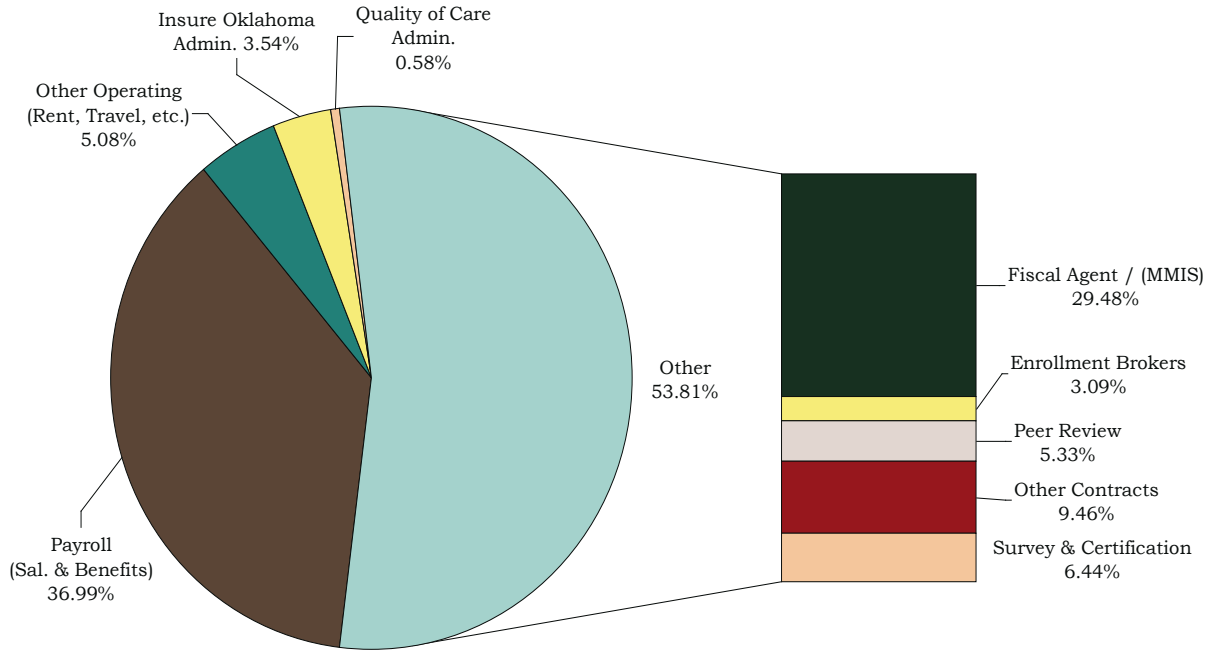
The administration of the SoonerCare program is divided among six different state agencies: the Oklahoma Health Care Authority (OHCA), the Oklahoma Department of Human Services (OKDHS), the Oklahoma State Department of Health (OSDH), the Office of Juvenile Affairs (OJA), the Department of Mental Health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

FIGURE 17 OHCA SOONERCARE EXPENDITURE PERCENTAGES—SFY2008



Finally, OHCA's administrative expenses are divided between direct operating expenses and vendor contracts. Of the $77 million spent by OHCA in SFY2008 on administration, 46 percent went to direct operation expenses, while 54 percent went toward vendor contracts.

FIGURE 18 OHCA ADMINISTRATIVE EXPENSES—SFY2008



Strategic Planning

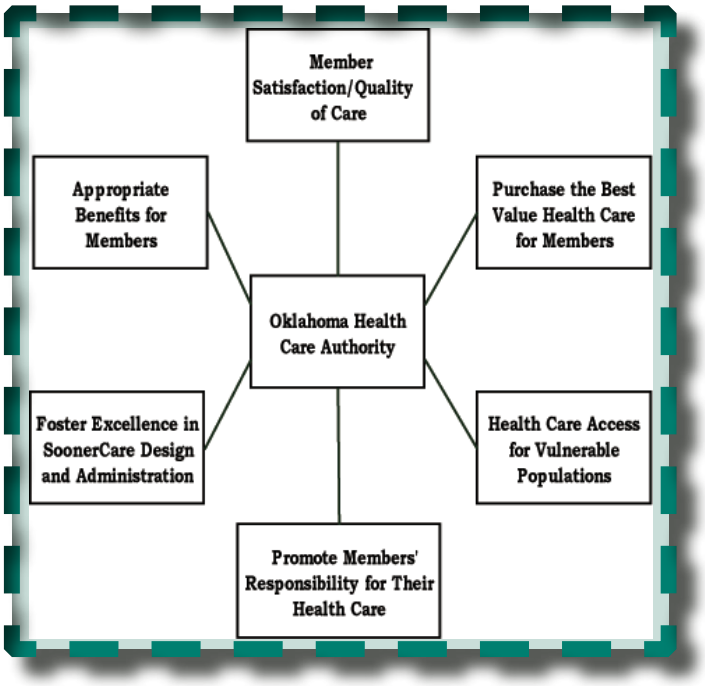
It is difficult to overestimate the importance and impact of SoonerCare it serves so many people in so many different population groups, and it plays a role to finance virtually every state program that relates to health. By any measure, SoonerCare makes a positive difference, even a critical difference, 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 under served 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.

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

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

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

- clarification and streamlining of SoonerCare policies, rules and billing procedures;
- increased payment integrity, recovery of inappropriately billed payments and avoidance of future losses;
- education of providers regarding proper billing practices;
- termination of providers from participation in the 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 performs 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 age 21. 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 SFY2008. Additional information on APS Healthcare may be found at www.apshealthcare.com.

Figure 19 Post-Payment Review Recoveries—SFY2008

Provider Type	SFY2008
Adult Day Care	$18,447
Behavioral Health	$703,738
Case Management	$22,877
Dental Services	$56,931
Durable Medical Equipment	$1,090,867
Hospital	$1,741,831
Nursing Facilities	$668,754
Personal Care/Habilitation Training Specialist	$151,305
Outpatient	$64,522
Physician & Other Practitioners	$1,323,627
Pharmacy	$145,912
Podiatrists	$156,436
School Corporation	$107,751
Vision	$137,416
Various Other Provider Types	$4,340
Total - OHCA Recoveries	**$6,394,754**
MFCU - Other	$592,454
MFCU - National Settlements	$7,216,495
Total SoonerCare Recoveries	**$14,203,703**

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 $1,996,985
- Other $11,071,287

COST AVOIDANCE

Cost avoidance is the method of either finding alternate responsible payers, such as other insurance coverage, or 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 $761,762,031
- Private Insurance $1,964,845,033

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.

- Product-Based Prior Authorization Cost Avoidance — SFY2008 $16,509,930

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.

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 71 percent of all prescriptions being dispensed as generic drugs. When the SMAC program was started in 2000, 400 products were 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 SFY2008.

Rebates and Fees

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.

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.

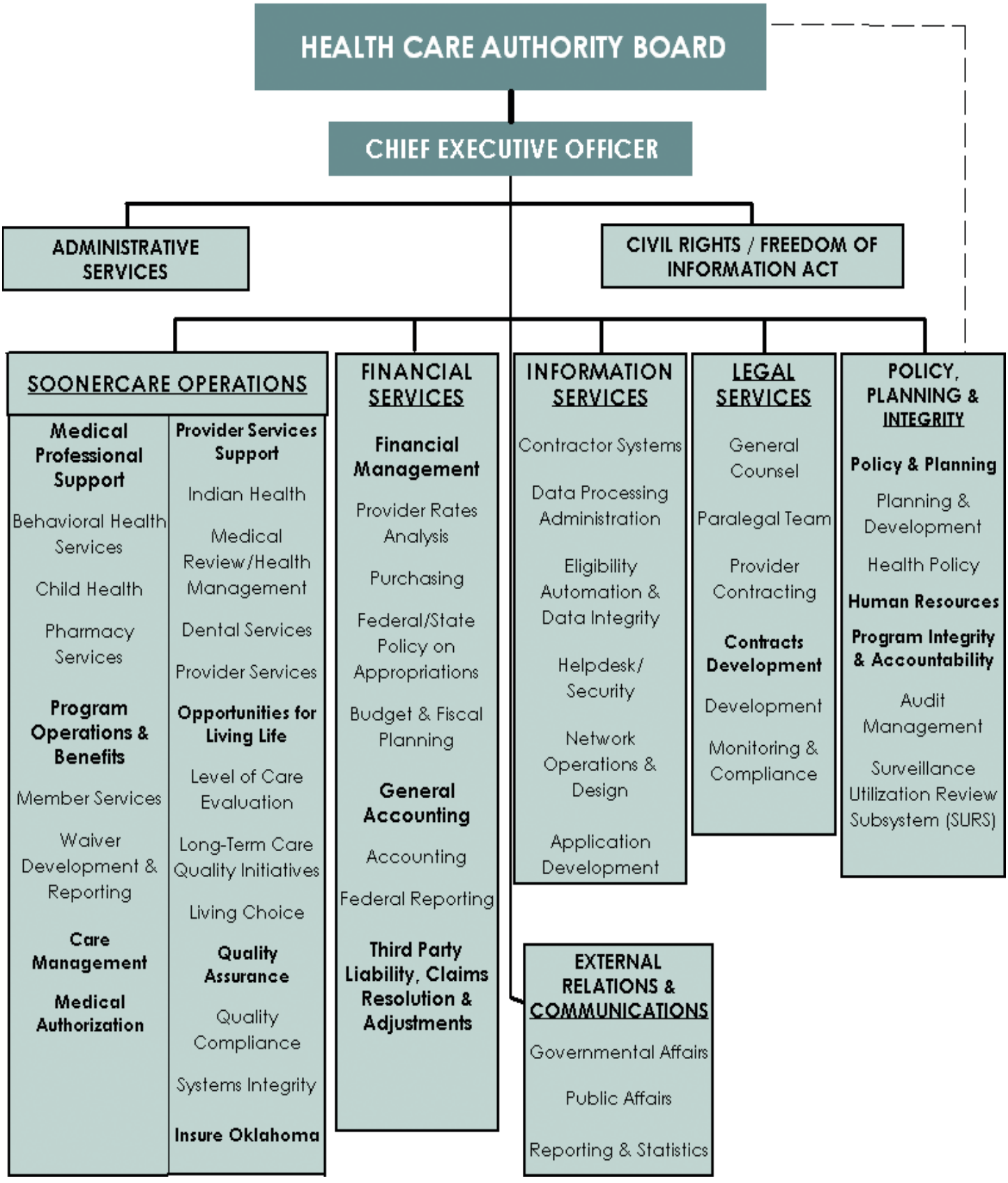
Rebates — Federal	$102,769,363
Rebates — State Supplemental	$5,518,369
Interest	$94,877

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.

Total Quality of Care Program revenues were $52,291,768.

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/About Us under Core Functions and Organizational Chart.

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 - Temporary Assistance for Needy Families, formerly known as Aid to Families with Dependent Children. Categorized in this report as Children and Parents.

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 SFY2008 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	$189,373,286	$0	$189,373,286	$0	$0	$0	$0
Ambulatory Clinics	$44,968,629	$36,359,492	$7,963,227	$0	$0	$93,946	$551,964
Behavioral Health - Case Management	$32,168,889	$534,805	$31,631,030	$0	$0	$0	$3,054
Behavioral Health - Clinic	$88,024,269	$87,997,820	$0	$0	$0	$26,449	$0
Behavioral Health - Inpatient	$125,119,539	$117,982,590	$7,128,810	$0	$0	$0	$8,139
Behavioral Health - Outpatient	$8,221,547	$8,082,296	$0	$0	$0	$0	$139,251
CMS Payments	$170,973,509	$165,871,880	$0	$5,101,629	$0	$0	$0
Dentists	$125,942,668	$118,877,704		$0	$6,836,606	$470	$227,888
Family Planning/ SoonerPlan	$5,861,141	$0	$5,861,141	$0	$0	$0	$0
GME/IME/DME	$113,801,369	$0	$113,801,369	$0	$0	$0	$0
Home and Community Based Waiver	$147,549,660	$0	$147,549,660	$0	$0	$0	$0
Home Health Care	$17,036,550	$16,977,668	$0	$0	$0	$0	$58,882
Homeward Bound Waiver	$94,150,493	$0	$94,150,493	$0	$0	$0	$0
ICF/MR Private	$54,350,691	$34,989,010	$0	$18,474,785	$886,896	$0	$0
ICF/MR Public	$72,428,083	$0	$72,428,083	$0	$0	$0	$0
In-Home Support Waiver	$24,910,352	$0	$24,910,352	$0	$0	$0	$0
Inpatient Acute Care	$654,206,026	$601,998,312	$1,117,881	$486,687	$42,979,488	$1,821,903	$5,801,755
Lab & Radiology	$16,837,092	$16,047,916	$0	$0	$0	$146,121	$643,055
Medical Supplies	$50,450,391	$47,353,973	$0	$2,897,480	$0	$45,766	$153,172
Miscellaneous Medical Payments	$24,985,971	$24,867,916	$0	$0	$0	$0	$118,055
Nursing Facilities	$518,622,543	$333,725,456	$0	$142,747,877	$42,131,628	$0	$17,582
Other Practitioners	$39,110,392	$38,562,067	$0	$446,364	$0	$32,072	$69,889
Outpatient Acute Care	$182,351,901	$177,631,511	$0	$41,604	$0	$553,604	$4,125,182
Personal Care Services	$10,477,440	$0	$10,477,440	$0	$0	$0	$0
Physicians	$321,882,892	$234,675,285	$23,874,966	$58,101	$49,886,040	$1,190,350	$12,198,150
Premium Assistance*	$11,282,427	$0	$0	$0	$0	$11,282,427	$0
Prescription Drugs	$328,235,221	$286,818,834	$0		$36,713,568	$1,421,420	$3,281,399
Residential Behavioral Management	$28,865,671	$0	$28,865,671	$0	$0	$0	$0
SoonerCare Choice	$122,580,430	$87,327,605	$34,991,006	$0	$0	$52,949	$208,870
Targeted Case Management	$48,208,380	$0	$48,208,380	$0	$0	$0	$0
Therapeutic Foster Care	$0	$0	$0	$0	$0	$0	$0
Transportation	$25,038,123	$22,403,689	$0	$2,589,399	$28,071	$0	$16,964
Total SoonerCare Expenditures	**$3,698,015,575**	**$2,459,085,829**	**$842,332,795**	**$172,843,926**	**$179,462,297**	**$16,667,477**	**$27,623,251**

Source: OHCA Financial Service Division, September 2008. * HEEIA includes $11,282,427 paid out of Fund 245. Financial statement data represents actual cash expenditures as reported to the Office of State Finance while MMIS data warehouse expenditure data is net of overpayments and adjustments. The Medicaid Program Fund, the HEEIA Fund and the BCC (Oklahoma Cares) Revolving Fund are all funded by tobacco tax collections.

Appendix B Statewide SFY2008 Figures (continued)

Figure II Statewide SoonerCare Figures by county

County	Population Proj. July 2007*	Rank	Unduplicated SoonerCare Enrollees**	Rank	Population Enrolled in SoonerCare	Rank
ADAIR	21,902	38	8,698	29	40%	1
ALFALFA	5,593	69	616	74	11%	77
ATOKA	14,512	47	3,829	48	26%	26
BEAVER	5,380	70	712	70	13%	72
BECKHAM	19,700	41	5,190	40	26%	27
BLAINE	12,475	51	2,617	54	21%	51
BRYAN	39,563	25	11,222	19	28%	19
CADDO	29,296	33	7,922	31	27%	20
CANADIAN	103,559	5	13,471	9	13%	74
CARTER	47,582	16	12,657	13	27%	23
CHEROKEE	45,393	19	11,884	17	26%	31
CHOCTAW	15,011	45	5,628	38	37%	2
CIMARRON	2,664	77	533	75	20%	56
CLEVELAND	236,452	3	35,697	3	15%	68
COAL	5,709	68	1,849	64	32%	9
COMANCHE	113,811	4	22,962	4	20%	54
COTTON	6,299	65	1,376	67	22%	48
CRAIG	15,195	44	4,670	41	31%	14
CREEK	69,073	9	16,398	7	24%	40
CUSTER	26,111	35	6,143	37	24%	41
DELAWARE	40,406	23	10,676	20	26%	25
DEWEY	4,338	72	685	73	16%	67
ELLIS	3,911	73	478	76	12%	75
GARFIELD	57,657	12	13,336	12	23%	45
GARVIN	27,141	34	6,814	35	25%	37
GRADY	50,615	13	10,287	22	20%	52
GRANT	4,497	71	712	70	16%	66
GREER	5,810	67	1,526	65	26%	29
HARMON	2,837	76	898	69	32%	13
HARPER	3,254	75	687	72	21%	50
HASKELL	12,059	52	3,988	44	33%	6
HUGHES	13,680	49	3,525	50	26%	33
JACKSON	25,778	36	6,369	36	25%	39
JEFFERSON	6,273	66	2,084	63	33%	5
JOHNSTON	10,402	59	3,302	52	32%	12
KAY	45,638	17	12,186	15	27%	22
KINGFISHER	14,320	48	2,309	60	16%	63
KIOWA	9,456	60	2,488	58	26%	28
LATIMER	10,508	58	2,617	54	25%	38
LEFLORE	49,715	15	14,504	8	29%	17

Appendix B Statewide SFY2008 Figures (continued)

Figure II Statewide SoonerCare Figures by county (continued)

County	Expenditures	Rank	Annual Per Capita	Rank	Monthly Per Enrollee	Rank
ADAIR	$31,905,978	31	$1,457	9	$306	63
ALFALFA	$2,391,062	73	$428	73	$323	53
ATOKA	$14,382,924	50	$991	38	$313	58
BEAVER	$1,875,454	75	$349	77	$220	75
BECKHAM	$23,329,896	40	$1,184	23	$375	25
BLAINE	$10,191,131	56	$817	53	$325	50
BRYAN	$45,040,877	21	$1,138	26	$334	44
CADDO	$26,711,903	35	$912	45	$281	70
CANADIAN	$51,660,606	15	$499	72	$320	56
CARTER	$51,322,041	16	$1,079	34	$338	40
CHEROKEE	$52,978,434	14	$1,167	25	$371	26
CHOCTAW	$26,737,600	34	$1,781	3	$396	15
CIMARRON	$1,039,970	77	$390	75	$163	77
CLEVELAND	$140,423,328	3	$594	66	$328	47
COAL	$7,839,564	63	$1,373	16	$353	31
COMANCHE	$73,357,624	7	$645	64	$266	73
COTTON	$5,792,391	67	$920	44	$351	33
CRAIG ‡	$26,194,001	36	$1,724	4	$467	5
CREEK	$76,032,936	6	$1,101	31	$386	21
CUSTER	$25,276,913	39	$968	41	$343	37
DELAWARE	$39,267,104	25	$972	39	$307	62
DEWEY	$3,342,477	71	$771	57	$407	13
ELLIS	$2,264,688	74	$579	67	$395	16
GARFIELD ‡	$93,359,659	5	$1,619	5	$583	2
GARVIN ‡	$59,835,441	10	$2,205	1	$732	1
GRADY	$36,665,305	28	$724	61	$297	64
GRANT	$3,816,171	70	$849	49	$447	7
GREER	$7,514,369	64	$1,293	21	$410	12
HARMON	$4,538,002	69	$1,600	6	$421	10
HARPER	$2,431,531	72	$747	59	$295	66
HASKELL	$16,701,472	46	$1,385	13	$349	35
HUGHES	$19,407,240	43	$1,419	12	$459	6
JACKSON	$22,602,871	42	$877	46	$296	65
JEFFERSON	$8,272,549	61	$1,319	20	$331	46
JOHNSTON	$16,100,311	48	$1,548	7	$406	14
KAY	$42,966,576	23	$941	42	$294	67
KINGFISHER	$7,889,868	62	$551	71	$285	68
KIOWA	$10,699,740	55	$1,132	28	$358	29
LATIMER	$11,608,056	54	$1,105	30	$370	28
LEFLORE	$56,546,972	12	$1,137	27	$325	49

Appendix B Statewide SFY2008 Figures (continued)

Figure II Statewide SoonerCare Figures by county (continued)

County	Population Proj. July 2007*	Rank	Unduplicated SoonerCare Enrollees**	Rank	Population Enrolled in SoonerCare	Rank
LINCOLN	32,272	31	6,865	34	21%	49
LOGAN	36,435	28	7,305	32	20%	55
LOVE	9,112	61	2,347	59	26%	34
MCCLAIN	31,849	32	4,632	42	15%	71
MCCURTAIN	33,539	29	12,141	16	36%	3
MCINTOSH	19,709	40	5,311	39	27%	21
MAJOR	7,190	64	941	68	13%	73
MARSHALL	14,830	46	3,940	45	27%	24
MAYES	39,627	24	10,180	23	26%	35
MURRAY	12,695	50	3,228	53	25%	36
MUSKOGEE	71,116	8	20,499	5	29%	18
NOBLE	11,124	56	2,157	62	19%	59
NOWATA	10,723	57	2,520	57	24%	43
OKFUSKEE	11,248	55	3,704	49	33%	7
OKLAHOMA	701,807	1	155,820	1	22%	46
OKMULGEE	39,300	26	12,634	14	32%	10
OSAGE	45,523	18	7,233	33	16%	65
OTTAWA	32,474	30	9,880	25	30%	15
PAWNEE	16,447	43	3,867	46	24%	42
PAYNE	79,931	7	11,790	18	15%	69
PITTSBURG	44,711	20	10,495	21	23%	44
PONTOTOC	36,571	27	9,588	26	26%	30
POTTAWATOMIE	69,038	10	17,935	6	26%	32
PUSHMATAHA	11,666	54	3,514	51	30%	16
ROGER MILLS	3,308	74	366	77	11%	76
ROGERS	83,105	6	13,363	11	16%	64
SEMINOLE	24,179	37	8,340	30	34%	4
SEQUOYAH	41,024	22	13,453	10	33%	8
STEPHENS	43,322	21	9,516	27	22%	47
TEXAS	20,032	39	4,062	43	20%	53
TILLMAN	8,148	63	2,610	56	32%	11
TULSA	585,068	2	114,074	2	19%	58
WAGONER	67,239	11	9,882	24	15%	70
WASHINGTON	49,888	14	9,295	28	19%	61
WASHITA	11,667	53	2,209	61	19%	60
WOODS	8,319	62	1,524	66	18%	62
WOODWARD	19,505	42	3,844	47	20%	57
Out of State			3			
Other ◊	0		2,944			
TOTAL	**3,617,316**		**797,556**		**22.05%**	

*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 SFY2008 FIGURES (CONTINUED)

FIGURE II STATEWIDE SOONERCARE FIGURES BY COUNTY (CONTINUED)

County	Expenditures	Rank	Annual Per Capita	Rank	Monthly Per Enrollee	Rank
LINCOLN	$25,310,399	38	$784	56	$307	61
LOGAN	$30,311,141	32	$832	51	$346	36
LOVE	$7,430,538	65	$815	54	$264	74
MCCLAIN	$17,692,727	45	$556	70	$318	57
MCCURTAIN	$48,749,708	19	$1,454	11	$335	43
MCINTOSH	$26,177,100	37	$1,328	18	$411	11
MAJOR	$4,873,264	68	$678	62	$432	9
MARSHALL	$15,788,504	49	$1,065	35	$334	45
MAYES	$41,426,705	24	$1,045	37	$339	39
MURRAY	$13,750,538	52	$1,083	33	$355	30
MUSKOGEE	$96,739,847	4	$1,360	17	$393	17
NOBLE	$14,231,667	51	$1,279	22	$550	3
NOWATA	$9,911,613	57	$924	43	$328	48
OKFUSKEE ‡	$23,258,549	41	$2,068	2	$523	4
OKLAHOMA	$600,255,020	1	$855	48	$321	54
OKMULGEE	$58,176,991	11	$1,480	8	$384	22
OSAGE	$29,229,999	33	$642	65	$337	41
OTTAWA	$38,011,284	27	$1,171	24	$321	55
PAWNEE	$18,032,131	44	$1,096	32	$389	20
PAYNE	$45,837,434	20	$573	68	$324	51
PITTSBURG	$49,399,445	18	$1,105	29	$392	18
PONTOTOC	$50,456,708	17	$1,380	15	$439	8
POTTAWATOMIE	$66,834,530	8	$968	40	$311	60
PUSHMATAHA	$16,148,087	47	$1,384	14	$383	23
ROGER MILLS	$1,195,181	76	$361	76	$272	71
ROGERS	$61,114,044	9	$735	60	$381	24
SEMINOLE	$35,167,560	30	$1,454	10	$351	32
SEQUOYAH	$54,125,480	13	$1,319	19	$335	42
STEPHENS	$35,518,104	29	$820	52	$311	59
TEXAS	$8,397,806	60	$419	74	$172	76
TILLMAN	$8,519,449	59	$1,046	36	$272	72
TULSA	$467,366,512	2	$799	55	$341	38
WAGONER	$38,361,298	26	$571	69	$323	52
WASHINGTON	$43,457,756	22	$871	47	$390	19
WASHITA	$9,831,094	58	$843	50	$371	27
WOODS	$6,388,650	66	$768	58	$349	34
WOODWARD	$13,130,586	53	$673	63	$285	69
Out of State	$10,362,380					
OTHER ◊	$412,258,838				$11,669	
TOTAL	**$3,713,543,704**		**$1,027**		**$388**	

‡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 $113,272,212 in Medicare Part A & B (Buy-In) payments and $57,701,257 in Medicare Part D (claw-back) payments; $150,046,103 in Hospital Supplemental payments; $70,246,418 in GME payments to Medical schools; $6,945,335 in Public ICF/MR cost settlements; $1,641,506 in FQHC wrap-around payments; $116,435 in RHC cost settlement payments; $11,144,983 in O-EPIC premiums and $94,264 in O-EPIC out-of-pocket payments; $869,858 in EPSDT bonus payments; and $180,467 in non-member specific provider adjustments. Non-Emergency Transportation payments of $24,981,808 is also included in this category.

Appendix B Statewide SFY2008 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	$12,778,884	$31,905,978	40%
ALFALFA	$1,366,406	$2,391,062	57%
ATOKA	$6,686,274	$14,382,924	46%
BEAVER	$1,331,525	$1,875,454	71%
BECKHAM	$16,337,159	$23,329,896	70%
BLAINE	$4,448,770	$10,191,131	44%
BRYAN	$53,100,579	$45,040,877	118%
CADDO	$16,154,917	$26,711,903	60%
CANADIAN	$24,459,504	$51,660,606	47%
CARTER	$45,527,464	$51,322,041	89%
CHEROKEE	$51,567,077	$52,978,434	97%
CHOCTAW	$15,790,692	$26,737,600	59%
CIMARRON	$267,010	$1,039,970	26%
CLEVELAND	$109,032,427	$140,423,328	78%
COAL	$3,250,303	$7,839,564	41%
COMANCHE	$71,236,433	$73,357,624	97%
COTTON	$2,786,284	$5,792,391	48%
CRAIG	$20,250,363	$26,194,001	77%
CREEK	$48,622,431	$76,032,936	64%
CUSTER	$20,093,504	$25,276,913	79%
DELAWARE	$22,904,675	$39,267,104	58%
DEWEY	$1,835,448	$3,342,477	55%
ELLIS	$2,114,049	$2,264,688	93%
GARFIELD	$87,447,080	$93,359,659	94%
GARVIN	$45,199,107	$59,835,441	76%
GRADY	$21,850,408	$36,665,305	60%
GRANT	$1,897,737	$3,816,171	50%
GREER	$3,908,014	$7,514,369	52%
HARMON	$2,964,951	$4,538,002	65%
HARPER	$1,620,180	$2,431,531	67%
HASKELL	$17,773,902	$16,701,472	106%
HUGHES	$8,742,238	$19,407,240	45%
JACKSON	$17,274,331	$22,602,871	76%
JEFFERSON	$3,409,493	$8,272,549	41%
JOHNSTON	$9,707,434	$16,100,311	60%
KAY	$31,200,905	$42,966,576	73%
KINGFISHER	$8,454,833	$7,889,868	107%
KIOWA	$8,879,709	$10,699,740	83%
LATIMER	$6,332,774	$11,608,056	55%
LEFLORE	$38,614,454	$56,546,972	68%
LINCOLN	$11,677,255	$25,310,399	46%

APPENDIX B STATEWIDE SFY2008 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	$16,417,672	$30,311,141	54%
LOVE	$2,982,800	$7,430,538	40%
MCCLAIN	$9,251,769	$17,692,727	52%
MCCURTAIN	$26,260,393	$48,749,708	54%
MCINTOSH	$30,134,518	$26,177,100	115%
MAJOR	$2,491,878	$4,873,264	51%
MARSHALL	$8,785,600	$15,788,504	56%
MAYES	$21,331,979	$41,426,705	51%
MURRAY	$7,037,639	$13,750,538	51%
MUSKOGEE	$91,546,871	$96,739,847	95%
NOBLE	$8,037,409	$14,231,667	56%
NOWATA	$5,421,229	$9,911,613	55%
OKFUSKEE	$15,602,738	$23,258,549	67%
OKLAHOMA	$874,870,165	$600,255,020	146%
OKMULGEE	$31,640,476	$58,176,991	54%
OSAGE	$7,408,615	$29,229,999	25%
OTTAWA	$35,385,533	$38,011,284	93%
PAWNEE	$9,746,438	$18,032,131	54%
PAYNE	$34,860,820	$45,837,434	76%
PITTSBURG	$41,330,575	$49,399,445	84%
PONTOTOC	$52,515,548	$50,456,708	104%
POTTAWATOMIE	$43,359,400	$66,834,530	65%
PUSHMATAHA	$23,279,422	$16,148,087	144%
ROGER MILLS	$254,884	$1,195,181	21%
ROGERS	$35,280,633	$61,114,044	58%
SEMINOLE	$21,593,441	$35,167,560	61%
SEQUOYAH	$52,255,695	$54,125,480	97%
STEPHENS	$27,304,033	$35,518,104	77%
TEXAS	$6,860,937	$8,397,806	82%
TILLMAN	$6,269,577	$8,519,449	74%
TULSA	$652,818,857	$467,366,512	140%
WAGONER	$12,094,083	$38,361,298	32%
WASHINGTON	$30,020,596	$43,457,756	69%
WASHITA	$5,486,195	$9,831,094	56%
WOODS	$4,135,195	$6,388,650	65%
WOODWARD	$10,474,709	$13,130,586	80%
Out of State	$120,220,956	$10,362,380	
Other ◊	$449,877,441	$412,258,838	
Total	**$3,713,543,704**	**$3,713,543,704**	**69%**

◊ Non-county specific payments include $113,272,212 in Medicare Part A & B (Buy-In) payments and $57,701,257 in Medicare Part D (clawback) payments; $150,046,103 in Hospital Supplemental payments; $70,246,418 in GME payments to Medical schools; $6,945,335 in Public ICF/MR cost settlements; $1,641,506 in FQHC wrap-around payments; $116,435 in RHC cost settlement payments; $11,144,983 in O-EPIC premiums and $94,264 in O-EPIC out-of-pocket payments; $869,858 in EPSDT bonus payments. Member Other includes $180,467 in non-member specific adjustments and Provider Other includes $12,817,262 in non-provider specific provider adjustments. Non-Emergency Transportation payments of $24,981,808 is also included in this category so as not to skew county totals.

Appendix B Statewide SFY2008 Figures (continued)

Figure IV Expenditures by Type of Service Percent of Change SFY2007 vs. SFY2008

Type of Service	SFY2007			SFY2008			Percent Change		
	Expenditures	Members	Avg Per Member	Expenditures	Members	Avg Per Member	Expend-itures	Mem-bers	Aver-age
Adult Day Care	$3,035,678	631	$4,811	$3,548,968	711	$4,992	17%	13%	4%
Adv Comp Health*	$83,442,983	14,270	$5,847	$8,400,322	12,403	$677	-90%	-13%	-88%
Advanced Practice Nurse	$1,887,336	16,459	$115	$1,746,792	13,697	$128	-7%	-17%	11%
ADvantage Home Delivered Meals	$10,291,489	10,401	$989	$12,424,844	12,256	$1,014	21%	18%	2%
Ambulatory Surgery	$5,609,177	13,245	$423	$7,010,099	15,553	$451	25%	17%	6%
Architectural Modification	$662,316	284	$2,332	$701,428	315	$2,227	6%	11%	-5%
Audiology	$141,029	546	$258	$111,824	708	$158	-21%	30%	-39%
Behavioral Health	$68,431,530	45,728	$1,496	$89,876,123	54,158	$1,660	31%	18%	11%
Capitated (CAP)	$99,103,939	549,194	$180	$98,788,797	729,626	$135	0%	33%	-25%
Capitated (CAP) - GME	$57,711,032	-	$0	$70,246,418	-	$0	22%	0%	0%
Chiropractic	$11,845	225	$53	$13,149	206	$64	11%	-8%	21%
Clinic	$11,305,656	42,385	$267	$26,033,230	66,785	$390	130%	58%	46%
Clinics - OSA	$8,884,563	98,593	$90	$9,417,491	110,812	$85	6%	12%	-6%
Community Mental Health	$37,689,173	23,637	$1,594	$37,099,321	23,587	$1,573	-2%	0%	-1%
Dental	$110,802,168	210,450	$527	$124,810,349	257,521	$485	13%	22%	-8%
Direct Support	$181,361,549	4,443	$40,820	$190,342,216	6,222	$30,592	5%	40%	-25%
Employee Training Specialist	$24,707,562	2,656	$9,303	$25,848,073	2,747	$9,410	5%	3%	1%
End Stage Renal Disease (ESRD)	$11,107,324	1,764	$6,297	$12,826,834	1,961	$6,541	15%	11%	4%
Eye Care and Exam	$5,370,675	65,239	$82	$5,142,867	76,788	$67	-4%	18%	-19%
Eyewear	$5,927,041	52,232	$113	$6,432,005	60,268	$107	9%	15%	-6%
Free Standing Birthing Center	$23,891	34	$703	$0	-	$0	-100%	-100%	-100%
Group Home	$17,925,296	599	$29,925	$18,850,872	620	$30,405	5%	4%	2%
Home Health	$16,285,275	7,660	$2,126	$16,000,053	6,942	$2,305	-2%	-9%	8%
Homemaker	$672,439	261	$2,576	$577,608	238	$2,427	-14%	-9%	-6%
Hospice	$1,101,083	85	$12,954	$1,999,917	150	$13,333	82%	76%	3%
HSP - Indirect Medical Education (IME)	$25,955,100	-	$0	$26,811,620	-	$0	3%	0%	0%
HSP - Graduate Medical Education	$16,243,372	-	$0	$16,243,331	-	$0	0%	0%	0%
HSP - Acute DSH	$31,175,423	-	$0	$61,859,233	-	$0	98%	0%	0%
HSP - Upper Payment Limit	$29,690,425	-	$0	$45,131,919	-	$0	52%	0%	0%
ICF-MR	$125,769,370	1,811	$69,447	$126,158,493	1,831	$68,901	0%	1%	-1%
Inpatient	$559,561,584	122,941	$4,551	$617,967,323	134,521	$4,594	10%	9%	1%
Laboratory	$19,422,439	171,237	$113	$19,340,815	177,377	$109	0%	4%	-4%

APPENDIX B STATEWIDE SFY2008 FIGURES (CONTINUED)

FIGURE IV EXPENDITURES BY TYPE OF SERVICE PERCENT OF CHANGE SFY2007 VS. SFY2008 (CONTINUED)

Type of Service	SFY2007			SFY2008			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	$107,753,230	-	$0	$113,272,212	-	$0	5%	0%	0%
Medicare Part D Payments	$53,193,255	-	$0	$57,701,278	-	$0	8%	0%	0%
Mid Level Practitioner	$178,592	2,397	$75	$199,399	2,486	$80	12%	4%	8%
Medical Supplies/ Durable Goods	$61,129,925	72,805	$840	$67,877,969	79,190	$857	11%	9%	2%
Nursing Facility	$490,658,264	21,544	$22,775	$519,266,402	23,147	$22,433	6%	7%	-1%
Nursing	$34,375,772	7,188	$4,782	$11,778,939	21,108	$558	-66%	194%	-88%
Nutritionist	$430,589	677	$636	$701,072	787	$891	63%	16%	40%
ESI Out-of-Pocket	$49,990	-	$0	$94,264	-	$0	89%	0%	0%
ESI Premium	$3,614,205	-	$0	$11,144,983	-	$0	208%	0%	0%
Other Practitioners	$0	-	$0	$2,314,850	5,001	$463	0%	0%	0%
Outpatient Hospital^	$188,691,195	375,034	$503	$184,600,245	422,431	$437	-2%	13%	-13%
Personal Care	$11,628,586	3,647	$3,189	$102,499,597	22,701	$4,515	781%	522%	42%
Physician Services**	$318,840,208	509,749	$625	$345,082,620	678,388	$509	8%	33%	-19%
Podiatry	$875,048	5,018	$174	$689,697	4,634	$149	-21%	-8%	-15%
Prescribed Drugs	$297,300,325	441,740	$673	$325,322,956	551,329	$590	9%	25%	-12%
Prosthetic/Orthotic	$912,769	927	$985	$144,951	218	$665	-84%	-76%	-32%
Psychiatric	$81,353,380	4,284	$18,990	$96,514,068	5,833	$16,546	19%	36%	-13%
Residential Behavior Management Services	$31,124,823	2,913	$10,685	$28,865,570	2,981	$9,683	-7%	2%	-9%
Respite Care	$462,651	135	$3,427	$610,023	385	$1,584	32%	185%	-54%
Room and Board	$148,408	681	$218	$220,182	811	$271	48%	19%	25%
School Based	$5,069,042	11,508	$440	$6,050,977	10,114	$598	19%	-12%	36%
Specialized Foster Care/MR	$3,921,355	257	$15,258	$4,188,357	270	$15,512	7%	5%	2%
Targeted Case Manager	$53,935,884	37,553	$1,436	$88,130,207	52,893	$1,666	63%	41%	16%
Therapy	$2,148,389	1,337	$1,607	$2,354,563	1,708	$1,379	10%	28%	-14%
Transportation - Emergency	$30,730,923	62,871	$489	$32,598,899	76,408	$427	6%	22%	-13%
Transportation - Non-Emergency	$22,727,223	679,166	$33	$24,981,808	706,253	$35	10%	4%	6%
X-Ray	$3,109,288	27,840	$112	$2,895,259	26,606	$109	-7%	-4%	-3%
Unknown Services by Service Type	$1,412,250	12,344	$114	$1,680,023	4,889	$344	19%	-60%	200%
TOTAL	$3,377,085,329	745,474	$4,530	$3,713,543,704	771,105	$4,816	10%	3%	6%

*Adv Comp Health Services shifted to Personal Care Services. ^Decrease in outpatient hospital services due to a reclassification of I/T/U from the outpatient hospital services to clinic services. **The $30 million increase in physician services is due to a reclassification from individual contracts to group contracts.

Source: OHCA Financial Service Division, September 2008. 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 SFY2008 Figures (continued)

Figure VExpenditures by Type of Service Totals

SFY2008	Totals		
Type of Service	Expenditures	Members Served	Avg per Member Served
Adult Day Care Services	$3,548,968	711	$4,992
Adv Comp Health Services	$8,400,322	12,403	$677
Advanced Practice Nurse (APN) Services	$1,746,792	13,697	$128
ADvantage Home Delivered Meals Services	$12,424,844	12,256	$1,014
Ambulatory Surgical Services	$7,010,099	15,553	$451
Architectural Modification Services	$701,428	315	$2,227
Audiology Services	$111,824	708	$158
Behavioral Hlth Services	$89,876,123	54,158	$1,660
Capitated (CAP) Services	$98,788,797	729,626	$135
Capitated (CAP) Services - GME to Med Schools	$70,246,418	-	$0
Chiropractic Services	$13,149	206	$64
Clinic Services	$26,033,230	66,785	$390
Clinics - OSA Services	$9,417,491	110,812	$85
Community Mental Heath Services	$37,099,321	23,587	$1,573
Dental Services	$124,810,349	257,521	$485
Direct Support Services	$190,342,216	6,222	$30,592
Employee Training Specialist Services	$25,848,073	2,747	$9,410
End Stage Renal Disease (ESRD) Services	$12,826,834	1,961	$6,541
Eye Care and Exam Services	$5,142,867	76,788	$67
Eyewear Services	$6,432,005	60,268	$107
Free Standing Birthing Center Services	$0	-	$0
Group Home Services	$18,850,872	620	$30,405
Home Health (HH) Services	$16,000,053	6,942	$2,305
Homemaker Services	$577,608	238	$2,427
Hospice Services	$1,999,917	150	$13,333
Hospital (HSP) Indirect Medical Education (IME)	$26,811,620	-	$0
Hospital (HSP) Graduate Medical Education (GME)	$16,243,331	-	$0
Hospital (HSP) Acute DSH	$61,859,233	-	$0
Hospital (HSP) Upper Payment Limit	$45,131,919	-	$0
ICF-MR Services	$126,158,493	1,831	$68,901
Inpatient Services	$604,842,796	134,521	$4,496
Laboratory Services	$19,340,815	177,377	$109
Medicare Part A & B (Buy-In) Payments	$113,272,212	-	$0
Medicare Part D Payments	$57,701,278	-	$0
Mid Level Practitioner (MLP) Services	$199,399	2,486	$80
Medical Supplies/Durable Goods	$67,877,969	79,190	$857
Nursing Facility Services	$519,266,402	23,147	$22,433
Nursing Services	$11,778,939	21,108	$558
Nutritionist Services	$701,072	787	$891

APPENDIX B STATEWIDE SFY2008 FIGURES (CONTINUED)

FIGURE V EXPENDITURES BY TYPE OF SERVICE TOTALS (CONTINUED)

SFY2008	Totals		
Type of Service	Expenditures	Members Served	Avg per Member Served
Insure Oklahoma ESI Out-of-Pocket	$94,264	-	$0
Insure Oklahoma ESI Premium	$11,144,983	-	$0
Other Practitioner Services	$2,314,850	5,001	$463
Outpatient Hospital Services	$184,600,245	422,431	$437
Personal Care Services	$102,499,597	22,701	$4,515
Physician Services	$345,082,620	678,388	$509
Podiatry Services	$689,697	4,634	$149
Prescribed Drugs Services	$325,322,956	551,329	$590
Prosthetic/Orthotic Services	$144,951	218	$665
Psychiatric Services	$109,638,596	5,833	$18,796
Residential Behavior Management Services (RBMS)	$28,865,570	2,981	$9,683
Respite Care Services	$610,023	385	$1,584
Room and Board Services	$220,182	811	$271
School Based Services	$6,050,977	10,114	$598
Specialized Foster Care/MR Services	$4,188,357	270	$15,512
Targeted Case Manager (TCM) Services	$88,130,207	52,893	$1,666
Therapy Services	$2,354,563	1,708	$1,379
Transportation - Emergency	$32,598,899	76,408	$427
Transportation - Non-Emergency	$24,981,808	706,253	$35
X-Ray Services	$2,895,259	26,606	$109
Unknown Services by Claim Type	$1,680,023	4,889	$344
Total	**$3,713,543,704**	**771,105**	**$4,816**

Source: OHCA Financial Service Division, September 2008. 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 SFY2008 Figures (continued)

Figure VI Expenditures by Type of Service by Adult and Child

SFY2008 (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	$3,517,372	702	$5,011	$31,597	9	$3,511
Adv Comp Health Services	$8,400,322	12,403	$677	$0	-	$0
Advanced Practice Nurse (APN)	$850,761	5,317	$160	$896,031	8,380	$107
ADvantage Home Delivered Meals	$12,424,844	12,256	$1,014	$0	-	$0
Ambulatory Surgical Services	$2,662,693	7,609	$350	$4,347,406	7,944	$547
Architectural Modification	$605,532	283	$2,140	$95,896	32	$2,997
Audiology Services	$5,497	87	$63	$106,328	621	$171
Behavioral Health Services	$26,553,857	16,592	$1,600	$63,322,266	37,566	$1,686
Capitated (CAP) Services	$18,859,599	128,144	$147	$79,929,198	601,482	$133
Capitated (CAP) Services - GME to Med Schools	$0	-	$0	$70,246,418	-	$0
Chiropractic Services	$13,149	206	$64	$0	-	$0
Clinic Services	$8,713,613	26,146	$333	$17,319,616	40,639	$426
Clinics - OSA Services	$2,333,639	23,583	$99	$7,083,852	87,229	$81
Community Mental Health	$27,022,239	12,643	$2,137	$10,077,082	10,944	$921
Dental Services	$13,591,683	23,795	$571	$111,218,666	233,726	$476
Direct Support Services	$171,609,897	5,005	$34,288	$18,732,319	1,217	$15,392
Employee Training Specialist	$24,884,499	2,584	$9,630	$963,574	163	$5,911
End Stage Renal Disease (ESRD)	$12,779,777	1,945	$6,571	$47,057	16	$2,941
Eye Care and Exam Services	$648,284	9,369	$69	$4,494,583	67,419	$67
Eyewear Services	$0	-	$0	$6,432,005	59,994	$107
Free Standing Birthing Center	$0	-	$0	$0	-	$0
Group Home Services	$17,481,148	580	$30,140	$1,369,724	40	$34,243
Home Health (HH) Services	$3,770,809	3,861	$977	$12,229,245	3,081	$3,969
Homemaker Services	$372,636	124	$3,005	$204,973	114	$1,798
Hospice Services	$1,897,052	144	$13,174	$102,864	6	$17,144
HSP - Indirect Medical Education (IME)	$26,811,620	-	$0	$0	-	$0
HSP - Graduate Medical Education (GME)	$8,121,666	-	$0	$8,121,666	-	$0
HSP - Acute DSH	$0	-	$0	$61,859,233	-	$0
HSP - Upper Payment Limit	$0	-	$0	$45,131,919	-	$0
ICF-MR Services	$122,116,933	1,754	$69,622	$4,041,560	77	$52,488
Inpatient Services	$337,823,891	74,551	$4,531	$267,018,905	59,970	$4,453
Laboratory Services	$9,817,833	68,570	$143	$9,522,982	108,807	$88
Medicare Part A & B (Buy-In) Payments	$113,272,212	-	$0	$0	-	$0
Medicare Part D Payments	$57,701,278	-	$0	$0	-	$0
Mid Level Practitioner (MLP) Services	$73,713	713	$103	$125,686	1,773	$71
Medical Supplies/Durable Goods	$46,898,941	53,270	$880	$20,979,027	25,920	$809
Nursing Facility Services	$518,246,966	23,100	$22,435	$1,019,436	47	$21,690
Nursing Services	$11,767,802	21,105	$558	$11,137	3	$3,712

APPENDIX B STATEWIDE SFY2008 FIGURES (CONTINUED)

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

SFY2008 (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	$694,798	760	$914	$6,274	27	$232
Insure Oklahoma ESI Out-of-Pocket	$94,264	-	$0	$0	-	$0
Insure Oklahoma ESI Premium	$11,144,983	-	$0	$0	-	$0
Other Practitioner Services	$400,807	945	$424	$1,914,043	4,056	$472
Outpatient Hospital Services	$85,248,281	156,755	$544	$99,351,965	265,676	$374
Personal Care Services	$101,848,690	22,593	$4,508	$650,907	108	$6,027
Physician Services	$182,914,728	275,143	$665	$162,167,892	403,245	$402
Podiatry Services	$443,338	3,852	$115	$246,359	782	$315
Prescribed Drugs Services	$153,997,232	136,195	$1,131	$171,325,724	415,134	$413
Prosthetic/Orthotic Services	$69,440	132	$526	$75,512	86	$878
Psychiatric Services	$352,397	400	$881	$109,286,199	5,433	$20,115
Residential Behavior Management Services (RBMS)	$0	-	$0	$28,865,570	2,981	$9,683
Respite Care Services	$567,373	355	$1,598	$42,650	30	$1,422
Room and Board Services	$60,612	219	$277	$159,570	592	$270
School Based Services	$0	-	$0	$6,050,977	10,114	$598
Specialized Foster Care/MR Services	$2,545,296	155	$16,421	$1,643,061	115	$14,287
Targeted Case Manager (TCM) Services	$67,433,333	27,079	$2,490	$20,696,874	25,814	$802
Therapy Services	$972,131	1,036	$938	$1,382,432	672	$2,057
Transportation - Emergency	$22,597,831	55,697	$406	$10,001,067	20,710	$483
Transportation - Non-Emergency	$19,079,334	201,627	$95	$5,902,474	504,626	$12
X-Ray Services	$2,183,729	13,896	$157	$711,530	12,710	$56
Unknown Services by Claim Type	$617,710	4,640	$133	$1,062,313	246	$4,318
Total	**$2,264,918,062**	**250,461**	**$9,043**	**$1,448,625,642**	**526,085**	**$2,754**

Source: OHCA Financial Service Division, September 2008. 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 SFY2008 Figures (continued)

Figure VII 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	$3,548,968
Adv Comp Health	$0	$0	$0	$0	$0	$8,400,322
Advanced Practice Nurse	$445,379	$1,213,531	$18,173	$18,977	$50,730	$0
ADvantage Home Delivered Meals	$0	$0	$0	$0	$0	$12,424,844
Ambulatory Surgical	$1,187,611	$4,798,550	$32,204	$37,102	$953,694	$937
Architectural Modification	$0	$0	$0	$0	$0	$701,428
Audiology	$17,128	$90,428	$0	$0	$1,628	$2,641
Behavioral Health	$33,446,590	$51,743,688	$5,703	$0	$523,937	$4,156,205
Capitated (CAP)	$0	$98,788,797	$0	$0	$0	$0
Capitated (CAP) - GME to Med Schools	$0	$70,246,418	$0	$0	$0	$0
Chiropractic	$0	$0	$0	$0	$13,149	$0
Clinic	$9,074,454	$15,762,476	$58,243	$400,121	$737,783	$153
Clinics - OSA	$2,181,201	$5,238,811	$1,970	$1,995,486	$22	$0
Community Mental Health	$18,157,231	$18,879,992	$20,137	$32	$41,929	$0
Dental	$19,031,566	$101,400,106	$470	$0	$3,864,686	$513,521
Direct Support	-$40,654	$0	$0	$0	$0	$190,382,870
Employee Training Specialist	$0	$0	$0	$0	$0	$25,848,073
End Stage Renal Disease	$2,797,459	$2,873,794	$3,554	$0	$7,146,550	$5,478
Eye Care and Exam	$1,023,676	$3,834,758	$1,744	$0	$282,649	$41
Eyewear	$1,171,216	$5,254,919	$0	$0	$5,026	$844
Free Standing Birthing Center	$0	$0	$0	$0	$0	$0
Group Home	$0	$0	$0	$0	$0	$18,850,872
Home Health	$7,413,774	$8,574,544	$0	$0	$8,520	$3,215
Homemaker	$0	$0	$0	$0	$0	$577,608
Hospice	$11,571	$97,037	$0	$0	$0	$1,891,308
HSP - Indirect Medical Education (IME)	$26,811,620	$0	$0	$0	$0	$0
HSP - Graduate Medical Education (GME)	$16,243,331	$0	$0	$0	$0	$0
HSP - Acute DSH	$61,859,233	$0	$0	$0	$0	$0
HSP - Upper Payment Limit	$45,131,919	$0	$0	$0	$0	$0
ICF-MR	$126,126,128	$32,365	$0	$0	$0	$0
Inpatient	$303,330,252	$262,825,368	$1,880,187	$6,380	$36,800,183	$427
Laboratory	$8,976,354	$9,299,860	$114,116	$710,037	$240,403	$46
Medicare Part A & B (Buy-In) Payments	$113,272,212	$0	$0	$0	$0	$0
Medicare Part D Payments	$57,701,278	$0	$0	$0	$0	$0

APPENDIX B STATEWIDE SFY2008 FIGURES (CONTINUED)

FIGURE VII 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	$128,008	$63,906	$6,179	$978	$328	$0
Medical Supplies/Durable Goods	$14,783,268	$22,063,807	$46,136	$65,362	$11,285,301	$19,634,094
Nursing Facility	$496,576,273	$416,612	$0	$0	$22,038,110	$235,407
Nursing	$54	$54	$0	$0	$0	$11,778,831
Nutritionist	$62,461	$500	$0	$0	$1,539	$636,573
ESI Out-of-Pocket*	$0	$0	$94,264	$0	$0	$0
ESI Premium*	$0	$0	$11,144,983	$0	$0	$0
Other Practitioner	$538,736	$1,776,114	$0	$0	$0	$0
Outpatient Hospital	$39,232,261	$121,048,302	$559,113	$469,470	$23,287,394	$3,705
Personal Care	$926,129	$2,052,528	$0	$0	$7,399,498	$92,121,441
Physician	$108,811,577	$195,770,581	$1,249,529	$839,002	$35,951,828	$2,460,103
Podiatry	$101	$499,511	$1,882	$0	$188,007	$196
Prescribed Drugs	$80,427,038	$232,034,625	$1,299,480	$775,830	$5,689,207	$5,096,776
Prosthetic/Orthotic	$11,800	$64,352	$0	$0	$68,799	$0
Psychiatric	$81,281,463	$28,109,019	$0	$0	$248,114	$0
Residential Behavior Management Services (RBMS)	$28,844,004	$21,567	$0	$0	$0	$0
Respite Care	$0	$0	$0	$0	$0	$610,023
Room and Board	$79,244	$140,938	$0	$0	$0	$0
School Based	$1,220,367	$4,830,610	$0	$0	$0	$0
Specialized Foster Care/MR	$0	$0	$0	$0	$0	$4,188,357
Targeted Case Manager	$37,733,283	$1,596,706	$0	$0	$0	$48,800,219
Therapy	$559,549	$829,888	$0	$0	$644	$964,483
Transportation - Emergency	$8,653,402	$12,039,147	$0	$73	$3,973,935	$7,932,341
Transportation - Non-Emergency	$24,981,808	$0	$0	$0	$0	$0
X-Ray	$678,004	$1,820,769	$30,698	$0	$365,651	$136
Unknown Services by Service Type	$1,596,288	$31,093	$52,643	$0	$0	$0
Grand Total	**$1,782,495,647**	**$1,286,166,068**	**$16,621,410**	**$5,318,850**	**$161,169,240**	**$461,772,489**
Members Served	**737,279**	**513,908**	**14,751**	**24,493**	**85,532**	**29,984**
Average Per Member Cost	**$2,418**	**$2,503**	**$1,127**	**$217**	**$1,884**	**$15,401**

Source: OHCA Financial Service Division, September 2008. *Insure Oklahoma IP and ESI includes $94,264 in Insure Oklahoma ESI Out-of-Pocket and $11,144,983 ESI Premium payments; and $5,382,163 in Insure Oklahoma IP payments. ** HCBS expenditures include all services paid to waiver members. HCBS members may receive services paid through Title XIX funds.

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 SFY2008 Figures (continued)

Figure VIII 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
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
Mid Level Practitioner	$466	$27,594	$147,033	$2,599	$756	$0	$144

APPENDIX B STATEWIDE SFY2008 FIGURES (CONTINUED)

FIGURE VIII 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*
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
Other Practitioner	$4,877	$38,731	$2,269,513	$574	$0	$0	$1,155
Outpatient Hospital	$11,560,415	$47,625,282	$120,151,756	$4,093,968	$469,470	$82,076	$617,278
Personal Care	$57,511,216	$44,968,971	$8,562	$0	$0	$10,849	$0
Physician	$21,593,034	$97,458,055	$211,061,556	$12,394,144	$839,242	$231,051	$1,505,538
Podiatry	$110,823	$302,374	$257,480	$17,060	$0	$0	$1,961
Prescribed Drugs	$3,904,605	$166,755,199	$149,202,492	$2,935,638	$775,830	$387,562	$1,361,630
Prosthetic/Orthotic	$29,810	$86,852	$27,763	$306	$0	$220	$0
Psychiatric	$255,954	$24,723,868	$84,359,684	$519	$0	$233,621	$64,948
Residential Behavior Management Services	$0	$1,381,674	$27,474,372	$0	$0	$0	$9,524
Respite Care	$264,745	$345,278	$0	$0	$0	$0	$0
Room and Board	$529	$44,445	$168,009	$7,040	$0	$159	$0
School Based	-$7,409	$2,597,670	$3,364,988	$0	$0	$95,728	$0
Specialized Foster Care/MR	$0	$4,188,357	$0	$0	$0	$0	$0
Targeted Case Manager	$28,413,293	$42,419,655	$17,291,028	-$175	$0	$1,017	$5,390
Therapy	$25,117	$1,557,062	$759,155	$0	$0	$13,229	$0
Transportation - Emergency	$2,826,429	$18,622,897	$11,026,623	$114,923	$73	$2,991	$4,963
Transportation - Non-Emergency	$7,586,964	$13,668,680	$3,671,577	$17,562	$0	$28,085	$8,940
X-Ray	$266,851	$1,194,985	$1,285,433	$116,517	$0	$513	$30,960
Unknown Services by Service Type	$1,064,730	-$5,221	$19,970	$0	$0	$0	$600,544
Total	**$790,211,948**	**$1,343,087,754**	**$1,306,193,610**	**$27,516,266**	**$5,319,089**	**$2,562,875**	**$238,652,160**
Unduplicated Members Served	**58,587**	**106,114**	**585,910**	**8,328**	**24,493**	**237**	18,445
Average Cost Per Member Served	**$12,519**	**$12,004**	**$2,167**	**$3,384**	**$193**	**$9,529**	-

Source: OHCA Financial Service Division, September 2008. *Other includes include $150,046,103 in Hospital Supplemental payments; $70,246,418 in GME payments to Medical schools; $94,264 ESI Out-of-Pocket; $11,144,983 ESI Premium payments; and $5,382,164 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 SFY2008 Figures (continued)

Figure IX 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	$15,728	$15,868	$0	$0	$0
Adv Comp Health	$0	$0	$0	$0	$0
Advanced Practice Nurse (APN)	$33,928	$95,934	$107,762	$656,077	$2,331
ADvantage Home Delivered Meals	$0	$0	$0	$0	$0
Ambulatory Surgical	$193,602	$357,398	$649,343	$3,142,640	$4,423
Architectural Modification	$61,968	$33,928	$0	$0	$0
Audiology	$21,014	$9,426	$24,557	$51,272	$58
Behavioral Health	$6,045,376	$18,206,259	$7,006,257	$32,038,248	$26,125
Capitated (CAP)	$3,604,467	$60,867	$10,946,966	$65,303,439	$13,458
Capitated (CAP) - GME to Med Schools	$0	$0	$0	$0	$70,246,418
Chiropractic	$0	$0	$0	$0	$0
Clinic	$725,601	$1,375,324	$2,552,956	$12,597,722	$68,013
Clinics - OSA	$853,281	$782,902	$613,230	$4,455,163	$379,276
Community Mental Health	$1,291,673	$2,138,794	$1,375,756	$5,265,508	$5,350
Dental	$4,182,203	$8,830,733	$21,818,955	$76,276,826	$109,949
Direct Support	$7,966,445	$10,770,633	$0	-$4,760	$0
Employee Training Specialist	$185,653	$777,921	$0	$0	$0
End Stage Renal Disease	-$6,317	$41,331	$0	$12,043	$0
Eye Care and Exam	$209,666	$432,278	$937,160	$2,910,973	$4,506
Eyewear	$387,835	$677,719	$1,284,405	$4,144,025	$6,780
Free Standing Birthing Center	$0	$0	$0	$0	$0
Group Home	$285,865	$1,083,860	$0	$0	$0
Home Health (HH)	$8,500,929	$1,568,533	$340,527	$1,819,256	$0
Homemaker	$38,456	$166,517	$7,818	-$7,818	$0
Hospice	$69,653	$879	$0	$32,332	$0
HSP - Indirect Medical Education (IME)	$0	$0	$0	$0	$0
HSP - Graduate Medical Education (GME)	$0	$0	$0	$0	$8,121,666
HSP - Acute DSH	$0	$0	$0	$0	$61,859,233
HSP - Upper Payment Limit	$0	$0	$0	$0	$45,131,919
ICF-MR	$2,179,602	$1,719,191	$1,939	$140,829	$0
Inpatient	$33,879,253	$27,418,516	$16,220,200	$189,102,735	$398,200
Laboratory	$339,920	$582,084	$737,813	$7,658,566	$204,600
Medicare Part A & B (Buy-In) Payments	$0	$0	$0	$0	$0
Medicare Part D Payments	$0	$0	$0	$0	$0
Mid Level Practitioner (MLP)	$3,599	$29,072	$14,470	$78,461	$84

APPENDIX B STATEWIDE SFY2008 FIGURES (CONTINUED)

FIGURE IX 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*
Medical Supplies/Durable Goods	$8,630,508	$2,588,988	$1,880,219	$7,877,981	$1,333
Nursing Facility	$691,959	$326,767	$0	$710	$0
Nursing	-$82,963	$94,100	$0	$0	$0
Nutritionist	-$2,866	$9,140	$0	$0	$0
ESI Out-of-Pocket	$0	$0	$0	$0	$0
ESI Premium	$0	$0	$0	$0	$0
Other Practitioner	$24,173	$40,296	$131,455	$1,716,880	$1,239
Outpatient Hospital	$5,957,239	$6,324,961	$12,564,815	$74,321,541	$183,408
Personal Care	$544,851	$99,845	$0	$6,210	$0
Physician	$14,767,455	$17,689,820	$16,593,157	$112,769,502	$347,959
Podiatry	$9,059	$23,579	$54,533	$159,111	$78
Prescribed Drugs	$44,069,447	$22,384,775	$23,992,839	$80,689,842	$188,821
Prosthetic/Orthotic	$45,605	$2,215	$8,340	$19,352	$0
Psychiatric	$21,459,098	$39,651,106	$10,875,763	$37,235,283	$64,948
Residential Behavior Management Services (RBMS)	$17,881	$28,537,877	$22,782	$277,507	$9,524
Respite Care	$10,950	$31,700	$0	$0	$0
Room and Board	$34,538	$8,371	$10,487	$106,174	$0
School Based	$2,474,834	$737,208	$687,713	$2,151,222	$0
Specialized Foster Care/MR	$128,600	$1,514,461	$0	$0	$0
Targeted Case Manager (TCM)	$1,527,557	$17,282,586	$316,101	$1,565,626	$5,005
Therapy	$574,487	$244,906	$133,438	$429,600	$0
Transportation - Emergency	$1,040,907	$1,242,151	$768,557	$6,943,154	$6,298
Transportation - Non-Emergency	$2,337,658	$433,334	$549,551	$2,578,481	$3,448
X-Ray	$46,830	$45,126	$128,906	$489,998	$670
Unknown Services by Service Type	$1,021,355	$23,438	$0	$293	$17,227
Grand Total	**$176,398,564**	**$216,512,716**	**$133,358,768**	**$735,012,005**	**$187,412,347**
Unduplicated Members Served	**20,310**	**39,497**	**118,010**	**455,247**	**4,606**
Average Per Member Served Cost	**$8,685**	**$5,482**	**$1,130**	**$1,615**	

Source: OHCA Financial Service Division, September 2008. 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 $115,112,818 in Hospital Supplemental (GME/DSH and UPL) payments and $70,246,418 in GME payments to Medical schools. 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 SFY2008 Figures (continued)

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

Home and Community-Based Services (HCBS)*	Total	ADvantage	Community	Homeward Bound	In-Home Support
Adult Day Care Services	$3,548,968	$2,540,017	$632,241	$0	$376,711
Adv Comp Health Services	$8,400,322	$8,400,322	$0	$0	$0
ADvantage Home Delivered Meals	$12,424,844	$12,424,844	$0	$0	$0
Architectural Modification Services	$701,428	$233,791	$201,426	$132,869	$133,342
Audiology Services	$2,641	$2,214	$322	$105	$0
Behavioral Health Services	$4,156,205	$125	$2,946,295	$1,045,459	$164,326
Direct Support Services	$190,382,870	$0	$91,188,161	$80,261,004	$18,933,704
Dental Services	$513,521	$0	$180,407	$315,812	$17,302
Employee Training Specialist	$25,848,073	$0	$17,437,101	$5,057,442	$3,353,529
End Stage Renal Disease (ESRD) Services	$5,478	$5,478	$0	$0	$0
Group Home Services	$18,850,872	$0	$18,771,619	$79,253	$0
Home Health Services	$3,215	$3,573	($358)	$0	$0
Homemaker Services	$577,608	$0	$456,856	$6,714	$114,039
Hospice Services	$1,891,308	$1,891,308	$0	$0	$0
Medical Supplies/Durable Goods	$19,634,094	$15,162,890	$2,532,483	$940,218	$998,502
Nursing Facility Services	$235,407	$235,407	$0	$0	$0
Nursing Services	$11,778,831	$7,497,917	$1,920,873	$2,352,028	$8,014
Nutritionist Services	$636,573	$0	$358,029	$274,138	$4,406
Personal Care Services	$92,121,441	$92,121,441	$0	$0	$0
Physician Services	$2,460,103	$14,444	$1,735,022	$595,904	$114,734
Prescribed Drugs Services	$5,096,776	$3,946,476	$683,629	$408,883	$57,789
Respite Care Services	$610,023	$553,471	$43,752	$0	$12,800
Specialized Foster Care/MR	$4,188,357	$0	$4,133,407	$54,750	$200
Targeted Case Manager (TCM)	$48,800,219	$48,800,219	$0	$0	$0
Therapy Services	$964,483	$67,634	$538,609	$255,746	$102,494
Transportation Services	$7,932,341	$6,622	$4,540,158	$2,804,366	$581,195
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	**$461,766,002**	**$193,908,191**	**$148,300,033**	**$94,584,691**	**$24,973,087**
Unduplicated Members Served**	**29,984**	**24,421**	**2,784**	**781**	**2,099**
Average Cost per Member	$15,400	$7,940	$53,269	$121,107	$11,898

Source: OHCA Financial Service Division, September 2008. Claim dollars were extracted from the MMIS claims history file for claims paid within the fiscal year. Financial statement data represents actual cash expenditures as reported to the Office of State Finance while MMIS data warehouse expenditure data is net of overpayments and adjustments.
*Services above are all only services paid with HCBS waiver funds. Members may receive services paid through Title XIX funds. **Unduplicated Member Served figures are the unduplicated counts of members that received a service.

APPENDIX B STATEWIDE SFY2008 FIGURES (CONTINUED)

FIGURE XI 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)	$3,969,115	1,380	$2,876
Inpatient (Acute - Freestanding)	$9,601,340	1,763	$5,446
Psychiatric Residential Treatment Facility (PRTF)	$99,140,904	3,915	$25,323
Outpatient (Private)	$56,704,674	27,942	$2,029
Outpatient - CMHC (Public)	$428,316	1,011	$424
Outpatient - CMHC (Contracted)	$9,648,766	10,751	$897
Psychologist	$4,522,782	6,383	$709
Psychiatrist	$1,274,670	4,853	$263
Residential Behavior Mgmt Services (Group)	$8,688,764	1,232	$7,053
Residential Behavior Mgmt Services (TFC)	$20,176,805	1,749	$11,536
Targeted Case Management (TCM)	$263,868	1,204	$219
Other Outpatient Behavioral Health Services	$553,288	220	$2,515
Total	**$214,973,291**	**45,089**	**$4,768**

BEHAVIORAL HEALTH SERVICES FOR ADULTS

Type of Service	Expenditures	Members Served	Average per Member Served
Inpatient (Acute - General)	$8,262,482	2,100	$3,935
Inpatient (Acute - Freestanding)	$887,532	631	$1,407
Psychiatric Residential Treatment Facility (PRTF)*	$1,343	6	$224
Outpatient (Private)	$20,550,528	9,295	$2,211
Outpatient - CMHC (Public)	$4,623,266	3,329	$1,389
Outpatient - CMHC (Contracted)	$22,398,973	10,915	$2,052
Psychologist	$973,126	1,131	$860
Psychiatrist	$1,531,906	4,750	$323
Residential Behavior Mgmt Services (Group)	$0	-	$0
Residential Behavior Mgmt Services (TFC)	$0	-	$0
Targeted Case Management (TCM)	$606,585	3,059	$198
Other Outpatient Behavioral Health Services	$2,597,679	1,000	$2,598
Total	**$62,433,420**	**26,989**	**$2,313**

Total All Behavioral Health Services	**$277,406,711**	**71,900**	**$3,858**

*PRTF expenditures include all ancillary services.
Source: OHCA Financial Service Division, September 2008. 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 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 SFY2008 Board Approved Rules

Board Approval Date	Rule Description	Savings/Total Cost/State Share	Effective Date
Jul-12-2007	Revising rules to remove the requirement for submission of a specific form for sterilization consent and allow providers to use any form that is federally approved or mandated for sterilization consent. APA WF#07-02	Budget neutral	Sep-1-2007
Aug-15-2007	Revising Developmental Disabilities Services rules to: (1) reflect current residential support options through the DDSD Home and Home and Community-Based Services (HCBS) Waiver program as approved by the Centers for Medicare and Medicaid Services (CMS); and (2) provide a new residential support option known as Community Transition Services (CTS). APA WF#07-28	Budget neutral	Oct-1-2007
Aug-15-2007	Revising rules to clarify reimbursement for therapy for adults in the inpatient and outpatient hospital settings. APA WF#07-30	Budget neutral	Oct-1-2007
Aug-15-2007	Revising rules to require written prescription be written on tamper-proof paper in order to qualify for FFP. APA WF#07-44	Budget neutral	Oct-1-2007
Aug-15-2007	Revising rules to expand current O-EPIC Employer Sponsored Insurance (ESI) and Individual Plan (IP) maximum income standards from 185% of the Federal Poverty Level to 200%. APA WF#07-39	Annual State Share $226,000	Oct-1-2007
Aug-15-2007	Revising rules to clarify that a member: (1) has the option to enroll in SoonerPlan only, even if they may be otherwise eligible for SoonerCare; and (2) may not receive family planning waiver benefits if he or she has had a sterilization procedure. APA WF#07-46	Budget neutral	Oct-1-2007
Sep-13-2007	Revising rules to postpone until 2011 the requirements that suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) must be accredited by Medicare-deemed accreditation organization for quality standards for DMEPOS suppliers in order to receive reimbursement from the SoonerCare program. APA WF#07-48	Budget neutral	Nov-1-2007
Sep-13-2007	Revising SoonerCare application procedure rules to allow the acceptance of facsimile signatures on all SoonerCare applications. APA WF#07-25	Budget neutral	Nov-1-2007
Sep-13-2007	Revising rules to add Licensed Genetic Counselors (LGCs) to individual providers and specialties who provide health care to SoonerCare members. APA WF#07-41	Annual State Share $13,836	Nov-1-2007
Sep-13-2007	Revising rules to add Registered Lactation Consultants (RLCs) and International Board Certified Lactation Consultants (IBCLCs) to individual providers and specialties who provide health care to SoonerCare members. APA WF#07-42	Annual State Share $90,953	Dec-1-2007
Sep-13-2007	Revising rules to add Maternal and Infant Health Licensed Clinical Social Workers (MIHLCSWs) to individual providers and specialties who provide health care to SoonerCare members. APA WF#07-40	Annual State Share $159,329	Nov-1-2007
Sep-13-2007	Revising rules to permit additional reimbursement to providers treating a member who is confirmed to be medically/obstetrically "high risk" and allow additional ultrasounds and non stress tests needed beyond the basic benefit. APA WF#07-38	Annual State Share $362,190	Nov-1-2007
Oct-11-2007	Revising rules to exclude certain pregnancy related services from the Insure Oklahoma/O-EPIC Individual Plan benefit package. Excluded are: (1) services of an International Board Certified Lactation Consultant (IBCLC); (2) services of a Maternal and Infant Health Licensed Clinical Social Worker (MIHLCSW); and (3) enhanced services for medically high risk pregnancies. APA WF#07-53	Budget neutral	Dec-1-2007
Oct-11-2007	Revising rules to allow certain exceptions for coverage of external breast prostheses. APA WF#07-47	State Share Savings	Dec-1-2007

APPENDIX D SFY2008 BOARD APPROVED RULES (CONTINUED)

Board Approval Date	Rule Description	Savings/Total Cost/State Share	Effective Date
Oct-11-2007	Revising eligibility requirements to recognize children who reside in IHS, BIA or Tribal controlled dormitories as residents of Oklahoma for SoonerCare eligibility purposes. APA WF#07-50	Annual State Share $49,300	Dec-1-2007
Oct-11-2007	Revising rules to add pregnancy related benefits to improve health outcomes for children who are citizens at birth. APA WF#07-58	Annual State Share $1,190,973	Jan-1-2008
Nov-8-2007	Revising rules to allow SoonerCare providers to bill and receive payment for an evaluation and management service and an amniocentesis on the same date of service. APA WF#07-51	Budget neutral	Jan-1-2008
Nov-8-2007	Revising rules to implement Section 6021 of the Deficit Reduction Act regarding Long-Term Care Insurance Partnership programs. Rules regarding income and resource disregards are also amended to specifically address the following payments as allowable income or resource disregards when determining eligibility for SoonerCare services: (1) payments made to certain Vietnam veterans' children with spina bifida; (2) payments made to certain Korea service veterans' children with spina bifida; and (3) payments made to the children of women Vietnam veterans who suffer from certain birth defects. APA WF#07-57	Budget neutral	Dec-18-2007
Nov-8-2007	Revising rules to eliminate the requirement that an Explanation of Medicare Benefits be attached to a cross-over claim before it can be processed. APA WF#07-65	Budget neutral	Jan-1-2008
Dec-13-2007	Revising SoonerRide Non-Emergency Transportation rules to remove the exclusion of stretcher services. APA WF#07-63	Budget neutral	Jan-18-2008
Dec-13-2007	Revising Pharmacy rules to comply with Section 6002 of the Deficit Reduction Act of 2005 requiring the National Drug Code (NDC) to be collected on multiple source, physician administered drugs in order to secure drug rebates. APA WF#07-62	State Share Rebates $1,645,000	Jan-18-2008
Dec-13-2007	Revising SoonerCare eligibility rules to exempt the $90 VA pension when calculating the member's share of the nursing facility vendor payment. APA WF#07-55	Annual State Share $108,000	Feb-1-2008
Dec-13-2007	Revising rules to limit subcontractor allowable charges for SoonerCare members in PRTF facilities to the Medicaid fee schedule. APA WF#07-59	Budget neutral	Feb-1-2008
Dec-13-2007	Revising rules to concur with recent changes to the ADvantage Home and Community Based Services Waiver document as approved by the Centers for Medicare and Medicaid Services. APA WF#07-59	Budget neutral	Feb-1-2008
Dec-13-2007	Revising rules to: (1) limit payment for lenses and frames to one pair of glasses per 12 month period unless medically necessary or glasses are lost or damaged beyond repair; and (2) allow physicians to separate the refractive service from the medical evaluation when billing ophthalmology services. APA WF#07-49	Budget neutral	Feb-1-2008
Feb-14-2008	Revising rules to allow SoonerCare providers to bill and receive partial payment for the lesser surgeries when multiple surgeries are performed at the same setting in an outpatient hospital facility or ambulatory surgical center. APA WF#07-26	Budget neutral	Apr-1-2008
Mar-13-2008	Revising Dental rules to add definitions for certain terminology, clarify rules regarding payment for permanent restorations, and revise rules regarding payment for radiographs. APA WF#07-68	Budget neutral	May-1-2008

Appendix D SFY2008 Board Approved Rules (continued)

Board Approval Date	Rule Description	Savings/Total Cost/State Share	Effective Date
Mar-13-2008	Revising rules for DDSD services to: (1) reflect current services in the Home and Community-Based Services (HCBS) Waivers; (2) reflect changes in prescreening requirements and home standards in the home profile process; (3) allow experienced designated DDSD staff to complete certain architectural modification assessments; (4) specify dental services for members receiving services through HCBS Waivers; (5) clarify individual placement for job coaching services and update requirements for employment services through HCBS Waivers; (6) update terminology; (7) eliminate obsolete provisions; and (8) correct scrivener's errors. APA WF#07-60A & 07-60B	Budget neutral	Jul-25-2008
Mar-13-2008	Revising rules regarding eligibility for ADvantage services to require the State to redetermine level of care annually for members participating in the ADvantage program. APA WF#07-66	Budget neutral	Jul-25-2008
Mar-13-2008	Revising rules regarding reimbursement for long term care facilities to: (1) remove outdated information regarding payment to the nursing facility when the member is in the hospital; (2) add language to freeze the Quality of Care fee at levels in effect July 1, 2004, and implement 5.5% as a maximum, as per federal law; (3) add language to include additional items needed in the Quality of Care Report in order to implement the Focus on Excellence Program; (4) update language to add the requirement regarding the filing of cost reports on the Secure Website and to change the due date from September 1st to October 31st; (5) define the cost report requirement for partial year reports; and (6) delete obsolete language. APA WF#07-67	Budget neutral	Jul-25-2008
Mar-13-2008	Revising rules to end the existing reimbursement methodology for PACT services effective June 30, 2008. APA WF#07-71	Budget neutral	Jul-25-2008
Mar-13-2008	Revising rules to update the agency's designated agent that reviews the length of stay and appropriateness of hospital admissions from the Oklahoma Foundation for Medical Quality (OFMQ) to the generic term "Quality Improvement Organization (QIO)" since the agency no longer contracts with the OFMQ. APA WF#07-37	Budget neutral	Jul-25-2008
Mar-13-2008	Revising rules to strike current outpatient behavioral health reimbursement language and replace it with language that refers to the State Plan. APA WF#07-56	Budget neutral	Jul-25-2008
Mar-13-2008	Revising rules to remove the list of medical and surgical modifiers and refer providers to the Physicians' Current Procedural Terminology (CPT) book for guidance in billing surgery claims. Further, revisions are made to remove duplicative language found in the surgery sections that are also in other sections of policy. Opportunities for Living Life (OLL) rules are also revised to remove inconsistencies regarding payment of durable medical equipment. APA WF#07-61	Budget neutral	July 25,2008
Mar-13-2008	Revising rules to update current Indian health rules and add a section regarding inpatient medical care by IHS facilities. APA WF#07-64	Budget neutral	Jul-25-2008
Mar-13-2008	Revising rules to eliminate obsolete provisions and set out required qualifications for individual providers who render Individual Rehabilitative Treatment services for redevelopment therapy in a foster care setting. APA WF#07-74	Budget neutral	Jul-25-2008
Mar-13-2008	Revising rules to update terminology, clarify correct billing procedures for general physicians performing psychiatric services, and remove language requiring submission of documentation of training to the Oklahoma Health Care Authority. APA WF#07-75	Budget neutral	Jul-25-2008
Mar-13-2008	Revising rules to comply with federal mandate requiring the use of the prescriber's National Provider Identification number, remove specific drug names from policy and clean up outdated terminology. APA WF#07-76	Budget neutral	Jul-25-2008

Appendix D SFY2008 Board Approved Rules (continued)

Board Approval Date	Rule Description	Savings/Total Cost/State Share	Effective Date
Apr-10-2008	Revising DDSD rules to provide current Home and Community Based Services Waiver provisions for respite care, including types of respite care. Other revisions denote a new level of support, pervasive level of support, through agency companion services and agency companion services salary options. APA WF#08-03	Budget neutral	Jun-1-2008
Apr-10-2008	Revising rules to include the Oklahoma Municipal Assurance Group as an approved carrier within the Insure Oklahoma/O-EPIC carrier definition. APA WF#08-09	Budget neutral	Jun-1-2008
May-8-2008	Revising Program of All-Inclusive Care for the Elderly (PACE) rules to allow for the involuntary disenrollment of a participant in the program based on the threatening or disruptive behavior or actions of the participant's caregiver or guardian to pay or make satisfactory arrangements to pay, any premium due to PACE organization. APA WF#08-01	Budget neutral	Jul-1-2008
May-8-2008	Revising inpatient psychiatric hospital rules to allow for review of individual plans of care for children in an inpatient setting no less than every 9 calendar days in acute care situations and every 16 calendar days in the longer term treatment program or specialty psychiatric residential treatment facility. APA WF#08-09	Budget neutral	Jun-1-2008
May-8-2008	Revising outpatient behavioral health rules to remove the language referring to the reimbursement methodology for Program of Assertive Community Treatment (PACT) services. APA WF#08-08	Budget neutral	Jul-1-2008
Jun-12-2008	Revising rural health clinic rules to: (1) eliminate age and gender restrictions for SoonerCare members to receive family planning services; and (2) reimburse on a fee-for-service rather then an encounter basis. APA WF#08-011	Annual State Share $329	Aug-1-2008
Jun-12-2008	Revising Physician rules to: (1) allow reimbursement of one non stress and/or one biophysical profile to a Maternal Fetal Medicine (MFM) specialist without requiring a prior authorization; and (2) remove the OB signature requirement from the high risk OB treatment plan form unless the OB provider wishes to request authorization of the ante partum management fee. APA WF#08-12	Budget neutral	Aug-1-2008

Appendix E SFY2008 Contracted SoonerCare Providers

Provider Type	SFY2008
Adult Day Care	60
Advance Practice Nurse	796
Advantage Comprehensive Health Care	0
Advantage Home Delivered Meal	21
Ambulatory Surgical Center (ASC)	65
Audiologist	95
Capitation Provider - IHS Case Manager	82
Case Manager	329
Certified Registered Nurse Anesthetist (CRNA)	781
Chiropractor	32
Clinic - EPSDT	3
Clinic - Early Intervention Services	1
Clinic - Family Planning	6
Clinic - Federally Qualified Health Clinic	29
Clinic - Group	3,483
Clinic - Maternity	7
Clinic - Rural Health	83
Clinic - Speech/Hearing	4
Clinic - Tuberculosis	3
County Health Department	1
DDSD - Architectural Modification	42
DDSD - Community Transition Services	21
DDSD - Employee Training Specialist	94
DDSD - Group Home	44
DDSD - Homemaker Services	196
DDSD - Supportive Living Arrangements	52
DDSD - Volunteer Transportation Provider	411
Dentist	804
Direct Support Services	270
DME/Medical Supply Dealer	1,809
End-Stage Renal Disease Clinic	95
Extended Care and Skilled Nursing Facilities	327
Extended Care Facility - ICF/MR	94
Extended Care Facility - Respite Care	94
Genetic Counselor	6
Home Health Agency	204
Hospital - Acute Care	584
Hospital - Critical Access	53
Hospital - Native American	50
Hospital - Psychiatric	22
Hospital - Residential Treatment Center	50
Laboratory	267
Lactation Consultant	17
Long Term Care Authority Hospice	62
Maternal/Child Health LCSW	3
Mental Health Provider - Counselor	25
Mental Health Provider - Psychologist	363
Mental Health Provider - Social Worker	94
Nursing Agency - Non-Skilled	38
Nursing Agency - Skilled	38
Nutritionist	143
Optician	56
Optometrist	529
Outpatient Mental Health Clinic	434
Personal Care Services	134
Pharmacy	1240
Physician - Allergist	35
Physician - Anesthesiologist	867
Physician - Cardiologist	523
Physician - General Pediatrician	1,384
Physician - General Surgeon	588
Physician - General/ Family Medicine	2,097
Physician - Internist	1,663
Physician - Obstetrician/ Gynecologist	579
Physician - Other Specialist	3,677
Physician - Pediatric Specialist	262
Physician - Radiologist	1,025
Physician Assistant	756
Preadmission Screening and Resident Review	5
Program for Assertive Community Treatment	7
Residential Behavior Management Services	20
Respite Care	222
Room and Board	8
School Corporation	236
Specialized Foster Care/ MR	202
Therapist - Physical	431
Therapist - Occupational	184
Therapist - Speech/ Hearing	394
Transportation Provider	256
X-Ray Clinic	56

The term "contracted" is defined as a provider that was enrolled with Oklahoma SoonerCare within SFY2008, 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 (Available only 5 p.m. to 8 a.m. and weekends)
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.org*

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

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

Oklahoma State Department of Health — *www.ok.gov/health*

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

Centers for Medicare 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

Health Care for Oklahomans