Oklahoma Health Care Authority

SFY2005 Annual Report

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10 Year Agency Anniversary Edition

July 2004 through June 2005

Our Mission Statement

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

Our Vision

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

Our Values and Behaviors

- **OHCA staff will operate as members of the same team, with a common mission and each with a unique contribution to make toward our success.**
- **OHCA will be open to new ways of working together.**
- **OHCA will use qualitative and quantitative data to guide and evaluate our actions and improve our performance in a purposeful way over time.**

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State of Oklahoma

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Lieutenant Governor

Terry Cline, Ph.D.

Health Cabinet Secretary

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50th Legislature (2005-2006)

Mike Morgan

Senate Pro Tempore

Todd Hiett

House of Representatives Speaker

OHCA Board Members and Chief Executive Officer

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

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

Message from the Chief Executive Officer...

The year 2005 marks the 40th birthday of the federal/state Medicaid program. While many changes have been made, the basic principles and policies in federal Medicaid law have been locked in time, still reflecting its 1965 "welfare" system roots.

Now is an appropriate time to acknowledge Medicaid's contribution to health care for many millions of our nation's children and individuals who are elderly or disabled. But it is also time to recognize its woeful inadequacies and outdated policies in meeting today's health care needs. As the nation's largest publicly funded purchaser of health care, Medicaid can and should be retooled and redirected to provide access to quality health care for those who cannot afford it.

The information in this report will confirm that in Oklahoma, just as in the program throughout the nation, Medicaid has developed into two distinct and very different programs: One, an "insurance" model paying for preventive and primary care and the treatment of acute and chronic conditions and two, the provision of long term services for individuals who require ongoing support to meet the needs of daily living; including skilled nursing, attendant care, housing, food and nutrition, recreation, transportation and social services.

The Oklahoma Health Care Authority has been given some flexibility through waivers granted by the federal agency, Centers for Medicare & Medicaid Services. Over the last 10 years we have implemented and refined ***SoonerCare***, a purchaser and manager of health care services that operates much like a commercial insurance program. In recent months two additional "products" have been added. The **Oklahoma Cares** product offers the full range of ***SoonerCare*** benefits to women diagnosed with breast or cervical cancer and the **SoonerPlan** product offers family planning benefits to Oklahomans age 19 and older. Both of these initiatives are exceptions to the traditional "welfare" category limitations that restrict coverage to only children and disabled or elderly adults.

Later this year, you will see the culmination of three years of planning when we introduce the **Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC)**. For the first time, it will make federal/state Medicaid funds available to assist employers and employees in purchasing commercial group health policies. The Governor and Legislature have led Oklahomans to provide state match funds through passage of the tobacco tax and have legislated public policy directing the creation of this new program. O-EPIC is an outstanding testimonial to the creative, out of the box, planning and hard work of the OHCA Board and staff.

As we continue to move this Medicaid insurance approach toward a more commercial business model, we will build on both the efficiencies and quality care improvement of effective care management. The model will also encourage increased personal responsibility and investment by the enrollees through modest premiums, co-insurance and/or deductibles.

The other "face" of Medicaid, those support services that provide Oklahomans who are elderly or disabled an opportunity to live life as fully as possible, is also in need of major change. Many challenges exist in trying to coordinate the medical and non-medical services and programs in a system that is accessible, timely, and easily navigated. Reform of this program must include state and local collaboration and a clear mission to provide services that offer timely and meaningful choices.

Federal Medicaid reform should independently address the policies, administration and funding of these two very different programs. Publicly-funded purchasing of primary care and treatment of acute medical conditions should be freed from the antiquated policies by repealing them from the federal Medicaid law. A separate program supporting services that range from a home delivered meal to 24-hour skilled nursing care should replace the current patchwork of programs. Federal Medicaid policy favoring a medical model of services and highly biased toward institutional care should be replaced by a more comprehensive and rational system of long term supportive services.

In the meantime, the Oklahoma Health Care Authority will continue to take full advantage of every opportunity granted by our federal partner to demonstrate superior program policy, design and operation.

We hope that you will find in these pages, information that gives you valuable insight into a program that over the last 40 years has provided so much help to so many. Yet, it will also reveal a program in need of substantial change in order to meet the health care and long term support needs of today.

General

Understanding Medicaid

Oklahoma Medicaid

Understanding OHCA

Figures

SFY2005 Highlights

Enrollees

- There were 696,743 unduplicated beneficiaries enrolled during SFY2005; of those 687,451 received services.
- Overall Medicaid enrollees increased by 4 percent and the number served increased 3 percent from the last State Fiscal Year (June 2003 through July 2004).
- At 65 percent of the total enrolled, children under age 18 are the majority of Oklahoma Medicaid enrollees.
- Medicaid covers more than 50 percent of the births in Oklahoma.
- During SFY2005, OHCA extended eligibility to more than 3,200 Family Planning (***SoonerPlan***) enrollees and approximately 1,600 individuals needing further diagnosis or treatment for breast and/or cervical cancer under Oklahoma Cares.

Expenditures and Revenues

- The bulk of Medicaid expenditures were made on behalf of the elderly and disabled. 65 percent of expenditures were made for services provided to the aged, blind and disabled, who made up 20 percent of Medicaid enrollees for SFY2005.
- Medicaid funded 75 percent of Oklahoma's total long-term care actual bed days.
- OHCA expended $2.6 million on behalf of the Breast and Cervical Cancer enrollees and more than $79,000 on ***SoonerPlan*** enrollees.
- Quality of Care revenues totaled $55,651,586.
- Dollars recovered through post payment reviews totaled $3,895,104.
- Drug Rebate collections increased by 38 percent to $97,945,103.
- By limiting the amount paid for generic drugs, OHCA saved more than $62 million through the State Maximum Allowable Cost (SMAC) program.

Administration

- The OHCA processed 15 emergency rules and 14 permanent rules and 13 State Plan amendments.
- OHCA held 21 OKDHS county worker training sessions with an estimated attendance overall of 735 workers within SFY2005. Additionally, there were 2,214 provider training sessions held during SFY2005.
- OHCA received and investigated 8,571 ***SoonerCare*** beneficiary complaints. This represents just over 1.5 percent of the entire 535,367 ***SoonerCare*** enrollees.
- There were 94 provider and 35 beneficiary formal appeals filed. This is less than one quarter of one percent of both populations.
- OHCA administrative costs comprised 2.1 percent of the total Medicaid expenditures, of that OHCA operating costs represent 42 percent of the total Oklahoma Medicaid administrative expenditures. Contract costs constitute 58 percent of the Health Care Authority's administrative expenditures.

SFY2005 Year in Review

Oklahoma Cares—Breast and Cervical Cancer Treatment Program goes into effect

The Breast and Cervical Cancer (BCC) Treatment Program for women went into effect on January 1, 2005. The state of Oklahoma is now providing Medicaid benefits to low-income, uninsured women under age 65 who are identified through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and are in need of treatment for breast or cervical cancer (including pre-cancerous conditions and early stage cancer.)

Oklahoma Cares is a collaborative partnership to provide treatment for breast and cervical cancer and pre-cancerous conditions to eligible women. OHCA's partners in this endeavor are the Oklahoma State Department of Health (OSDH), the Cherokee Nation, the Kaw Nation of Oklahoma and the Oklahoma Department of Human Services (OKDHS). Oklahoma Cares was established as a result of the National Breast and Cervical Cancer Prevention and Treatment Act of 2000.

Family planning services began April 1, 2005

Low income, uninsured women and men can now receive family planning services under a new program, ***SoonerPlan***, implemented in April 2005. Eligibility requirements for ***SoonerPlan*** stipulate that the applicants are residents of Oklahoma, age 19 or older and be U.S. citizens or qualified aliens. They must have no other health insurance coverage for family planning, not be eligible for regular Medicaid and must have income below 185 percent of the federal poverty level.

SoonerPlan pays for office visits and physical exams related to family planning, birth control information and supplies, laboratory tests related to family planning services (pap smears and screening for sexually transmitted infections), tubal ligations for women age 21 and older, pregnancy tests and vasectomies for men age 21 and older. ***SoonerPlan*** services are available through any Medicaid provider who offers family planning services. Although additional medical services are not covered under ***SoonerPlan***, the OHCA will provide referral information to beneficiaries where they may obtain needed medical services at their own expense.

SoonerCare *contracting successful*

More than 95 percent of ***SoonerCare*** primary care providers opted to continue their contracts with the Oklahoma Health Care Authority during the 2005 contract renewal period. In addition, 17 new providers from across the state were added to the program. With the completion of the contracting period in January 2005, patient capacity in the ***SoonerCare*** program increased 9 percent from September 2004. " This is an excellent accomplishment for the ***SoonerCare*** staff," said Becky Pasternik-Ikard, Director of ***SoonerCare*** and Care Management Services. "It speaks very well of the relationship our Provider Representatives have developed with the provider community." Providers with the ***SoonerCare*** program gave input that was used in preparing the 2005 agreement. Major revisions were incorporated in the capitated benefit package, Pasternik-Ikard noted. In the Indian Health Services, Tribal and Urban Indian health clinics' Primary Care Case Management (PCCM) program, all existing contractors continued for 2005, with the addition of two new Indian Health Service contracts.

SFY2005 Year in Review (continued)

Federal waiver to expand health care access

The Oklahoma Health Care Authority is seeking approval from the federal government to provide premium assistance to Oklahoma's low income individuals and small businesses for health care coverage. The proposal was submitted to the Centers for Medicare and Medicaid Services under the Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative.

The program, authorized by the Oklahoma Health Care Recovery Act, will be open to small businesses with 25 or fewer workers, including those that currently offer health insurance coverage. Premium assistance will be available for workers and spouses with household incomes at or below 185 percent of the federal poverty level that are not eligible for Medicaid. Participating employers, as well as employees, will be required to pay a portion of the premiums. Employees will also be responsible for any applicable deductibles and co-payments. More information can be obtained at www.oepic.ok.gov.

OHCA enhances pharmacy information for providers

In November 2004, OHCA contracted with EPOCRATES®, Inc. to provide pharmacy benefit information to prescribers and pharmacists using their desktop computer or their Personal Digital Assistant (PDA). The service allows users to verify drug coverage status, preferred alternatives, prior authorization requirements, quantity limits and other drug-specific messages programmed by OHCA. This results in a quicker transaction at the pharmacy and decreases paperwork and hassles for the prescriber.

The pharmacy coverage is updated regularly by OHCA and is then downloaded by the physician weekly, so the information is timely. This helps the physician by reducing the amount of time spent with pharmacy call backs and prior authorization forms. The patients are more satisfied with their experience at the pharmacy.

Physicians can also get updated drug information such as dosing, monitoring, drug interactions and precautions which reduces the risk of medication errors. The OHCA drug list has been adding about 500 new users every quarter for a total of approximately 1,500 users by the end of SFY2005.

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

The Oklahoma Health Care Authority and Oklahoma State University-Oklahoma City, along with various state agencies, partnered to develop a pilot program to certify nurse's aides to work at long term care facilities. The classes are available at no cost for qualifying Oklahoma and Logan county pilot area) residents who earn certification and subsequently gain and hold employment at a Medicaid long term care facility for at least twelve months. OSU-OKC provides a curriculum designed to prepare students to complete the state's nurse aide competency examination. According to a 2003 American Health Care Association survey, Oklahoma had a 135 percent turnover rate for CNAs; the highest in the nation. "Oklahoma's long term care facilities have long struggled with a manpower shortage," said OHCA Chief Executive Officer Mike Fogarty. "We believe this program is an important step in helping Medicaid facilities in their quest to provide enduring quality care to their residents." Expansion of the program is being considered for 2006.

OHCA seeks to improve performance reporting

In June 2004, the Oklahoma Health Care Authority received a $30,000 demonstration grant from the National Center for Civic Innovation (NCCI). The grant allows state and local governments to take steps to increase awareness of their performance reporting and encourage public participation in the process. The OHCA is using its grant funding to gather citizens and stakeholders input on the goals of the agency. Currently, the OHCA produces a "Service Efforts and Accomplishments (SEA)" report. This report lists the goals and objectives of the agency and outlines the progress toward achieving these goals using key performance indicators, trends and benchmarks. OHCA received a Certificate of Excellence from the Association of Government Accountants for the SFY2004 SEA report. The SEA report is available on OHCA's website at: www.okhca.org/Research/Reports.

Understanding Medicaid

What is Medicaid?

Who is Eligible?

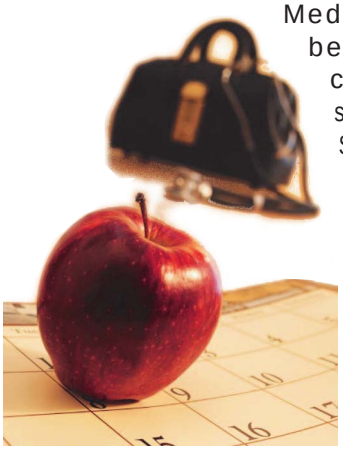
Medicaid Eligibility Trends

How is Medicaid Financed?

Where are the Dollars Going?

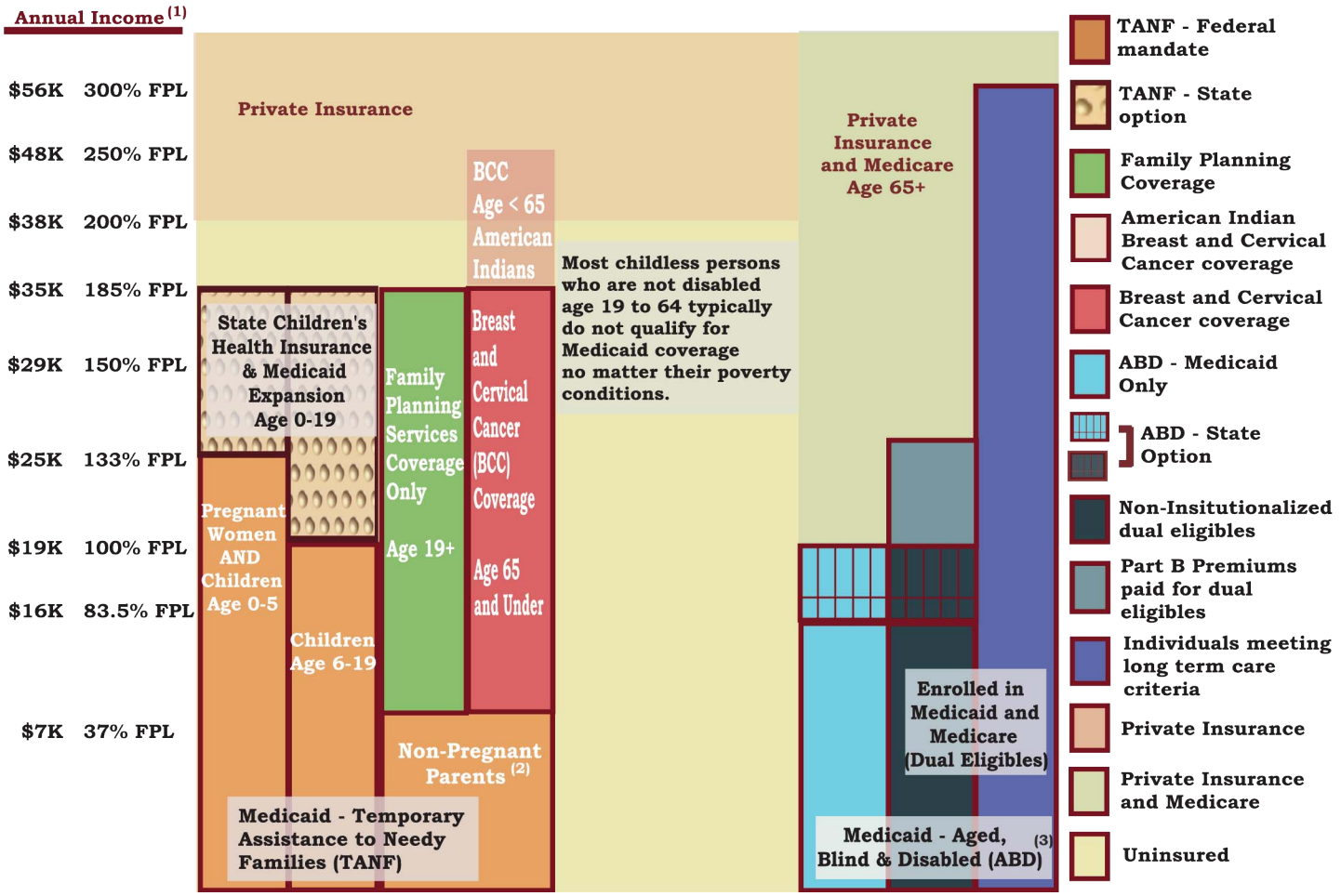
What Services does Medicaid Cover?

What is Medicaid?



Medicaid is a federal and state entitlement program that provides funding for medical benefits to low-income individuals who have inadequate or no health insurance coverage. Medicaid guarantees coverage for basic health and long-term care services based upon income and/or resources. Created as Title XIX of the Social Security Act in 1965, Medicaid is administered at the federal level by the Centers of Medicare and Medicaid Services (CMS) within the Department of Health and Human Services (HHS). CMS establishes and monitors certain requirements concerning funding, eligibility standards and quality and scope of medical services. States have the flexibility to determine some aspects of their own programs, such as setting provider reimbursement rates and the broadening of the eligibility requirements and benefits offered within certain federal parameters. State Medicaid spending and optional programs are determined by the amount of money allotted by the legislature.

Figure 1 2005 Federal Poverty Levels (FPL) and Coverage



(1) 2005 Federal Poverty Guidelines, U.S. Department of Health and Human Services. Based on a family of four.
(2) 37 percent federal poverty level (FPL) based on single parent family.
(3) Incomes shown are for single individuals.
Eligibility for Breast and Cervical Cancer coverage is expanded to 250 percent of the federal poverty level for American Indians only.

Who is Eligible for Medicaid?

Medicaid serves as the nation's primary source of health insurance coverage for the poor. During the past decade, federal and state eligibility policy changes to promote Medicaid coverage of low-income pregnant women and children, the disabled and the elderly have resulted in greater coverage of these groups within the low-income population.

In exchange for 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.

Medicaid was created under Title XIX of the Social Security Act in 1965.

The decision by a state to cover an optional population or to provide optional benefits has important implications not just for Medicaid beneficiaries, but also for the state and health care providers that otherwise might be paying for or providing health services to low-income residents. Federal matching payments through Medicaid often allow states to partially finance the cost of services that states have traditionally provided at their expense or to pay for services that otherwise might be written off by providers as bad debt or charity care.

The terms on which federal Medicaid matching funds are available to states include five broad requirements related to eligibility: categorical, income, resources, immigration status and residency. In order to be eligible for Medicaid, an individual must meet all of these eligibility requirements.

The availability of federal matching funds for particular categories of individuals, however, does not necessarily mean that a state will cover these individuals since it must still contribute its own state revenue toward the cost of coverage.

Oklahoma Department of Human Services' Role in Eligibility

Each state sets an income limit within federal guidelines for Medicaid eligibility groups and determines what income counts towards that limit. Part of financial qualification for Medicaid is based upon the family size and relation of monthly income to the Federal Poverty Guidelines. According to Oklahoma State Statutes Title 63 Sec. 5009, the OHCA shall contract with the Oklahoma Department of Human Services (OKDHS) for the determination of Medicaid eligibility. This means that all applications for Oklahoma Medicaid enrollment are processed and approved or denied by OKDHS. Applications and renewals are reviewed by each county of residence OKDHS office for financial and/or medical requirements. After eligibility has been certified or extended, the records are sent to OHCA to coordinate medical services and process payments for services utilized.

Figure 2 2005 Federal Poverty Guidelines

Family Size	Annual (Monthly) Income			
	100%	133%	185%	200%
1	$9,310 ($776)	$12,382 ($1,032)	$17,224 ($1,435)	$18,620 ($1,552)
2	$12,490 ($1,041)	$16,612 ($1,384)	$23,107 ($1,926)	$24,980 ($2,082)
3	$15,670 ($1,306)	$20,841 ($1,737)	$28,990 ($2,416)	$31,340 ($2,612)
4	$18,850 ($1,571)	$25,071 ($2,089)	$34,873 ($2,906)	$37,700 ($3,142)
5	$22,030 ($1,836)	$29,300 ($2,442)	$40,756 ($3,396)	$44,060 ($3,672)
6	$25,210 ($2,101)	$33,529 ($2,794)	$46,639 ($3,887)	$50,420 ($4,202)
7	$28,390 ($2,366)	$37,759 ($3,147)	$52,522 ($4,377)	$56,780 ($4,732)
8	$31,570 ($2,631)	$41,988 ($3,499)	$58,405 ($4,867)	$63,140 ($5,262)

**For family units with more than eight members, add $3,180 for each additional member. Based on Federal Income Guidelines printed in the Federal Register, February 13, 2005*

Who is Eligible for Medicaid? (continued)

Nearly 1 in 5 Oklahomans Enrolled for Services

The state Medicaid program enrolled an unduplicated count of 696,743 individuals during SFY2005. On average, approximately 530,853 individuals were enrolled each month of the state fiscal year.

Figure 3 General Age Breakdown of Medicaid Enrollees

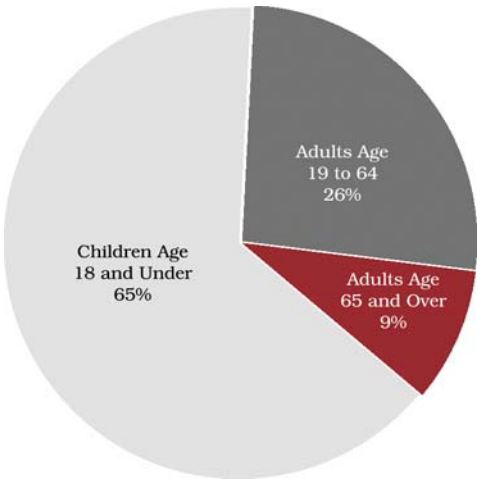
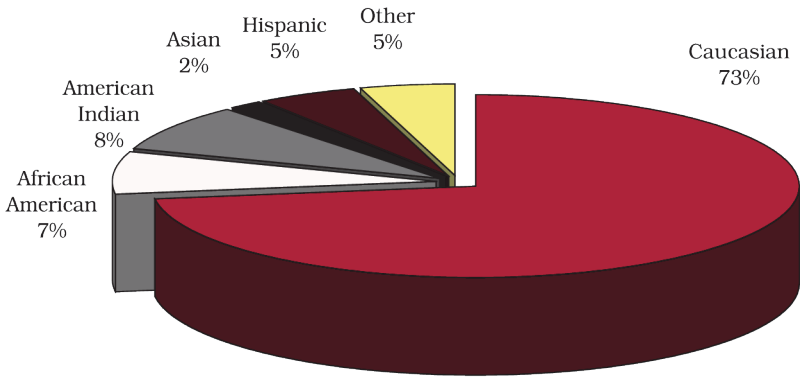


Figure 4 Medicaid Population by Race—1995 and 2005

Fiscal Year	Caucasian	African American	American Indian	Asian	Hispanic	Total
SFY1995	300,471	87,610	49,757	3,368	17,352	458,558
SFY2005	428,072	108,793	88,764	7,129	63,985	696,743
Percent Increase	42%	24%	78%	112%	269%	52%

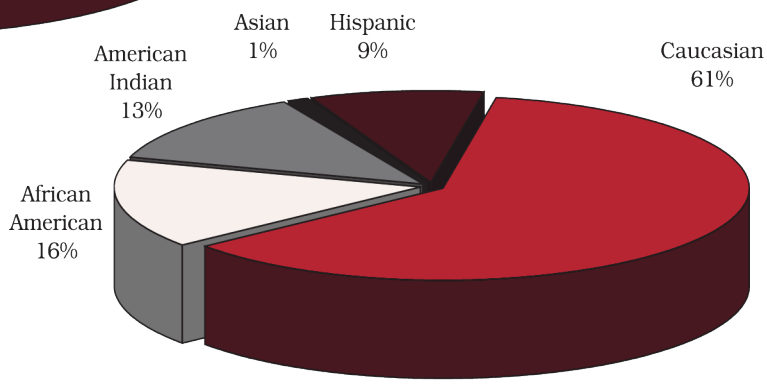
Figure 5 State and Medicaid Population by Race

State of Oklahoma 2003



Total Estimated Population 2003 - 3,428,390

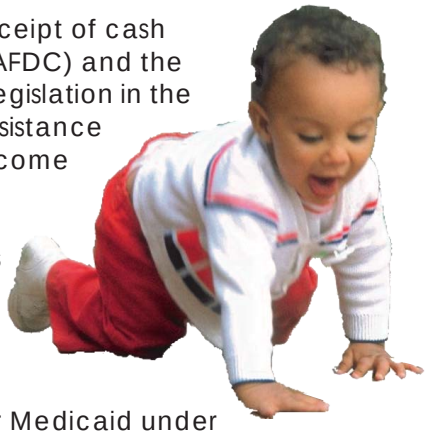
Oklahoma Medicaid Population SFY2005



Total Enrolled SFY2005 - 696,743

Oklahoma state totals based upon US Bureau of the Census Oklahoma State Data Center 2003 Population Estimates and Kaiser Commission, estimates based on pooled March 2002 and 2003 Current Population Surveys. Oklahoma Medicaid unduplicated are counts of enrolled individuals (not necessarily receiving services) based upon data extracted from beneficiary eligibility files on July 18, 2005. Race is self-reported by beneficiaries at the time of enrollment.

Medicaid Eligibility Trends

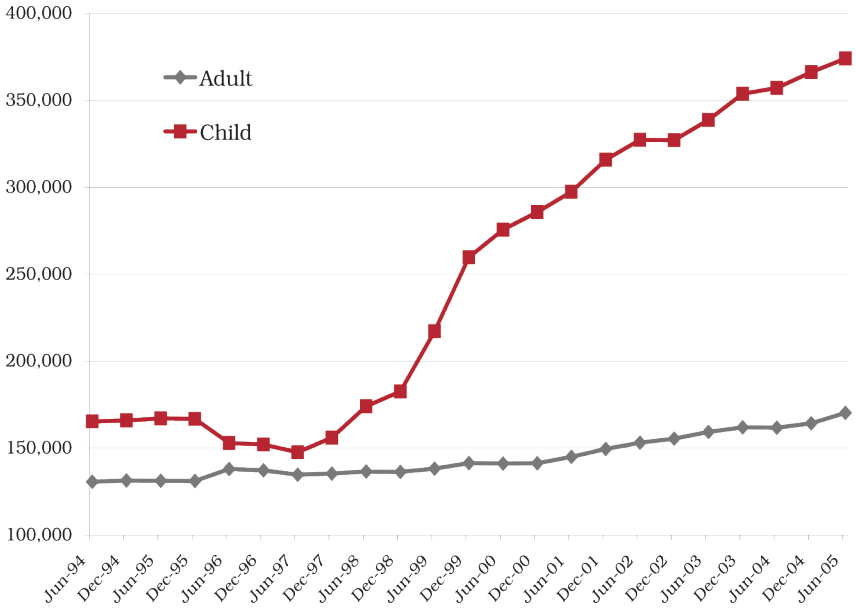


Medicaid eligibility has historically been linked to actual or potential receipt of cash assistance under the former Aid to Families with Dependent Children (AFDC) and the Supplemental Security Income (SSI) income maintenance programs. Legislation in the recent past, such as the 1996 replacement of AFDC with Temporary Assistance to Needy Families (TANF), has gradually expanded coverage to low-income pregnant women and children who have no ties to the welfare (cash assistance and food stamps) system. Additionally, partial coverage for new groups of low-income Medicare beneficiaries has been added as optional state programs. However, many low-income childless adults fall outside the program's eligibility categories and are precluded from coverage no matter how poor they are.

Parents and children. Most low-income women and children qualify for Medicaid under the TANF guidelines. In SFY2005, Oklahoma Medicaid covered roughly 472,000 low-income children under age 21 and just over 55,000 low-income adults in families with children, the vast majority of whom were women. Only 9 percent of the children enrolled in Medicaid received cash assistance. Preventive and acute primary care services make up the majority of Medicaid service needs for these beneficiaries.

Elderly. More than 64,450 adults 65 and over were covered by Medicaid in SFY2005. 36 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 Medicaid eligibility by incurring high medical or long term care expenses. In both cases, these elderly beneficiaries were covered for nursing home care and prescription drugs as well as other Medicaid services. Most of these beneficiaries are eligible within the Aged, Blind and Disabled (ABD) aid category.

Figure 6 Historic Enrollment by Adults, Age18 and Over, and Children, Under 18, June 1994—June 2005

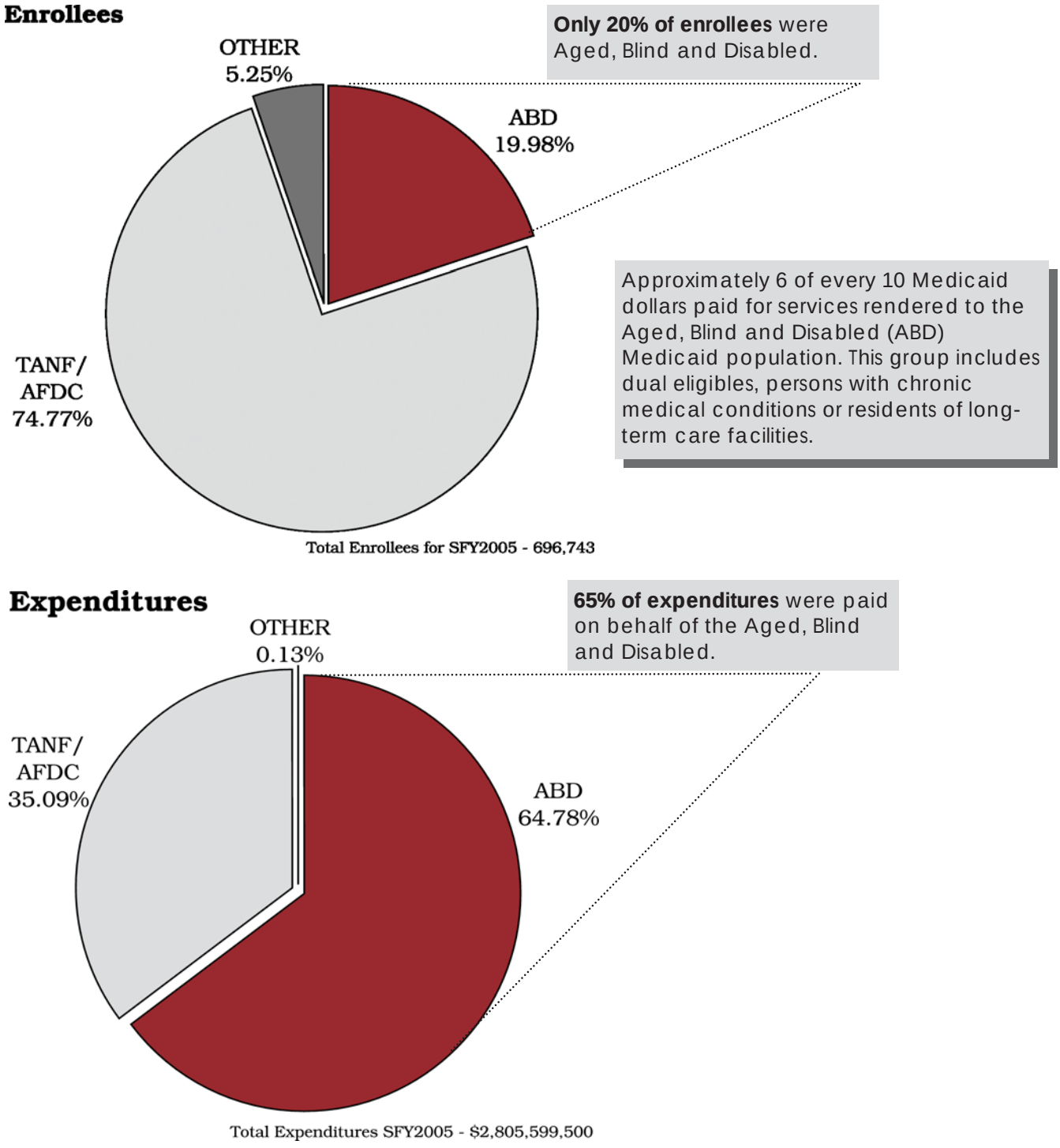


Disabled. Almost 20 percent (676,098 individuals) of the 2000 census survey respondents in Oklahoma reported some type of disability. In SFY2005, more than 75,000 Oklahomans with chronic conditions and disabilities received medical services through Medicaid. Almost 18 percent were enrolled because they received cash assistance through the SSI program. The remainder generally qualified by incurring large hospital, prescription drug, nursing home, or other medical or long-term care expenses to meet their "spend down" obligation. These beneficiaries are eligible under the Aged, Blind and Disabled (ABD) category.

Dual Eligibles. Some individuals are qualified for Medicaid and for 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 are eligible for some form of Medicaid benefit. Oklahoma Medicaid covered more than 80,000 dually eligible enrollees during SFY2005. These beneficiaries are accounted for under the Aged, Blind and Disabled (ABD) category.

Medicaid Eligibility Trends (continued)

Figure 7 Medicaid Enrollees and Expenditures by Aid Category (Unduplicated SFY2005)



OTHER category includes Family Planning and Breast and Cervical Cancer enrollees and expenditures.

Medicaid Eligibility Trends (continued)

Since 1995 the number of Oklahoma Medicaid beneficiaries receiving a medical service has increased 75 percent.

1995 served—393,496.558; 2005 served—687,451.

Total Oklahoma Medicaid enrollment has increased by 238,185 enrollees or 52 percent since 1995.

1995 enrollees—458.558; 2005 enrollees—696,743.

Figure 8 OHCA Highlights 1995—2005

Oklahoma Medicaid budget forcasted to reach $4B by 2000. HB1573 creates OHCA - July 1, 1994	Prior to 1995	Increasing Enrollment & Costs
***SoonerCare* Plus** (urban managed care) enrollment begins July 1st. Five managed care or-ganizations (MCOs) participating.	1995	Served 393,496 Cost $1.05B
Granted federal waiver to allow flexible program. ***SoonerCare* Choice** (rural managed care) begins October 1st.	1996	Served 396,219 Cost $1.02B
Expand eligibility for children and pregnant women to 185 percent of Federal Poverty Level (FPL).	1997	Served 407,249 Cost $1.21B
Hired 47 OKDHS outreach workers to increase child enrollment. Prepare to transition ABD population into managed care in 1999.	1998	Served 426,655 Cost $1.33B
ABD enrolled in managed care plans. ***SoonerRide*** implemented.	1999	Served 467,479 Cost $1.49B
Legislation increases provider rates, expands some benefits and establishes Quality of Care fee.	2000	Served 527,256 Cost $1.64B
Expand eligibility to include 18 year olds under 185 percent of FPL. Economy begins downturn.	2001	Served 579,508 Cost $2.00B
Heath Information Portability and Accountability Act (HIPAA) legislation enacted. Design & testing new MMIS.	2002	Served 609,954 Cost $2.37B
New MMIS system brought online. Secure internet claims processing available. One of remaining three MCOs drops out.	2003	Served 635,299 Cost $2.38B
SoonerCare goes statewide without MCOs. Adult pharmacy benefits and some provider rates increase.	2004	Served 669,102 Cost $2.64B
Breast & Cervical Cancer and Family Planning Waiver are implemented. Federal waiver sought for Premium Assistance progam.	2005	Served 687,451 Cost $2.80B

What Services Does Medicaid Cover?

Figure 9 Mandatory and Optional Medicaid Services

Federally Mandated Services

Early Periodic Screening, Diagnosis and Treatment (EPSDT) (Under age 21)
Family planning services & supplies
Inpatient Hospital
Laboratory & X-ray
Emergency transportation
Nurse midwife
Nurse practitioner
Nursing facility/home health (age 21+)
Outpatient hospital
Physician
Prenatal, delivery and postpartum care
Rural health clinic & federally qualified health center
Non-emergency transportation

State Optional Covered Services

Case management
Chiropractor
Clinic
Dental
Diagnostics
Emergency hospital
Inpatient hospital (age 65+) (institutions for mental disease)
Inpatient psychiatric under 21
Intermediate Care Facility for the Mentally Retarded (ICF/MR)
Nurse anesthetist
Nursing facility under 21
Occupational therapy
Optometrist
Personal care
Physical therapy
Podiatrist
Prescribed drugs
Preventive services
Private duty nursing
Prosthetic devices
Psychologist
Rehabilitative
Respiratory care
Speech/hearing/language disorders
Tuberculosis related

The above list is not all-inclusive and payment for these services depends upon many factors including eligibility, medical necessity, age, etc.

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

In Oklahoma, a prearranged fee (capitated payment) is paid to the ***SoonerCare*** Primary Care Provider/Case Manager (PCP/CM) monthly for primary and preventive care. Other services not included in the capitated benefit package are paid as fee-for-service. Under fee-for-service, payments are made directly to the providers once an allowable service has been provided and billed. Oklahoma Medicaid pays for covered services provided by an Oklahoma Medicaid contracted provider to an enrolled Oklahoma Medicaid beneficiary. Services may be limited by age, duration, coverage type and/or medical necessity. Providers participating in Medicaid must accept the Medicaid reimbursement level as payment in full. Each state has some discretion in determining (within federally-imposed upper limits and specific restrictions) the reimbursement methodology and resulting rate for services, with exceptions, such as for institutional services, in which payment may not exceed amounts that would be paid under Medicare payment rates.

How is Medicaid 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. Enhanced federal funding is 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 medical assistance percentage" (FMAP) is adjusted. States having lower per capita incomes receive a higher federal match. States must use their own or local tax dollars (called "matching dollars") to meet their share of Medicaid costs. In order to expand Medicaid services, a state must provide more of their own tax dollars to get more money from the federal government.

Figure 10 Historical Federal Medical Assistance Percentage (FMAP)

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

‡ *SCHIP: State Children's Health Insurance Program, see additional information on page 27. 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.*

Medicaid is the largest source of federal financial assistance in Oklahoma. Medicaid accounted for an estimated 40 percent of all federal funds flowing into Oklahoma. Federal payments for Medicaid exceeded those for highways, education, housing, Temporary Assistance to Needy Families (TANF), food stamps and child nutrition programs. Federal Medicaid dollars received for SFY2005 totaled over 1.9 billion dollars.

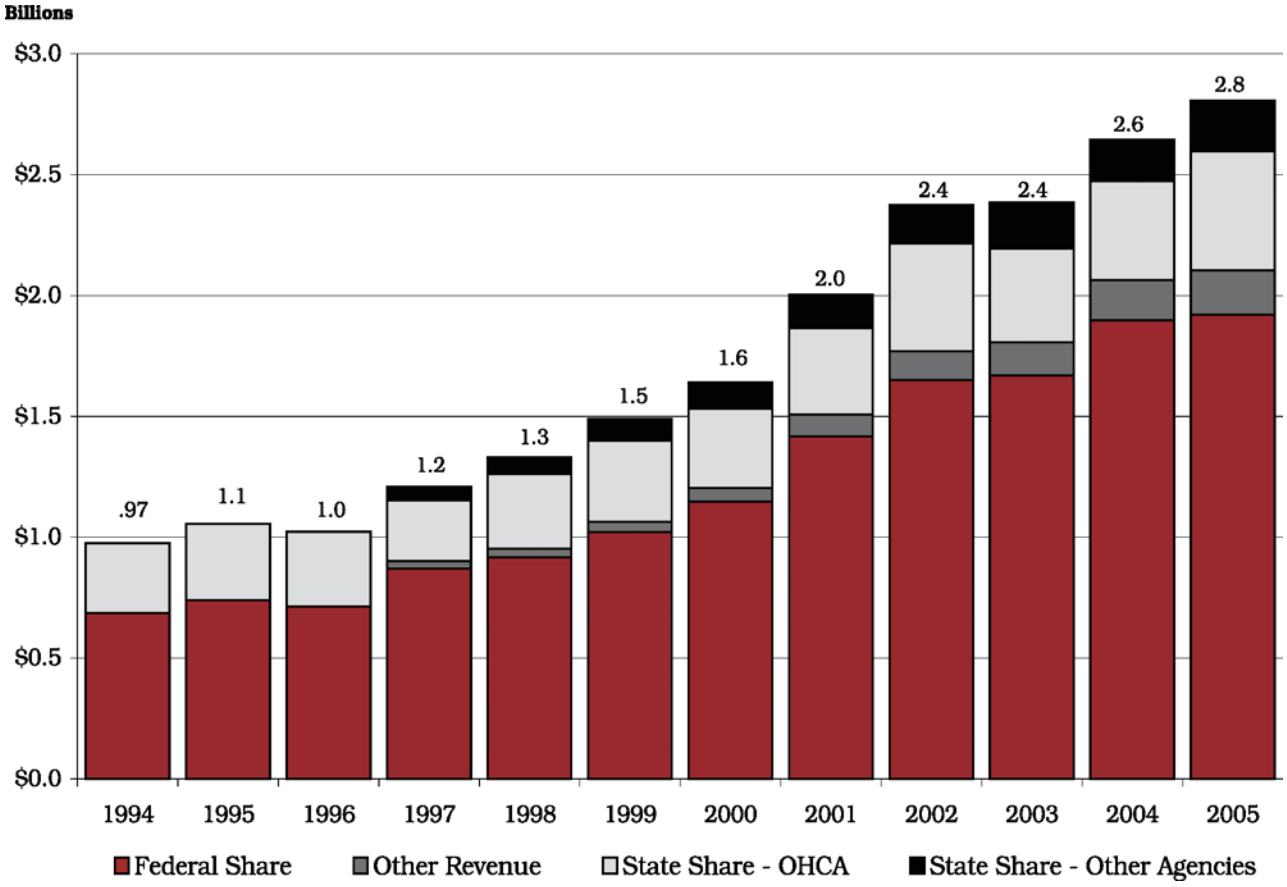
Figure 11 Condensed Summary of OHCA Revenues

Revenue Source	Actual Revenues
State Appropriations	$482,139,030
Federal Funds—OHCA	$1,453,143,803
Federal Funds for Other State Agencies	$496,179,518
Refunds from Other State Agencies	$216,371,264
Tobacco Tax Funds	$21,315,554
Drug Rebate	$97,945,103
Medical Refunds	$19,271,299
Quality of Care Fees	$55,651,586
Prior Year Carryover	$53,120,000
Other Revenue	$13,157,470
Total Revenue	**$2,908,294,627**

Source: OHCA Financial Services Division (August 2005).

How is Medicaid Financed? (continued)

Figure 12 Summary of Expenditures and Revenue Sources, Oklahoma Medicaid 1995—2005



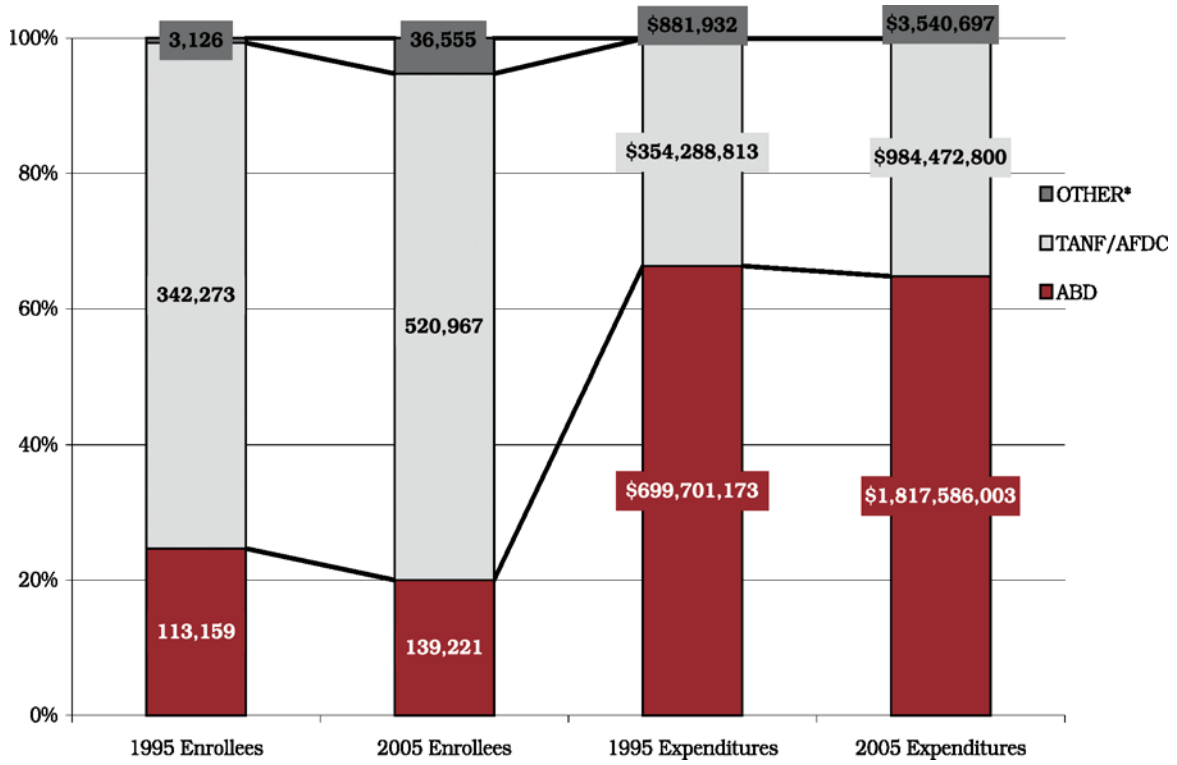
State Fiscal Year*	Total Expenditures	Federal Share	Other Revenue	State Share—OHCA	State Share—Other Agencies
1994	**$974,139,706**	$685,696,939		$288,442,767	
1995	**$1,054,871,918**	$738,937,779		$315,934,139	
1996	**$1,021,231,344**	$713,738,586		$307,492,758	
1997	**$1,207,875,885**	$869,474,048	$32,220,702	$250,131,050	$56,050,085
1998	**$1,328,847,600**	$917,107,356	$35,692,842	$308,012,119	$68,035,283
1999	**$1,487,064,240**	$1,021,093,307	$42,768,741	$335,408,642	$87,793,550
2000	**$1,639,609,396**	$1,147,484,713	$56,170,892	$328,705,610	$107,248,181
2001	**$2,002,335,338**	$1,416,570,113	$90,213,424	$358,174,870	$137,376,931
2002	**$2,372,098,884**	$1,649,376,278	$119,799,311	$445,842,697	$157,080,598
2003	**$2,384,136,980**	$1,669,197,685	$136,781,999	$388,181,072	$189,976,224
2004	**$2,642,481,484**	$1,897,667,825	$166,596,539	$408,889,974	$169,327,146
2005	**$2,805,599,500**	$1,920,731,328	$183,584,054	$492,641,139	$208,642,979

*Source: **1994-1996** Annual National Association of State Budget Officers (NASBO) Survey as prepared by OHCA Financial Services Division. Breakdown of state revenue sources not available for 1994 through 1996. **1997-2005** OHCA Financial Report; federal share from CMS 64.9.*

**1994 through 1996 figures are based on federal fiscal year (October through September). 1997 through 2005 figures are based on state fiscal year (July through June).*

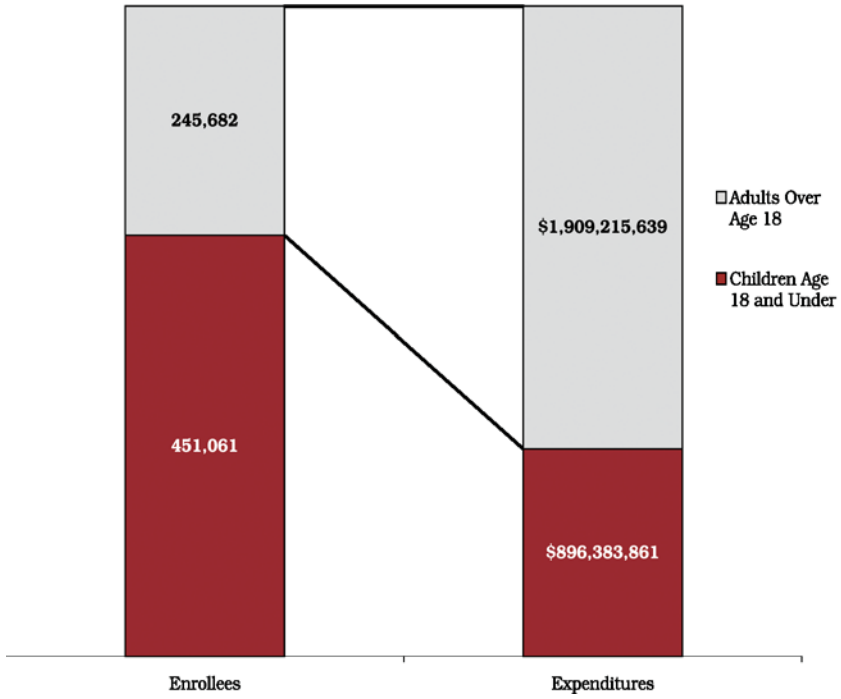
Where are the Medicaid Dollars Going?

Figure 13 Oklahoma Medicaid Enrollees and Expenditures by Aid Category—FFY1995 & SFY2005



OTHER includes—Child Custody, Refuge, SLMB, DDSD Supported Living and TB beneficiaries. SFY1995 includes the Medically Needy and SFY2005 includes Breast and Cervical Cancer and Family Planning beneficiaries.

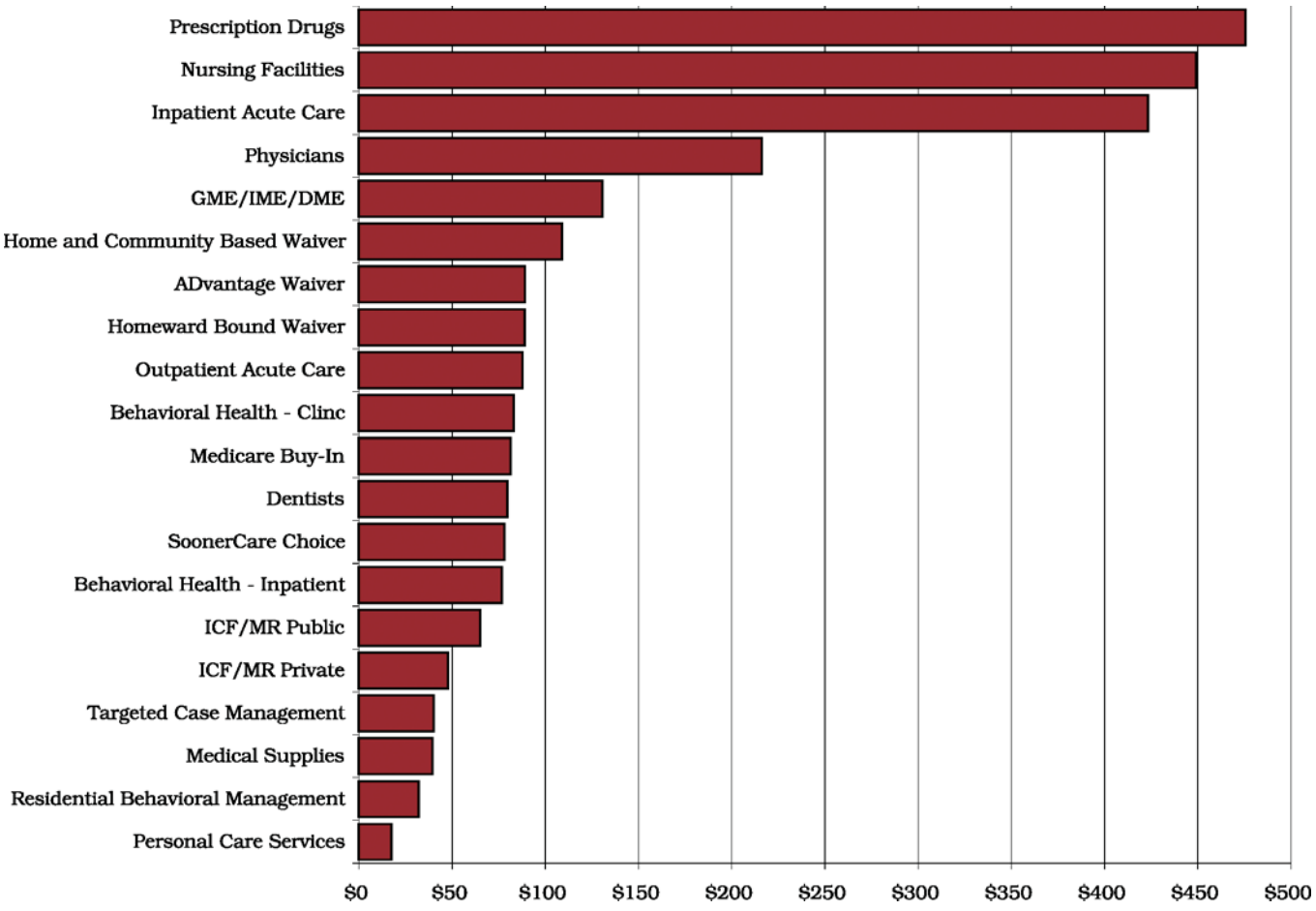
Figure 14 Oklahoma Medicaid Enrollees and Expenditures by Age–SFY2005



Source: Finance Division, 10/26/2005.

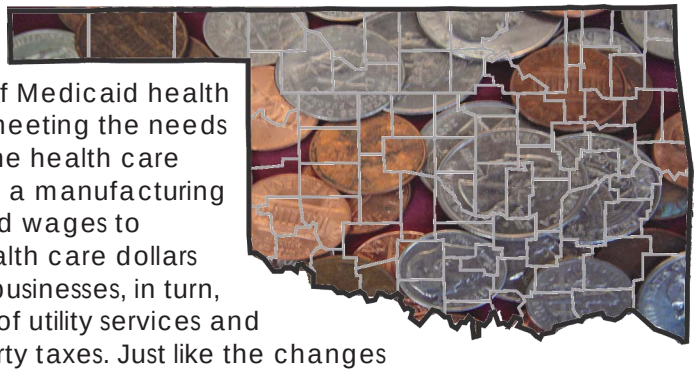
Where are the Medicaid Dollars Going? (continued)

Figure 15 Top 20 OHCA Expenditures—SFY2005



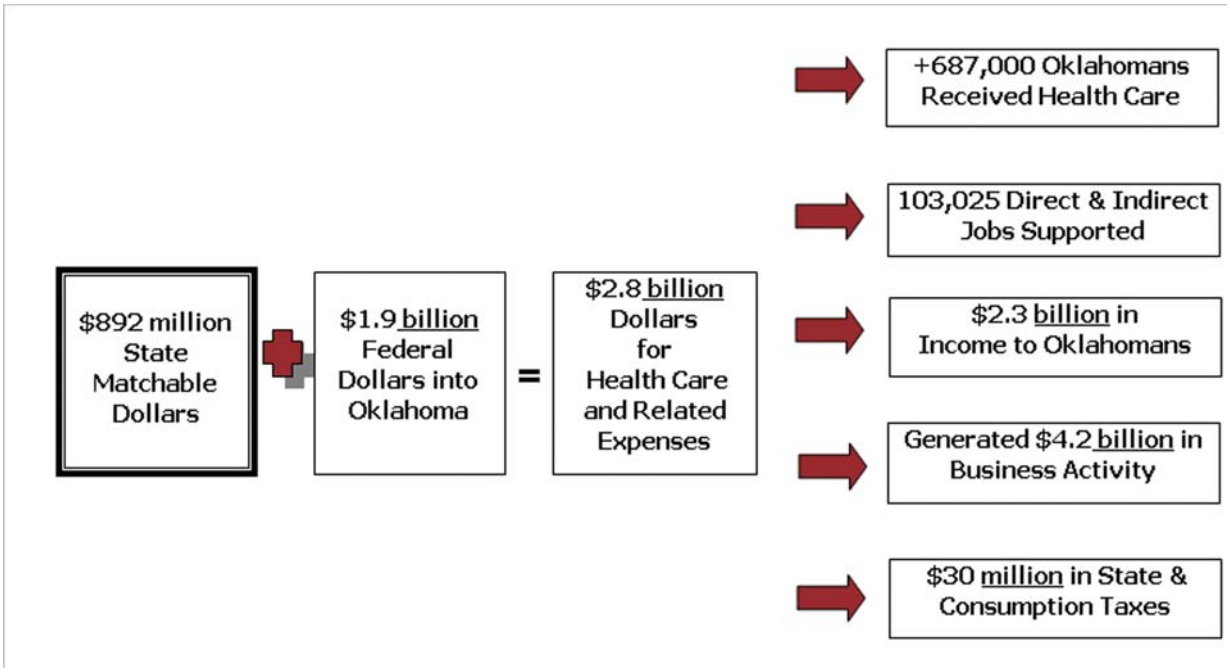
For detailed expenditure figures go to Appendix B on page 59.

Medicaid and the Economy



Health care services are a substantial economic presence in Oklahoma. Most people do not think of Medicaid health care services beyond the critical role they play in meeting the needs of the vulnerable and underserved Oklahomans. The health care sector affects the economy in much the same way a manufacturing plant does by bringing in money, providing jobs and wages to residents and providing an opportunity to keep health care dollars circulating within the state economy. Health care businesses, in turn, have an additional impact through the purchases of utility services and cleaning supplies, as well as the payment of property taxes. Just like the changes in a manufacturing plant or farm operation, changes in the health care sector influence the rest of the Oklahoma economy.

Figure 16 Estimated Direct and Indirect Impact of Oklahoma Medicaid Dollars



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

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

Oklahoma's Uninsured

Based upon a recent report from the State Health Access Data Assistance Center (SHADAC) 17 percent of Oklahomans were uninsured during the 2004 survey; the national uninsured rate was 16 percent. Further broken down, 13 percent of children under the age of 18 and 23 percent of Oklahomans between the ages of 18 and 63 were uninsured during the 2004 survey period.

Americans who lack health insurance when approaching retirement age are 43 percent more likely to die prematurely than their peers who have insurance.

Health Affairs, July 2004

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

The lack of health care coverage has significant impacts on the health of children. Health insurance helps assure access to appropriate health services that can monitor a child's cognitive, physical and emotional development. However, for low-income families who cannot afford health insurance, access to care on an ongoing basis is often out of reach. Frequently, the only medical attention their children receive comes from crowded emergency rooms for non-emergent care.

Children without health care coverage have substantially less access to health care services, including preventive care that ensures childhood immunizations are up to date, vision and hearing screening and routine dental care have been provided. Care for uninsured children is also 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. Making sure that children stay healthy is an important goal for all segments of society.

Also, 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 threaten their work productivity and job retention.

Economic Impact of Lack of Health Care Coverage

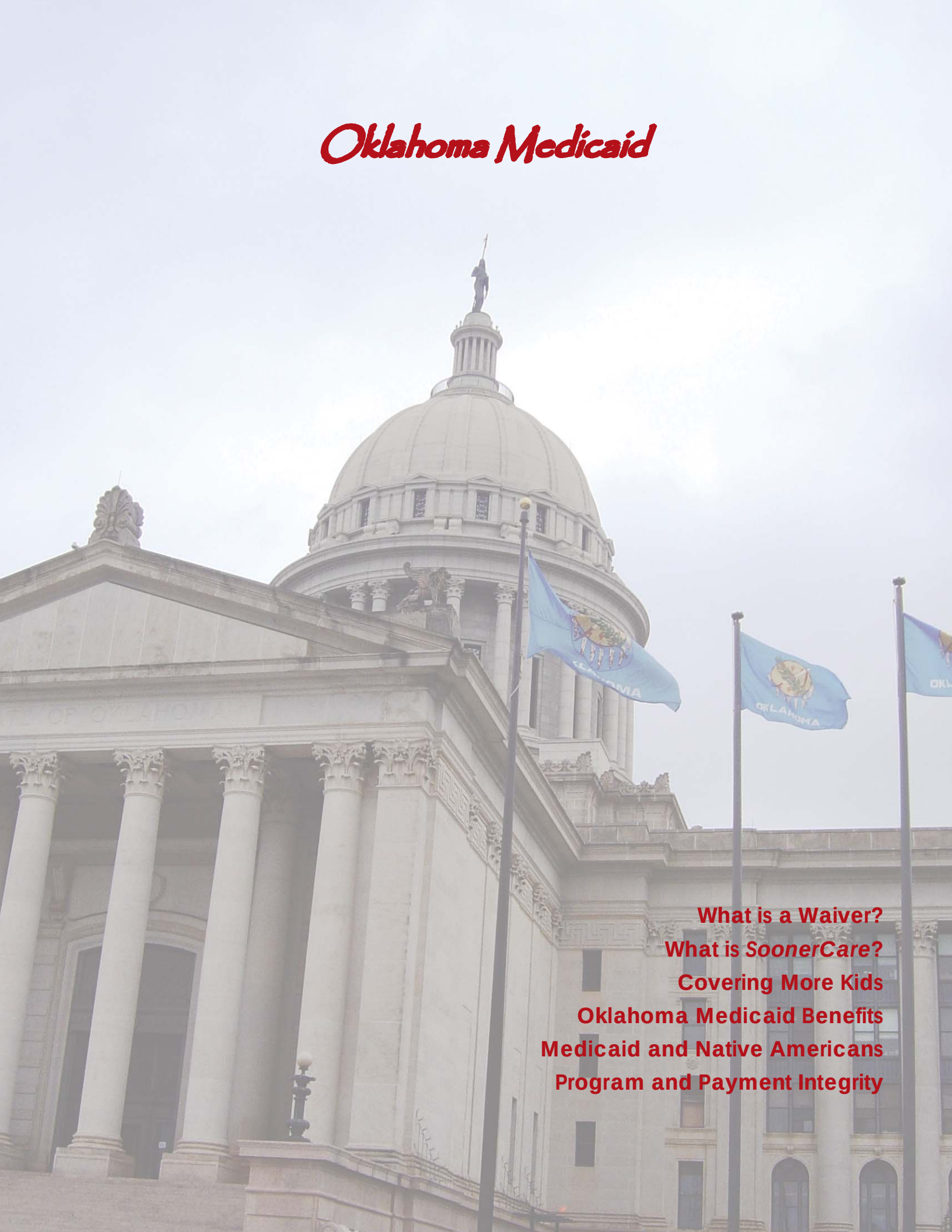
In spite of access problems and barriers the uninsured face in getting health care, they do receive *some* health care. Studies indicate that, on average, uninsured individuals pay for less than half of their health care costs. Obviously, others then are stepping in to pick up the tab.

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

In 2005, Oklahoma health insurance premiums for a family with private, employer-sponsored coverage are $1,781 higher due to the unpaid cost of health care for the uninsured. Premiums for individual health insurance coverage in Oklahoma are $680 higher.

Families USA, "Paying a Premium: The Added Cost of Care for the Uninsured" publication No. 05-101, 2005

Oklahoma Medicaid



What is a Waiver?

What is *SoonerCare*?

Covering More Kids

Oklahoma Medicaid Benefits

Medicaid and Native Americans

Program and Payment Integrity

What is a Waiver?

State Medicaid waivers are granted by the federal Centers for Medicare and Medicaid Services (CMS). The federal government allows states to request waivers to specifically "waive" certain federal requirements of the program. Waivers generally must be "budget neutral" to the federal government (that is, federal spending under a waiver cannot exceed what federal spending would have been without a waiver). Waivers typically are requested and given to allow for research and demonstration efforts that test innovative approaches to benefits, services, eligibility, program payments and service delivery. As such, they entail a lengthy federal review process and include extensive evaluation components. Waivers are usually granted for five years, although they may be renewed at CMS's option. Section 1115(a) demonstrations allow states to test new approaches aimed at saving money to allow states to extend Medicaid coverage to additional low-income and uninsured people. Oklahoma operates under a Section 1115(a) Demonstration and Research waiver to give the state flexibility in the design of its managed care delivery system—***SoonerCare***.

Family Planning Waiver

According to the 2002 Pregnancy Risk Assessment Monitoring System (PRAMS) data 51.5 percent of babies born to mothers in Oklahoma were unintended at the time of conception. In an effort to reduce unintended pregnancies, Oklahoma received CMS approval for the Family Planning Waiver. ***SoonerPlan*** provides family planning services and contraceptive products to traditionally ineligible women and men over age 19. Traditional Medicaid offers family planning services, but not all Oklahomans who are in need of these services are eligible for the full scope of Title XIX (Medicaid) benefits. ***SoonerPlan*** permits the state to extend Medicaid eligibility to a larger segment of the population that fall within the eligibility guidelines and are not otherwise eligible for Medicaid. ***SoonerPlan*** went into effect April 1, 2005 through the collaborative efforts of the Oklahoma Department of Human Services (OKDHS), Oklahoma State Department of Health (OSDH) and Oklahoma Health Care Authority (OHCA).

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 Medicaid-eligible individuals in institutions—long-term care hospitals, nursing facilities (NF) or intermediate care facilities for persons with mental retardation (ICFs/MR). The HCBS waiver program, authorized under §1915(c) of the Social Security Act, recognizes that many individuals at risk of being institutionalized can be cared for in a community-based setting, preserving their independence and ties to family and friends at a cost no higher than that of comparable institutional care.

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

- Community Waiver: Serves approximately 2,500 beneficiaries with mental retardation (MR) and certain persons with "related conditions" qualifyed for placement in an ICF/MR . This waiver covers children and adults, with the minimum age being 3 years old.
- ADvantage Waiver: Serves the "frail elderly" (Oklahomans age 65 years and older) and adults 21 years of age or older with physical disabilities who would otherwise qualify for placement in a nursing facility. Approximately 15,700 persons receive services through this waiver.

What is a Waiver? (continued)

Home and Community-Based Services (HCBS) Waivers (continued)

- Homeward Bound Waiver: Designed to serve the needs of individuals with MR or "related conditions" who are also members of the Plaintiff Class in *Homeward Bound et al. v. The Hissom Memorial Center, et al.* who would otherwise qualify for placement in an ICF/MR. This waiver covers just over 800 individuals.
- In-Home Supports Waiver for Adults: Designed to assist the state in removing adult individuals (ages 18 years of age and older) with mental retardation from a waiting list for waiver services. This waiver serves approximately 900 adults who would otherwise qualify for placement in an ICF/MR.
- In-Home Supports Waiver for Children: Designed to assist the state in removing children ages 3 through 17 years with mental retardation from a waiting list for waiver services. This waiver serves approximately 480 children who would otherwise qualify for placement in an ICF/MR.

Services through these waiver programs are available to individuals when the qualified beneficiary 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 beneficiary slots available. Individual waiver documents specify beneficiary eligibility criteria, any post-eligibility criteria, as applicable, as well as the waiver-specific services available.

SFY2005 Specific Information…

Waiver Expenditure Totals:

- ADvantage—$99,145,503
- Community—$109,743,259
- Homeward Bound—$89,769,111
- In-Home Supports—$12,726,145

For more waiver expenditure details go to Appendix B on page 72.

Depending on each person's needs as identified in their individual Plan of Care or Individual Habilitation Plan and the specific waiver they are enrolled under, services 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;
- architectural (environmental) modifications;
- habilitation services;
- vocational and pre-vocational services;
- adaptive equipment;
- supported employment;
- dental;
- transportation; and
- various therapies.

What is SoonerCare?

SoonerCare is a Primary Care Case Management (PCCM) program in which the state contracts directly with primary care providers to provide basic health care services. The ***SoonerCare*** program is partially capitated, in that providers are paid a monthly capitated rate for a fixed set of services with noncapitated services remaining compensable on a fee-for-service basis. Persons enrolled in Oklahoma Medicaid who are institutionalized, dual eligibles, in state or tribal custody or enrolled under a Home and Community-Based Waiver are *not* included in the ***SoonerCare*** program at this time.

Beneficiaries enrolled in ***SoonerCare*** are not "locked in" with a primary care provider/case manager (PCP/CM) and can change health care providers up to four times per year. This important facet to the program allows ***SoonerCare*** beneficiaries the opportunity to select a provider that has been added to the program. Providers contracting in this program include physicians, nurse practitioners and physician assistants.

To coordinate care for ***SoonerCare*** members with complex medical needs, OHCA employs nurse exceptional needs coordinators (ENCs) who support the Oklahoma Medicaid provider networks in both the ***SoonerCare*** program and fee-for-service areas through research, collaboration and problem resolution as related to members' access to care.

Oklahoma specifies a target EPSDT screen compliance rate each year. The calendar year 2004 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 the 983 providers evaluated, 243 received a bonus for a total payout of $419,723.

SFY2005 Specific Information…

Aged, Blind and Disabled (ABD)	Member Months	Capitation Payments
ABD Adults	344,112	$8,554,843
ABD Children	128,869	$3,047,030
IHS ABD Adults	5,307	$15,921
IHS ABD Children	2,007	$6,021
TOTAL	480,295	$11,623,814

Temporary Assistance to Needy Families (TANF)	Member Months	Capitation Payments
Poverty Related Adults	421,884	$9,505,991
Poverty Related Children	3,460,868	$59,469,919
IHS/Poverty Related Adults	7,042	$14,084
IHS/Poverty Related Children	60,058	$128,475
TOTAL	3,949,852	$69,118,469

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.

SFY2005 Specific Information…

Estimated total payments to be made to GME qualified colleges of medicine:

University of Oklahoma–OKC	$ 24,251,571
University of Oklahoma–Tulsa	$ 17,360,405
Oklahoma State University College of Osteopathic Medicine–Tulsa	$ 9,600,005

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

Covering More Kids—Title XIX Expansion and the State Children's Health Insurance Program (SCHIP)

First Came the Title XIX Expansion…

Recognizing the growing concern for the health and welfare of Oklahoma's children, the Legislature took action in 1997 by passing a Title XIX expansion. This legislation raised the eligibility level to 185 percent of the federal poverty level for children. The expansion includes children 18 and under as well as pregnant women regardless of age. The Title XIX expansion also includes these qualifying individuals even if they have other types of insurance coverage (third party liabilities).

And Then Came SCHIP…

Subsequently, the Federal Budget Act of 1997 made numerous Medicaid changes one which created the State Children's Health Insurance Program (SCHIP). The optional program, referred to as SCHIP or Title XXI, is designed to help states cover additional uninsured low-income children with a higher federal match assistance percentage (See Figure 10 Historical Federal Medical Assistance Percentage, Page 16).

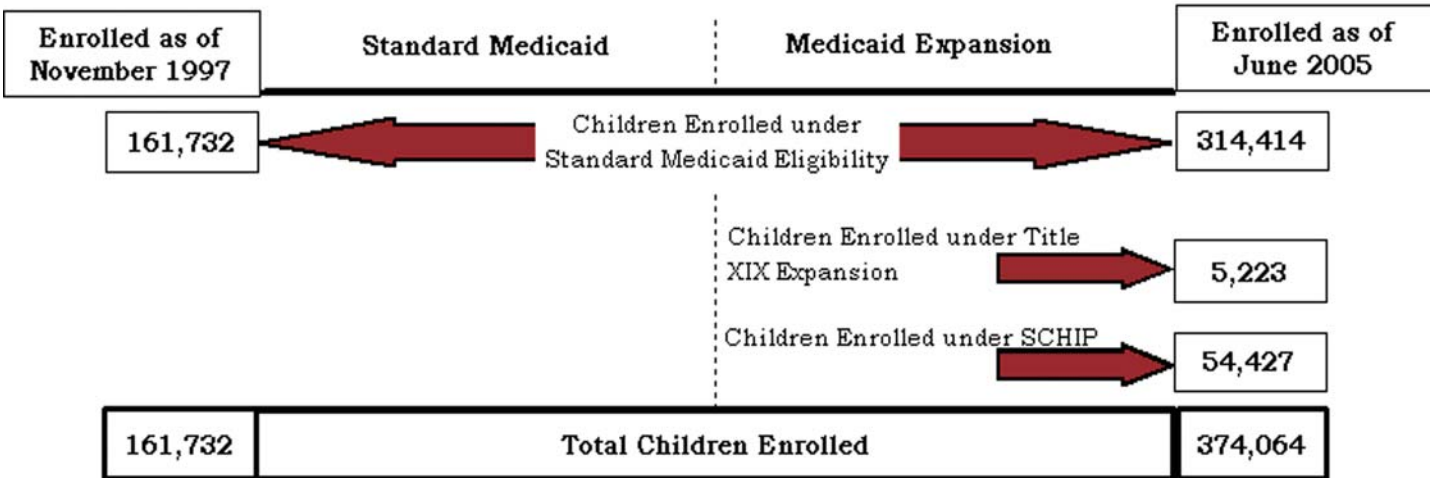
Since the implementation of the Medicaid eligibility expansion programs in 1997, the number of children enrolled in Oklahoma Medicaid has increased 131 percent.

Oklahoma SCHIP defines eligibility for "targeted low-income children" as children who meet all of the following criteria:

- family income below 185 percent of federal poverty (FPL) guidelines;
- under age 19; and
- not eligible for Medicaid under eligibility criteria in effect prior to November 1997 or any other federal health insurance program. Uninsured children who meet previous eligibility standards must be enrolled in Medicaid, not SCHIP.

With the implementation of Title XIX expansion and Title XXI (SCHIP), coupled with an aggressive outreach program, Oklahoma experienced a significant increase in the number of children covered by Medicaid. The collaborative outreach initiative provided an opportunity to reach not only newly eligible children in the expansion, but also those who had previously been eligible under the Medicaid eligibility standards prior to 1997.

Figure 17 Increased Enrollment of Children Since Implementing Expansion Programs



Oklahoma Medicaid Benefits

Behavioral Health Services

Medicaid becomes the behavioral health treatment lifeline for many Oklahomans with a serious mental illness or an emotional disturbance and/or alcohol and other drug disorders. Many people with these conditions either lose or are unable to obtain or afford private coverage. Mental health, alcohol and other drug disorder treatment benefits for those enrolled in Oklahoma Medicaid include inpatient acute care, crisis stabilization and emergency care, alcohol or other drug medical detoxification, residential treatment (children only), psychiatric outpatient services (including pharmacological services), individual/family/group psychotherapy, and psychosocial rehabilitative services.

SFY2005 Specific Information…

- Children under 21 accounted for 62 percent of the beneficiaries receiving behavioral health services and 60 percent of the expenditures.

OHCA is working in partnership with several other state agencies as well as state advocacy organizations and consumers to improve the behavioral health system of care in Oklahoma. One collaborative effort is the Partnership for Children's Behavioral Health. Another effort is a program for adults that will enhance the efficient use of monetary and human resources as well as increasing consumer participation and choice. A third collaborative effort is the development of the infrastructure needed to support an integrated system of care for all children and adults with mental health and/or alcohol or other drug disorders. It is hoped that through these multi-agency efforts, an improved array of evidence-based outpatient care can be developed for individuals who need treatment for severe mental illnesses, emotional disturbances, and/or alcohol and other drug disorders.

Dental

Oral health is a key component of an overall healthy and happy lifestyle. The earlier in life that children are put on the "right dental track" the better their chances of keeping their own teeth for the rest of their lives. The greatest challenge is prevention. Teaching parents to focus early on dental intervention and treatment is crucial. Dental services are federally mandated for children under 21 years of age through Early and Periodic Screening, Diagnosis and Treatment (EPSDT). This program covers all areas of dentistry for children, including orthodontia, based on medical necessity. Currently, adults age 21 and over are covered for emergency extractions only.

SFY2005 Specific Information…

- 179,261 children received dental services and accounted for 93 percent of the dental expenditures during SFY2005.
- Oklahoma Medicaid contracted with 550 dental providers in SFY2005.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Child Health Screens include:

- physicals;
- eye and hearing exams;
- dental exams;
- immunizations;
- nutritional review;
- lab tests; and
- anticipatory guidance.

Children are the largest number of enrollees in the Medicaid program with approximately 450,000 in SFY2005. That means more than 40 percent of all of Oklahoma's children have been enrolled in the Medicaid program at some point during the year. All children need basic preventive and early intervention healthcare in order to make sure we optimize their capacity to grow, learn and develop.

The federally mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) package is a set of comprehensive health services for children up to age 21. EPSDT is designed to ensure all Medicaid children receive regular health screenings in order to check for early signs of disorders or disease and obtain necessary follow up treatments or services. EPSDT provides immunizations and educates parents on safety, nutrition and child development.

Oklahoma Medicaid Benefits (continued)

Hospitals

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. Local hospitals serve as the cornerstone for a network of care providers that include such economic staples as primary care physicians, specialists and dieticians, etc.

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.

SFY2005 Specific Information…

Payments made to IME qualified hospitals:

Oklahoma Medical Center–OKC	$ 12,068,042
Hillcrest Health Systems–Tulsa	$ 12,068,042

Disproportionate Share Hospital (DSH) Payments

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

Disproportionate Share Hospitals	FFY2005
Arbuckle Memorial Hospital	$96
Arkansas Children's Hospital	$457,494
Atoka County Healthcare Authority	$162
Carl Albert Community Mental Health Center	$294,456
Griffin Memorial Hospital	$1,570,463
Haskell County Hospital	$2,316
Integris Bass Memorial Baptist Hospital	$17,109
J.D. McCarty Center	$1,501,137
Jim Taliaferro Community Mental Health Center	$310,246
Logan Hospital and Medical Center	$232
NW Center for Behavioral Health	$559,710
Oklahoma Youth Center	$186,895
OU Medical Center	$25,546,749
Parkside, Inc.	$351,476
Sequoyah Memorial Hospital	$1,132
St. Anthony Hospital	$338,177
TOTAL	$31,137,850

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

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

Oklahoma Medicaid Benefits (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 the state of 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 Medicaid services; and
- belong to the Council of Teaching Hospitals or show proof of affiliation with an approved Medical Education Program.

SFY2005 Specific Information…

- Hospital expenditures, $510,906,866 accounted for 18 percent of OHCA's total Medicaid expenditures.
- Oklahoma Medicaid hospital expenditures have increased 40 percent since FY1995. Nationwide, there has been a 70 percent increase in hospital expenditures.

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

DME Qualified Hospitals	SFY2005
Baptist Medical Center	$4,257,103
Bass Baptist Health Care Center	$11,363
Bone and Joint Hospital – OKC	$8,351
Comanche County Memorial Hospital	$65,798
Deaconess Hospital	$145,886
Hillcrest Medical Center – Tulsa	$6,971,424
Jackson County Memorial	$2,297
Jane Phillips Hospital	$12,414
Laureate Psych Hospital	$9,593
Medical Center of Southeastern Oklahoma	$110,432
OU Medical Center	$29,463,192
Saint Francis – Tulsa	$2,707,224
Shadow Mountain/Brown Schools Hospital	$43,632
Southwest Medical Center	$449,213
St. Anthony	$2,761,867
St. John – Tulsa	$2,658,073
Tulsa Regional Medical	$5,881,583
TOTAL	$ 55,559,445

Oklahoma Medicaid Benefits (continued)

Long-Term Care

With long-term care coverage largely unavailable through Medicare or traditional private health insurance plans, Medicaid is the nation's de facto financing system. Nationwide, almost 50 percent of all nursing home care in 2003 was paid for by Medicaid. In Oklahoma, Medicaid funds nearly 75 percent of all nursing home care. Medicaid provides coverage for poor persons and many middle-income individuals who have become impoverished by "spending down" their assets in order for Medicaid to cover the high costs of their long-term care.

Quality of Care

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

Statewide in 2005 , Oklahoma nursing facilities had a 65 percent occupancy rate.

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

Level of Care Evaluations – Long-Term Care Beneficiaries

In order to ensure that 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 persons, private pay and Medicaid, entering a long-term care facility. Furthermore, federal requirements also require that 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 insures that the beneficiary requires a long-term care facility and receives proper treatment for their MI and/or MR diagnosis.

SFY2005 Specific Information…

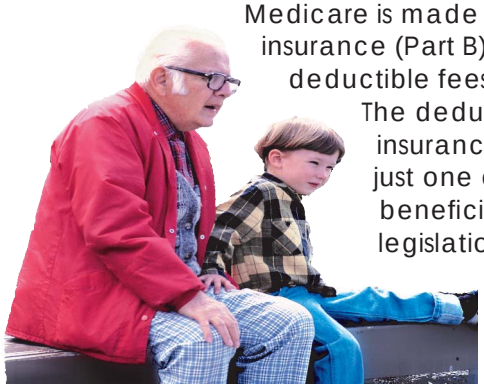
- Medicaid funded 5,428,026 nursing facility bed days for SFY2005; this represents 75 percent of the total actual nursing facility occupied bed days in the state.
- Total Quality of Care Program revenues were $56,181,701 and the state share of the total $193,714,649 Quality of Care expenditures was $58,048,239.

Facility Type	Unduplicated Beneficiaries	Bed Days	Reimbursement	Yearly Average Per Person	Average Per Day
Nursing Facilities	22,705	5,428,026	$448,467,167	$19,751.91	$82.62
ICFs/MR (Private)	1,545	475,226	$48,062,192	$31,108.21	$101.14
ICFs/MR (Public)	442	151,067	$65,028,850	$147,124.10	$430.46

ICFs/MR = Intermediate Care Facilities for the Mentally Retarded. Average Per Person figures do not include the patient liability that the beneficiary pays to the facility (average $20/day).

Oklahoma Medicaid Benefits (continued)

Medicare "Buy-In" Program



Medicare is made up of two parts, hospital insurance (Part A) and supplementary medical insurance (Part B). For hospital insurance expenses, Medicaid pays the coinsurance and deductible fees for hospital services and skilled nursing services for enrolled persons. The deductible and coinsurance fees are also paid for supplementary medical insurance expenses that are primarily physician services. This "buy-in" program is just one of many that Congress enacted to help protect low-income Medicare beneficiaries from the program's cost-sharing requirements. Subsequent legislation was passed to cover individuals eligible for both Medicare and Medicaid coverage with slightly higher income levels.

Individuals covered by both Medicare and Medicaid are collectively known as the dual eligible populations, or "dual eligibles".

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

Qualified Medicare Beneficiary (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 beneficiaries who are not otherwise eligible for Medicaid.

SFY2005 Specific Information…

- "Buy-In" expenditures totaled $81,269,288 for SFY2005.
- An average of 3,070 Part A premiums and 72,810 Part B premiums were paid each month.

Oklahoma Medicaid Benefits (continued)

Pharmacy Program

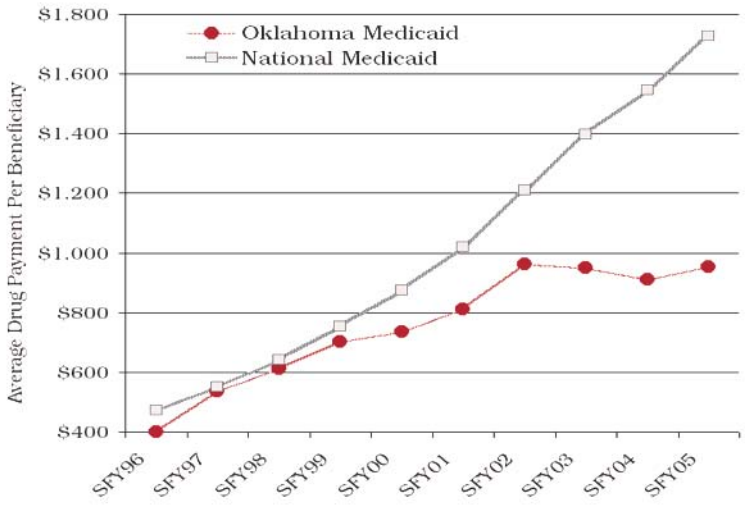
The value of prescription medications in modern health care is well documented. Because of its value, prescription medications are covered by every state's Medicaid program in spite of the fact that it is an optional benefit under federal law. It is almost impossible to imagine a health care benefit system in which medication therapies did not play a significant role.

The pharmacy benefit is accessed by 60 percent of enrolled individuals making it one of the most commonly utilized benefits in the Oklahoma Medicaid program. The cost of the pharmacy program represents one of every five dollars spent for services. In order to provide the most comprehensive benefit possible, the OHCA has formed partnerships with several organizations. One partnership is between OHCA, the Department of Mental Health and Substance Abuse and drug manufacturer, Eli Lilly. The goal is to educate physicians about drugs used to treat behavioral health issues and to provide information about their patient's total prescription utilization. The program, SoonerPSYCH (Prescription Solutions for Your Cognitive Health) is contracted to Comprehensive NeuroScience, Inc. and funded entirely by Eli Lilly.

To maintain quality of service, the agency contracts with Pharmacy Management Consultants at the University of Oklahoma College of Pharmacy to process medication prior authorization requests and staff a help desk for beneficiaries and providers. OHCA is also developing chronic disease management programs that include self-monitoring and patient education as ways to increase beneficiary involvement in and responsibility for their health status. Diabetes, asthma, smoking cessation and hypertension are all disease states which can be improved through patient education.

As required by both federal and state law, to enhance and improve the quality of pharmaceutical care and patient outcomes by encouraging optimal medication, OHCA has a Drug Utilization Review (DUR) Board. The DUR Board works to monitor medication therapies and to advise the OHCA on program policies to achieve appropriate use of pharmaceuticals for Oklahoma Medicaid beneficiaries.

Figure 18 Oklahoma and National Medicaid Average Drug Expenditure per Beneficiary SFY1996—SFY2005



SFY2005 Specific Information…

- Prescription drug program expenditures accounted for $475,606,181 or 17 percent of the total OHCA expenditures.
- The average cost per prescription funded by Medicaid was $65.85 and the average monthly prescription cost per patient funded by Medicaid was $211.73.
- $97.9 million dollars were collected through the Drug Rebate program. For more Pharmacy related cost savings information see pages 39 and 40.

Oklahoma Medicaid Benefits (continued)

Physicians and Other Practitioners

Physicians and other practitioners are a crucial component in the delivery of health care to Oklahoma's Medicaid enrollees. The Medicaid program would not be possible without the dedication of these providers who are committed to care for all individuals who need health care but cannot afford it on their own. Primary Care Physicians (PCPs) act as Oklahoma Medicaid's "front line".

This service to beneficiaries, as with all other Medicaid programs, is based on medical necessity, with physicians determining the need for medical care. Physicians provide patients education and coordinate their health care needs. Oklahoma should be proud of the health care professionals from many different and important fields participating in the state Medicaid program.

Crucial services provided by Physicians and Other Practitioners may include, but are not limited to:

- Prenatal care;
- Delivery;
- Postpartum care;
- Preventive care;
- Routine check-ups;
- Diagnostic services; and
- EPSDT screens.

SFY2005 Specific Information…

- In addition to various other provider types, OHCA contracts with more than 2,400 General Practitioners and just over 1,400 General Pediatricians.

School Based Services

Health care is a vital foundation for families wanting to ensure their children are ready to learn at school. We know that 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 focuses an outreach initiative in places, such as schools, where we know we can find low-income uninsured children. Parents rely on school systems to communicate important information about their children. This line of communication allows schools to become our partners in identifying and enrolling eligible children as well as contracting with OHCA to provide services by qualified health care professionals. Child Health Services staff conduct provider trainings, provide ongoing support services and oversight to the more than two hundred contracted school systems.

One of the greatest challenges to the success of the programs and the prevention and detection of childhood illnesses is reaching children early and informing families about available comprehensive health services, such as Early Periodic Screening, Diagnosis and Treatment known as EPSDT (see page 28.)

Oklahoma Medicaid Benefits (continued)

School Based Services (continued)

With Medicaid program assistance, many schools can now afford to employ nurses and health programs to help keep children healthy and productive. Schools may receive reimbursement for Medicaid enrolled children who are also eligible for 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 Medicaid compensable health services recommended and received in the plan for Medicaid enrolled children.

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

SFY2005 Specific Information…

- OHCA contracted with 219 school based providers in 62 counties.
- School based providers were reimbursed $5,553,110 for SFY2005.

SoonerRide (Non-Emergency Transportation)

Non-emergency transportation has been part of the Medicaid program since 1969 when federal regulations mandated that states ensure the service for all Medicaid beneficiaries. The purpose was clear, without transportation many of the very persons Medicaid was designed to aid would not get to the services needed. If an Oklahoma Medicaid beneficiary does not have a ride to a medically necessary service, ***SoonerRide*** can provide transportation if it is not an emergency.

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

SFY2005 Specific Information…

- Almost 74,000 beneficiaries utilized the ***SoonerRide*** services for more than 486,900 transports.
- The non-emergency transportation program costs were $15,118,558.

Medicaid and Native Americans

Oklahoma is home to 39 tribal governments and, according to the 2000 Census, more than 380,000 Native Americans live in the state. During SFY2005, there were more than 88,750 Native Americans enrolled in Oklahoma Medicaid.

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

SoonerCare and Native Americans

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

Native Americans and the Breast and Cervical Cancer Treatment Program

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

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

The Oklahoma Health Care Authority is working with the Cherokee Nation of Oklahoma to establish a Program of All-inclusive Care for the Elderly (PACE) program in the Cherokee Nation service area. PACE will serve individuals age 55 or older, certified by the state to need nursing home care, able to live safely in the community at the time of enrollment and live in a PACE service area. PACE programs will receive a capitated payment to provide the entire continuum of care and services to seniors with chronic care needs while maintaining their independence in their homes for as long as possible. A health care team will manage the care and services for beneficiaries.

SFY2005 Specific Information…

- Oklahoma Medicaid covers more than 50,500 Native American children under the age of 18.
- Since December 1999, the number of Native American children under 18 enrolled in Medicaid has increased almost 50 percent.
- During SFY2005, OHCA had just over 3,000 pregnant Native American women enrolled.

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 Medicaid, drain vital program dollars, hurting beneficiaries 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 have missing or insufficient documentation to show whether the claim was appropriate. Improper Medicaid 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 Oklahoma Health Care Authority protects taxpayer dollars and the availability of Medicaid 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 Oklahoma Medicaid 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 Medicaid 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 and 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.

To help control Medicaid spending Oklahoma Medicaid has other cost cutting initiatives. Cost avoidance is the method of either finding alternate responsible payers as in other insurance coverage or by optimizing pharmaceutical treatment options. Other methods include the Drug Rebate programs and nursing facility fee collection. To control costs on drugs, states receive rebates from pharmaceutical manufacturers through the drug rebate program. This ensures that Oklahoma Medicaid is receiving the best possible pricing for pharmacy purchases. To increase quality of care a fee is collected from all long-term care facilities to increase rates and provide other necessary services.

Actions as a result of the program and payment integrity efforts may include:

- clarification and streamlining of OHCA policies, rules and billing procedures;
- increased payment integrity, recovery of inappropriately billed payments and avoidance of future losses;
- education of providers regarding proper billing practices;
- termination of providers from participation in the Oklahoma Medicaid 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 Oklahoma Health Care Authority are responsible for separate areas of potential recoveries, cost avoidance and fee collection. The Surveillance Utilization and Review Services (SURS) Unit is in place to safeguard 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 performs audits and reviews of external providers in regard to inappropriate billing practices and noncompliance with OHCA policy. Reviews can be initiated based on risk-based assessments, complaints from other Medicaid providers, beneficiaries, concerned citizens or other state agencies.

Peer Review Organization (PRO)

Some Medicaid 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 Medicaid beneficiaries in the fee-for-service program. The purpose of the inpatient hospital utilization review program is to safeguard against unnecessary and inappropriate medical care rendered to Medicaid beneficiaries. Federal regulations require medical services and/or records to be reviewed for medical necessity, quality of care, appropriateness of place of service and length of stay by the PRO.

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

Figure 19 Post-Payment Review Recoveries, SFY2003 through SFY2005

Provider Type	SFY2003	SFY2004	SFY2005
Behavioral Health	$708,350	$357,218	$491,322
DME Supplies	$63,198	*$182,290	$212,271
EPSDT	$0	$653	$0
HMO	$229,707	$60,411	$28,297
Home and Community-Based Waiver	$129,288	$59,935	$163,514
Hospital	$694,417	$263,187	$1,439,492
Indian Health	$0	$79,535	$0
Long-Term Care Facilities	$137,952	$133,356	$753,809
Other Practitioners	$48,774	$143,997	$52,943
Pharmacy	$1,009,284	$301,232	$462,746
Physician	$31,472	$27,974	$136,009
School Corporation	$209	$102,006	$148,107
Transportation Provider	$2,607	$13,459	$6,594
Total – OHCA Recoveries	**$3,055,258**	**$1,796,335**	**$3,895,104**
Medicaid Fraud Control Unit—Other	$254,865	$71,320	$8,796
MFCU—National Settlements			$3,470,358
Total Medicaid Recoveries	**$3,310,123**	**$1,744,655**	**$7,374,258**

Figures are a combination of amounts recovered from SURS, Pharmacy, Audit Management, contractor and PRO reviews. SFY2004 totals include $83 in ADvantage recoveries.
**SFY2004 DME recoveries have been restated from the SFY2004 OHCA Annual Report.*

Program and Payment Integrity Activities (continued)

Post-Payment Reviews and Recoveries (continued)

Third Party Liability (TPL) Recoveries

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

Figure 20 Third Party Liability Recoveries, SFY2003 through SFY2005

	SFY2003	SFY2004	SFY2005
Estate Recoveries	$1,884,474	$1,735,020	$1,543,825
Other	$4,523,407	$4,166,187	$6,944,572
Total Recoveries	$6,407,881	$5,901,207	$8,488,397

Cost Avoidance

Third Party Liability Cost Avoidance

The Third Party Liability (TPL) program also reduces costs to the Medicaid program by identifying third parties liable for payment of a beneficiary'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).

Figure 21 Third Party Liabilities Cost Avoidance, SFY2003 through SFY2005

	SFY2003	SFY2004	SFY2005
Medicare	$715,618,830	$479,795,582	$541,167,474
Private Insurance	$45,243,945	$91,174,730	$264,469,573
Total Cost Avoidance	**$760,862,775**	**$570,970,312**	**$805,637,047**

Product Based Prior Authorization Cost Avoidance

The goal of the Product Based Prior Authorization (PBPA) program is to optimize each patient'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, SFY2003 through SFY2005

- SFY2003—$16,630,980
- SFY2004—$24,685,677
- SFY2005—$18,669,012

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 patient 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.

State Maximum Allowable Cost Program

The State Maximum Allowable Cost (SMAC) program was implemented in 2000 as a means to limit pharmacy reimbursement for generic products. Since that time, generic products have increased their share of the prescriptions dispensed to Medicaid beneficiaries. For SFY2005, generics were dispensed for 62 percent of all Medicaid prescriptions and in 96 percent of the prescriptions where a generic is available. When the SMAC program was started in 2000, there were 400 products included, the most recent list includes more than 1,100 drug products.

By limiting the amount paid for generic drugs, OHCA was able to save more than $62 million in state fiscal year 2005.

Program and Payment Integrity Activities (continued)

Rebates and Fees

Supplemental Drug Rebate Program

The Medicaid State Supplemental Drug Rebate program makes drugs available for beneficiaries while ensuring cost-effectiveness for the taxpayer. The 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 their products, then the products become available without prior authorization. This rebate is in addition to the federal Drug Rebate Program, which guarantees that the Medicaid program receives a "best price" for each product. With the Supplemental Drug Rebate program beneficiaries receive medications quickly, providers do not face red tape, staff resource needs are reduced and manufacturers are able to maintain or increase the market share of their products.

Drug Rebate Program

The Federal Drug Rebate Program (established by the enactment of the Omnibus Budget Reconciliation Act of 1990) was designed to offset prescription expenditures and guarantee that states pay no more than the lowest price charged by a manufacturer for prescription drugs. In exchange for the rebate, states must make all products of a contracted manufacturer available to Medicaid beneficiaries 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.

Figure 22 Drug Rebates and Interest Collections SFY2003 through SFY2005

	SFY2003	SFY2004	SFY2005
State Supplemental Drug Rebates			$1,643,316
Federal Drug Rebates	$55,708,182	$71,003,152	$96,288,789
Interest	$33,567	$24,663	$12,998
Total Collections	**$55,741,749**	**$71,027,815**	**$97,945,103**

Long-Term Care Quality of Care Program Fees

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

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

Figure 23 Quality of Care Fee, Penalty and Interest Assessment, SFY2003 through SFY2005

	SFY2003	SFY2004	SFY2005
Quality of Care Fees	$56,163,442	$58,101,070	$55,113,852
Penalties/Interest	$155,019	$223,375	$537,734
Total	**$56,318,461**	**$58,324,445**	**$ 55,651,586**

Understanding OHCA

OHCA and Medicaid

Administering the Medicaid Program

Strategic Planning

Operating Principles

Organizational Chart

Core Function Summary

OHCA and Medicaid

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 a slightly more than $1 billion. At the same time, the defeat of the proposed Health Care Provider Tax effectively capped the amount of money available to the state for entitlement programs – thus placing unavoidable and serious pressures on the state's budget. These financial realities, accompanied by ever-increasing eligible populations, would have led to the financial collapse of the state Medicaid system if left unchecked.

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.

House Bill 1573, the Oklahoma Health Care Authority Act of 1994, created the Authority as an executive agency with the mandate to:

- Purchase Medicaid benefits and state and education employees' health care benefits;
- Study all state-purchased and state-subsidized health care systems;
- Make recommendations and changes aimed at minimizing the financial burden on the state, while allowing the state to provide the most comprehensive health care possible; and
- Become the designated single state Medicaid agency effective January 1, 1995.

As we complete our tenth year managing the now $2.8 billion program, it is a long way from 1993 when the task force projected Medicaid would, if left unchecked, approach $4 billion by the year 2000. One-third of the $2.8 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 cautious. 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 providing funds to Medicaid contractors; developing Medicaid payment policies; managing programs to fight waste, fraud and abuse; maintaining the operating systems that support Medicaid payments; developing cost-effective health care purchasing approaches; monitoring contractor and provider performance; promoting and preserving beneficiary rights and protections; and disseminating information to the Oklahoma Legislature, congressional delegation, beneficiaries and the general public.

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

Administering the Medicaid 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 beneficiary groups; its means-tested eligibility rules; the scope of its benefits package (spanning over 30 different categories of acute and long-term care services); its interactions with other payers; its financial, regulatory and political transactions with a wide range of provider groups; and its joint federal and state financing.

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

In 1999 U.S. private insurers' average administration expenses were approximately 11.7 percent of the total premiums they collected. In Oklahoma, administrative expenses represented only 5.54 percent of the total Medicaid expenditures for SFY2005.

"Costs of Health Care Administration in the United States and Canada." Woolhandler, Steffie, New England Journal of Medicine, August 2003.

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

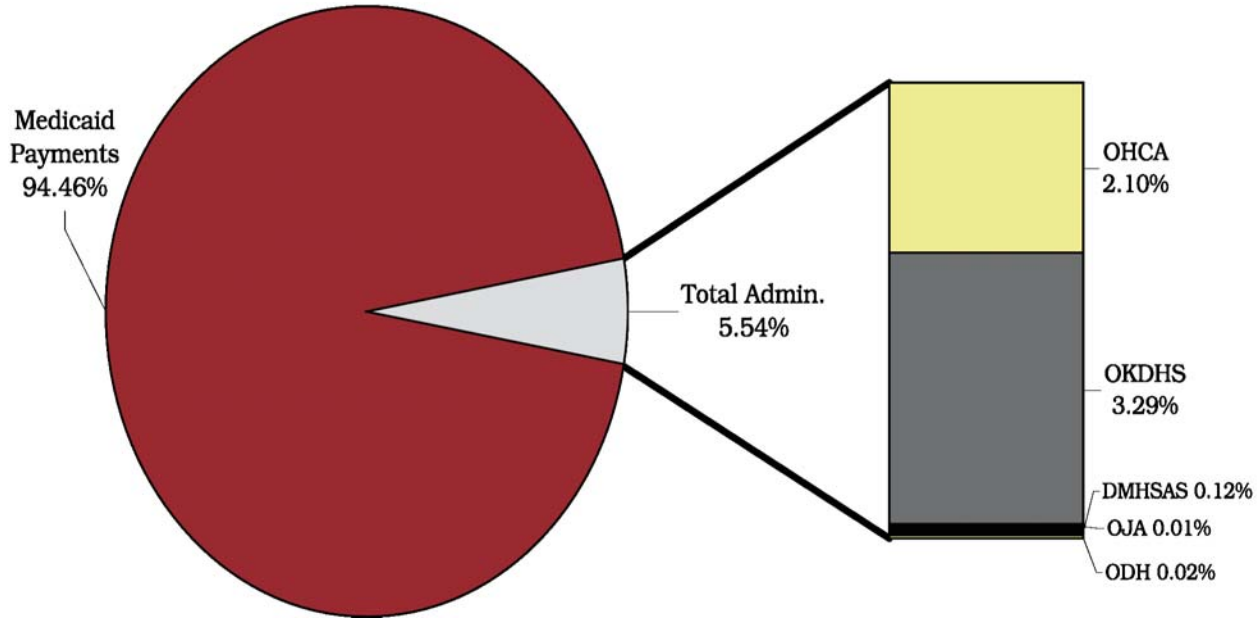
- inform individuals who are potentially eligible and enroll those who are qualified;
- determine what benefits it will cover in what settings;
- determine how much it will pay for the benefits it covers and from whom it will buy those services from;
- establish standards for the providers from which it will purchase covered benefits and enroll (or contract with) those which meet the standards;
- process and pay claims from fee-for-service providers and make capitation payments to primary care providers;
- monitor the quality of the services it purchases to ensure that beneficiaries 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 providers;
- have a process in place for resolving grievances by applicants, beneficiaries and providers;
- collect and report information necessary for effective administration and program accountability.

OHCA and Medicaid (continued)

Administering the Medicaid Program (continued)

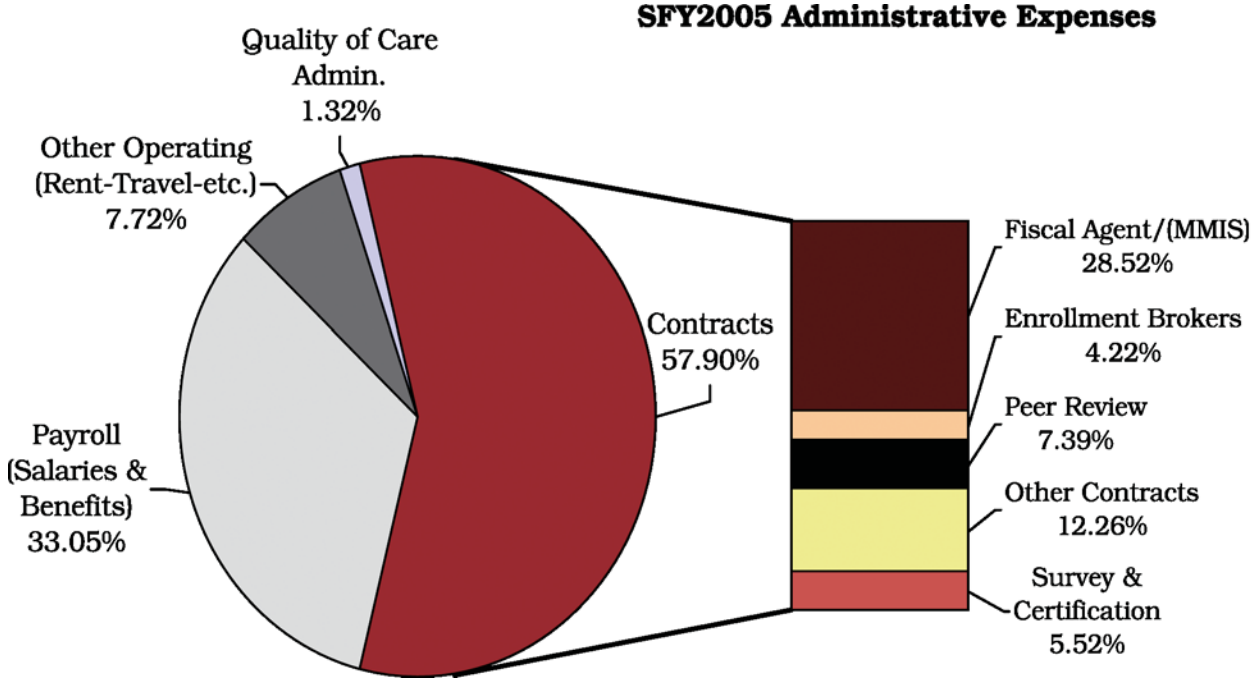
The administration of Oklahoma's Medicaid program is divided among five different state agencies; the Oklahoma Health Care Authority (OHCA), the Oklahoma Department of Human Services (OKDHS), the Oklahoma State Health Department (OSDH), the Office of Juvenile Affairs (OJA) and the Department of Mental Health and Substance Abuse Services (DMHSAS).

OHCA Medicaid Expenditure Percentages for SFY2005



Finally, OHCA's administrative expenses are divided between direct operating expenses and vendor contracts. Of the $59.9 million spent by OHCA in 2005 on administration, 42 percent went to direct operation expenses while 58 percent went toward vendor contracts.

SFY2005 Administrative Expenses



OHCA and Medicaid (continued)

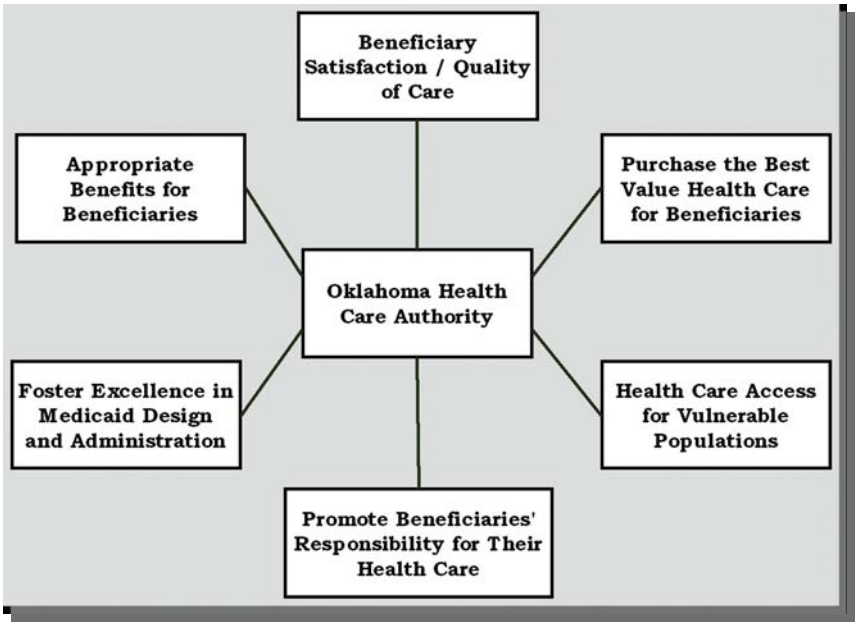
Strategic Planning

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

By its design, Medicaid's impact is greatest among the specific groups that are targeted for coverage, including children, pregnant women, adults and children with disabilities, persons with chronic medical and mental conditions and the elderly. Medicaid is now a major economic factor in many segments of the health care market place. Most significantly, Medicaid now has an enormous impact on state budgets.

In order to be a leader, OHCA must continually plan. Changes in environmental forces are now so volatile, a proactive planning stance is necessary. Societal needs and expectations, technological advances, demographic and economic changes—all indicate an opportune time for OHCA to take stock, assess its current position and strengths and build for the future.

How seriously we take our responsibilities, how willing we are to come together as a state to make difficult choices regarding direction and priorities and how committed we are to work together to support those choices in our future actions will determine whether this planning process is ultimately successful.



Broadly Stated Goals

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

- Improve health care access for the underserved and vulnerable populations of Oklahoma. (Medicaid Beneficiaries)
- Protect and improve beneficiary health and satisfaction, as well as ensure quality, with programs, services and care. (Beneficiary Satisfaction/Quality of Care)
- Promote beneficiaries' personal responsibility for their health services utilization, behaviors and outcomes. (Beneficiary Responsibility)
- Ensure that programs and services respond to the needs of beneficiaries by providing necessary medical benefits to our beneficiaries. (Benefits)
- Purchase the best value health care for beneficiaries 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 Medicaid program.

Operating Principles

As an adjunct to our Strategic Plan, the Oklahoma Health Care Authority developed a set of "operating principles" for the agency to clarify for ourselves and others how we need to operate in order to achieve our goals and objectives. In other words, the goals and objectives state what we aim to achieve as an agency and the 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 Beneficiary Focus

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

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

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

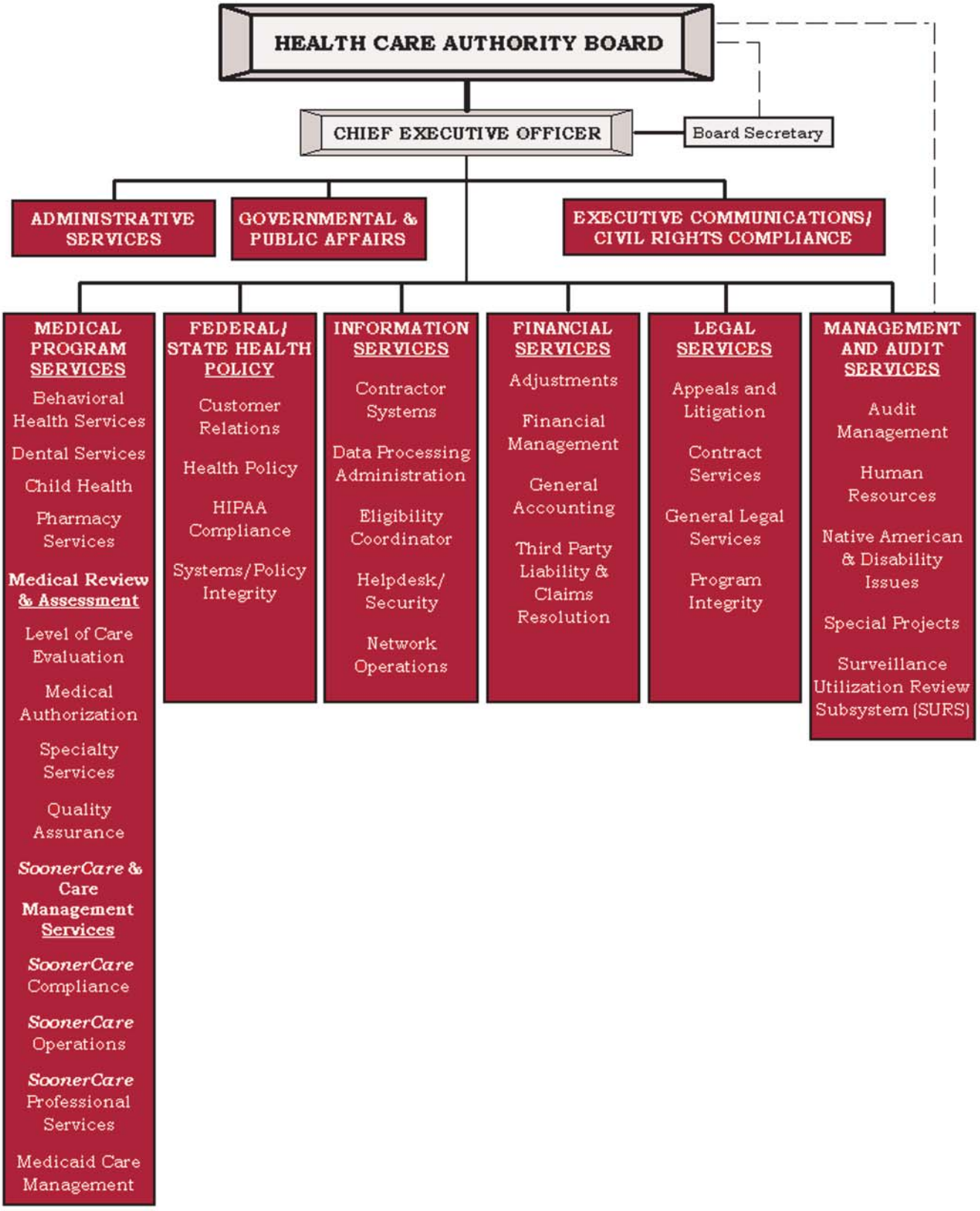
How We Work with Others in the Health Care System

- We will strive to be an even-handed and reliable business partner with plans, providers, states, contractors and other stakeholders in our programs.
- We will work collaboratively with our colleagues throughout the Oklahoma and federal government and territories, tribes, with accrediting bodies, beneficiary 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 more consistent in our use of qualitative and quantitative data to guide and evaluate our actions and improve our performance in a purposeful way over time.

Figure 24 OHCA's Organizational Chart



Organization as of June 2005.

Core Function Summary

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

EXECUTIVE OFFICE SUPPORT

Mike Fogarty, J.D., M.S.W., Chief Executive Officer Total FTE Filled: 22

Administrative Services answers and directs all calls that come into the main agency telephone number through the receptionist desk. We coordinate space requests and general maintenance issues. Our unit sorts and delivers all incoming and outgoing mail. The Administrative Services Unit performs the maintenance and assignment of the agency's vehicles, security and telephone systems. We also account for the economical and efficient management of agency records in compliance with state statute. (11 FTE) *Administrative Chief of Staff, James Smith (405) 522-7150.*

Governmental and Public Affairs acts as a connection point between OHCA and the legislative and executive branches of state government. Governmental Affairs provides clarification and information regarding agency programs and operations. This unit coordinates fiscal, policy and program impacts with agency staff regarding potential and pending legislation. Public Affairs develops comprehensive, public information strategies, outreach activities and goals. We also produce written material for the agency, including all enrollment publications, informational and or promotional materials to beneficiaries and content management for the agency's public web site. Our unit serves as the agency's primary contact for the media. The Information and Referral area within Governmental & Public Affairs documents and distributes items requiring response as well as documents for informational purposes. We handle all federal, state and other customer correspondence. This process ensures distribution of information and timely responses to requests. (7 FTE) *Director, Nico Gomez, (405) 522-7484.*

Civil Rights Compliance reports directly to the CEO and is responsible for planning and managing of all phases of the affirmative action program. This involves targeted recruitment, assessment of programmatic outcomes, required state and federal statistical analysis, as well as management and employee counseling. (1 FTE) *Civil Rights Compliance Officer, Donna Huckleberry (405) 522-7452.*

Mike Fogarty, OHCA's chief executive officer, was named the 2005 Administrator of the Year by the Oklahoma Chapter of the American Society for Public Administration. The award is given annually to a public servant in Oklahoma whose career exhibits the highest standards of excellence, dedication and accomplishment.

Core Function Summary (continued)

MEDICAID OPERATIONS

Lynn Mitchell, M.D., M.P.H., Director of Medicaid/Medical Services *Total FTE Filled: 132*

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

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

Child Health/EPSDT Services coordinates and monitors the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. We also work with school districts, the State Department of Education and the State Department of Health in maximizing EPSDT/EI (Early Intervention) services to Medicaid enrolled children through school based and Early Intervention services. Additionally, this unit provides education for parents and providers regarding EPSDT services and performs provider outreach. (10 FTE) *Director, Terrie Fritz, L.C.S.W. (405) 522-7377.*

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

OHCA received a Governor's Commendation at the Quality Oklahoma Team Day 2005 for the Supplemental Drug Rebate program. The program was cited for its efficiency in providing beneficiaries cost-effective pharmaceuticals.

Core Function Summary (continued)

MEDICAID OPERATIONS (continued)

Medical Review & Assessment — Director, J. Paul Keenan, M.D.

Level of Care Evaluation Unit (LOCEU) coordinates the federal PASRR (Pre-Admission Screening and Resident Review) program statewide. PASRR provides Level I screening to all persons entering Medicaid certified nursing facilities (NFs) for possible mental retardation (MR) and/or mental illness (MI) related diagnosis. Level II assessments are conducted when necessary to insure that this population requires nursing facility level of care and receives proper treatment for MI and/or MR within the nursing facility. LOCEU also makes level of care decisions on all beneficiaries entering public and private intermediate care facilities for the mentally retarded (ICF/MR), as well as on beneficiaries applying for three of the Oklahoma Department of Human Services (OKDHS), Developmental Disabilities Services Division (DDSD) Home and Community-Based Waivers. We also provide medical and categorical relationship determinations for disability and incapacity of OKDHS beneficiaries. Our unit also audits ADvantage, Community and In-Home Supports Home and Community-Based waiver programs. (8 FTE) *Manager, Kathy Smith, L.C.S.W. (405) 522-7309.*

Medical Authorization Unit reviews and responds to medical and/or dental requests and any services or durable equipment that require prior authorization for Medicaid enrolled children and adults. Our unit performs manual pricing when a standard allowable cost is not in the claims payment system. We also answer telephone inquiries from all sources regarding Medicaid policy, scope and procedures regarding medical authorization. (13 FTE) *Manager, Sharon Adair (405)-522-7371.*

Specialty Services recruits and supports specialty and subspecialty providers' active participation in Medicaid programs and responds to inquiries as well as requests for assistance from specialty providers. Provider Relations also communicates policies, procedures and program issues of particular importance to specialty providers. (2 FTE) *Manager, Kelevetta Nwajagu (405) 522-7301.*

Quality Assurance coordinates the quality assurance evaluation and improvement processes for all OHCA medical programs. This is accomplished through ongoing monitoring and evaluation of Medicaid services and implementation of improvement initiatives to help ensure that Medicaid beneficiaries receive appropriate and high quality health care. This unit also coordinates the activities of the agency quality assurance committee and provides technical support in developing and reporting federally required quality assurance/improvement activities of the agency. (4 FTE) *Manager, Angela Shoffner (405) 522-7355.*

OHCA submitted the ER Utilization quality initiative to the Quality Oklahoma Team Day 2005. In this project, emergency room utilization was analyzed for care management and quality improvement opportunities.

Core Function Summary (continued)

MEDICAID OPERATIONS (continued)

SoonerCare & Care Management Services — Director, Becky Pasternick-Ikard, J.D., R.N.

SoonerCare Compliance plans and implements comprehensive compliance activities through a systematic approach to maximize division staff and time. ***SoonerCare*** Compliance develops ***SoonerCare*** quality assurance initiatives in coordination with the Quality Assurance Division. We also coordinate and compile data and information needed for required reports. (7 FTE) *Director, Melinda Jones (405) 522-7125*.

SoonerCare Operations consists of Member Services and Contractor Services. Member Services facilitates resolution to issues/concerns addressed in internal reports, incident reports and telephone calls and also monitors the enrollment agent. We research and resolve members' calls and issues related to dire medical needs and follow up with members on as-needed basis to ascertain care received. Our unit identifies and participates in member outreach activities to promote selection of primary care provider/case manager (PCP/CM) and works in collaboration with the OKDHS county offices to resolve issues regarding member eligibility. Member Services helps identify system "barriers" that cause inaccurate transmission of data from OKDHS to OHCA. Another aspect of ***SoonerCare*** Operations is Contractor Services. Our unit facilitates and coordinates ***SoonerCare*** provider contracting. This includes the identification and resolution of provider contractual issues, provider training, complaints and review of network deficiencies or access/quality issues related to program standards. We recruit ***SoonerCare*** providers to maintain and monitor network capacity and access to care. (21 FTE) *Member Services Supervisor, James Reese (405) 522-7345.*

SoonerCare Professional Services monitors and reports on ***SoonerCare*** enrollment and expenditure data. We prepare related costing of financial impact for budget requests and budget reports, as well as monitor compliance of ***SoonerCare*** provider contracts in the area of financial data reporting. This unit also monitors the ***SoonerRide*** program and acts as a ***SoonerCare*** liaison to the Oklahoma Department of Human Services staff. (6 FTE) *Manager, Kevin Rupe, C.P.A. (405) 522-7498.*

Medicaid Care Management provides and facilitates care management services related to medically complex/special health care need members. Our unit includes nurse exceptional needs coordinators (ENCs). We coordinate access to care as it relates to specialty providers initiated by requests from primary care providers/case managers (PCP/CM), incident reports, member calls, interagency referrals and legislative requests. We also plan and put into operation enhanced Care Management outreach to select identified populations. Care Management coordinates with the Behavioral Health and Quality Assurance units to perform clinical studies and targeted consumer assessments. ENCs provide educational intervention for beneficiaries with inappropriate emergency room visits, high service utilization, conditions in need of medical regimen and dual medical/behavioral health needs. Our unit utilizes a computer based clinical care management software system for tracking member activities and productivity measurements. (32 FTE) *Manager, Marlene Asmussen, R.N. (405) 522-7123.*

Due to ***SoonerCare***'s efforts during the transition from managed care organizations to contracting directly with the PCP/CM, OHCA maintained a better than 95 percent retention rate. These efforts were also showcased at the Quality Oklahoma Team Day 2005.

Core Functions Summary (continued)

FEDERAL / STATE HEALTH POLICY

Charles Brodt, Director of Federal / State Health Policy *Total FTE Filled: 39*

Customer Relations consists of Customer Service and Provider Training and is responsible for technical assistance to all of the various participants in the Medicaid Program. Customer Relations answers a large volume of incoming telephone inquiries and correspondence from providers, vendors, beneficiaries, DHS county offices, legislators, other state Medicaid agencies relating to agency and federal Medicaid policy and OHCA procedures for all Medicaid programs. We also review and authorize processing for specialized claims requiring additional medical documentation. The Provider Training unit offers individual and group information and instruction regarding Medicaid policy and claims processing for non-school-based contracted providers. (25 FTE) Director, Vacant (405) 522-7360.

Health Policy develops and presents upcoming policy issues to the Medical Advisory Committee (MAC). We receive direction from the MAC members regarding additional consideration as well as requests from the members to research and subsequently report on other policy items. We coordinate with the Centers for Medicare and Medicaid Services (CMS) on questions related to Medicaid policy, issues of noncompliance, expenditures and the state plan. We also direct the OHCA's scheduled review of administrative rules, statutes and internal policies. We report to the Governor, the President Pro Tempore of the Senate, and the Speaker of the House of Representatives those rules to be modified or repealed and statutes or policies which should be promulgated pursuant to the Administrative Procedures Act (APA). This unit also monitors, analyzes and reports financial and operational data applicable to specific waiver programs; assuring that each specific waiver program meets all associated federal requirements and is operated within its conditions and limits. Additionally, we assist in preparing and submitting waiver applications and amendments to CMS. (9 FTE) *Director, Jim Hancock (405) 522-7268.*

HIPAA Compliance coordinates agency activities required for compliance with Health Insurance Portability and Accountability Act (HIPAA) rules and regulations. HIPAA Compliance also monitors and reviews federal rules and regulations relating to HIPAA. This unit is developing and monitoring a Business Continuity and Contingency Plan for addressing potential problems or issues with achieving HIPAA compliance. (0 FTE) *Vacant, (405) 522-7228*.

Systems/Policy Integrity maintains the reference and diagnosis file for the MMIS. We also coordinate the integrity of the MMIS during the development of new programs. This unit coordinates the development of new material and changes to the existing OHCA billing and procedure manual to ensure all programs and materials are in accordance with existing state and federal regulations. (3 FTE) *Coordinator, Nelia Atkinson (405) 522-7361.*

The OHCA secure website received a Governor's Commendation and the "Motivating the Masses" award at the Quality Oklahoma Team Day 2005. The secure website allows for HIPAA compliant and efficient claims processing.

Core Function Summary (continued)

INFORMATION SERVICES

John Calabro, Director of Information Services *Total FTE Filled: 33*

Contractor Systems monitors the Medicaid Management Information System (MMIS) and recommends appropriate actions to correct any deficiencies, analyzes test results, as well as coordinates all maintenance and modification system changes with ongoing enhancements. This unit is accountable for the fulfillment of data processing performed by the contracted fiscal agent, Electronic Data Systems (EDS). We also establish priorities for systems development and data processing projects according to departmental requirements, as well as develop plans for future utilization of data processing services in the overall agency program. (13 FTE) *Director, Donna Witty (405) 522-7242.*

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

Eligibility Coordination is accountable for management of all eligibility reporting from the OKDHS eligibility system. This area serves as the point of contact for all Medicaid eligibility concerns. This unit is also responsible for reporting and coordinating system and process modifications to continually improve the quality of eligibility data. (1 FTE) *Coordinator, Richard Evans (405) 522-7101.*

Helpdesk/Security is the central point through which computer systems problems or issues are reported and resolutions are coordinated. This unit also provides support to the agency and other entities accessing our network and MMIS. The Security aspect of this area maintains and audits the integrity of all agency systems and assures our compliance with state and federal security regulations. (2 FTE) *Systems Security Officer/Help Desk Supervisor, DeBorah Boneta (405) 522-7424.*

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

The Oklahoma City chapter of the International Association of Business Communicators presented a Bronze Quill award to OHCA for its hosting of the 2004 MMIS Conference and Exhibition. The Bronze Quill program is the chapter's awards venue for business communications efforts from the previous year.

Core Functions Summary (continued)

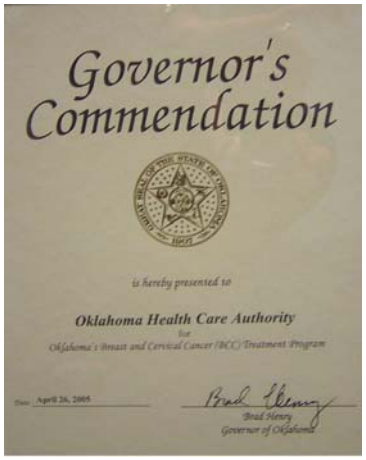
FINANCIAL SERVICES

Anne Garcia, C.G.F.M., Director of Financial Services *Total FTE Filled: 64*

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

Financial Management researches and analyzes claims history and cost report data in order to develop and implement reimbursement rates for institutional providers and submit state plan documentation. The Budget and Analysis Section within Financial Management prepares the annual agency budget request, processes agency budget work programs with necessary revisions. Our unit also analyzes data, tracks expenditures and prepares financial forecasting for the agency's program budgeting. Purchasing anticipates and processes purchase requests and encumbrance documents submitted by units within the agency. We track and monitor purchase orders, monitor funding amounts and approve invoices. The Provider Rates & Analysis unit, within this unit, reviews and maintains cost reports for nursing facilities and intermediate care facilities for the mentally retarded for the effective auditing of provider costs and subsequently calculating the annual "audit adjustment" and other annual costs. This information is kept for the purpose of rate setting. We also maintain copies of hospital cost reports for the determination of base year costs, establishment of other payment rates to hospitals and to make assurances to CMS that payment rates are within regulatory upper limits. (15 FTE) *Director, Debbie Ogles (405) 522-7270*.

General Accounting draws administrative and Medicaid program federal matching funds in accordance with the US Treasury Cash Management Improvement Act (CMIA) Agreement and maintains the general ledger for accounting of all funds, including balancing cash to Office of State Finance (OSF) and the State Treasurer's Office (STO). We post all receipts and expenditures of agency funds. We prepare the monthly financial statement reports and quarterly cost allocation schedules and make payments of claims for general agency operations and contracted services. We deposit all funds received by the agency and perform the billing, collection and administration of the Quality of Care fund. General Accounting tracks and reconciles adjudication reports produced by the fiscal agent before authorizing weekly payments, processing all Medicaid provider garnishments and tax levies. We reconcile and process all agency payrolls, as well as approving the annual 1099 and W2 information. (13 FTE) *Director, Carrie Evans (405) 522-7359.*


Governor's Commendation

is hereby presented to

Oklahoma Health Care Authority

for

Oklahoma's Breast and Cervical Cancer (BCC) Treatment Program

Date April 26, 2005

Brad Henry

Governor of Oklahoma

OHCA received the Governor's Commendation for the implementation of the Oklahoma Breast and Cervical Cancer Treatment Program.

Third Party Liability (TPL) & Claims Resolution investigates the legal liability of third parties to pay for care and services furnished to Medicaid beneficiaries. We seek reimbursement from the responsible third parties (TPL). We use the most cost-effective means of recovery, to cost-avoid the claim when there is probable existence of TPL at the time it is filed. For those claims that are not cost-avoided or a third party is discovered after Medicaid has paid, the pay and chase method of recovery is utilized. Claims Resolution monitors the timely and accurate processing of claims for Medicaid providers and resolve suspended edits during the claims processing cycle. (21 FTE) *Director, Lisa Gifford, J.D. (405) 522-7427.*

Core Function Summary (continued)

LEGAL SERVICES

Howard Pallotta, J.D., Director of Legal Services *Total FTE Filled: 25*

Appeals & Litigation coordinates all litigation for the agency, as well as all administrative law judge appeals filed by providers and beneficiaries. This unit aids the Third Party Liability Unit in estate recovery, worker's compensation, tort and insurance legal matters and represents the agency before administrative, state and federal courts or tribunals. (1 FTE) *Deputy General Counsel, Vacant (405) 522-7562.*

Contract Services consists of a Service Contracts Development Unit and a Service Contracts Operations Unit. Service Contracts Development oversees the procurement and/or development of the MMIS fiscal agent and the agency's professional services contracts. This unit insures that the agency is adhering to statutory laws, administrative procedures and agency regulations in obtaining professional contracted services and interagency agreements. The Service Contracts Operations Unit develops, maintains and oversees the Professional Provider Contract Procurement System and provides assistance to program providers regarding the contract processes. This unit drafts and processes new contracts and renewals for professional services, advises on payment and reporting requirements and determines if a fee-for-service or managed care contract is needed. Our unit operates and maintains a call center for inquiries on current contract status and provider numbers and/or effective contract dates and the location of specialty providers. We are also responsible for servicing contracts related to long-term care providers and nursing homes. We monitor survey and certification functions as well as temporary and permanent suspensions of payments and civil monetary penalties related to long-term care contract breaches. (19 FTE) *Manager, Beth Van Horn (405) 522-7234.*

General Legal Services renders legal opinions and advises the CEO, board members and agency management on administrative legal issues and provides legal opinions to agency personnel on issues relating to contracts, state finance, procurement and rate matters. Our unit reviews possible legislation and advises legislators and legislative staff members regarding Medicaid law. We advise advocacy and public interest groups regarding changes in Medicaid law. (3 FTE) *Deputy General Counsel, Lynn Rambo-Jones, J.D. (405) 522-7403.*

Program Integrity represents the agency in investigative matters and provides thorough research and surveillance to/for General Counsel. Our team also works with agency staff and General Counsel to develop an effective and efficient investigative component for the legal division of the agency. Program Integrity conducts information gathering field trips and/or interviews with necessary individuals and/or agency representatives. (1 FTE) *Program Integrity Specialist, Vacant (405) 522-0595.*

The State Charitable Campaign Trophy recognizing the state agency with the largest contribution increase was awarded to OHCA for 2004.

Core Function Summary (continued)

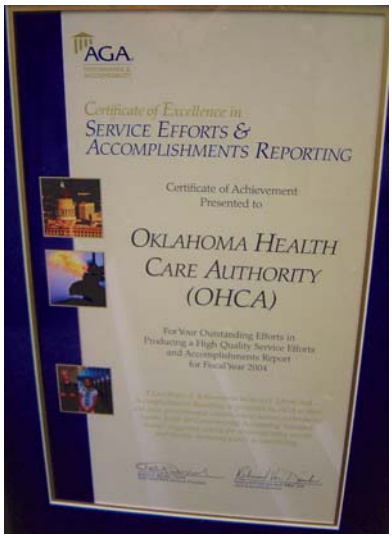
MANAGEMENT AND AUDIT SERVICES

Cindy Roberts, C.P.A., C.G.F.M., Director of Management and Audit Services *Total FTE Filled: 39.5*

Audit Management performs audits and reviews of organizational and functional activities. Our unit evaluates the adequacy and effectiveness of the management and the extent to which organizational units are performing their control activities. We review units for compliance with management instructions, applicable policy and procedures in a manner consistent with both agency objectives and high standards of administrative practice. This unit also completes federally mandated Payment Error Rate Measurement which requires performing a comprehensive claims payment review of the Medicaid Fee-for-Service, ***SoonerCare*** and SCHIP programs. Our unit also produces the Service Efforts and Accomplishments (SEA) report. The SEA report is a budget requirement and is a publicly available report detailing resource allocation and accountability measures. (8 FTE Filled) *Manager, Kelly Shropshire, C.P.A. (405) 522-7131.*

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

Native American & Disability Issues performs Native American liaison services between OHCA and CMS, Indian Health Services (IHS) and the tribes of Oklahoma for state and national issues. These issues include Native American work groups, policy development and compliance, tribal consultation, payment issues and elimination of health disparities. Our unit also develops and implements service delivery models which assure adequate access to Home and Community-Based supports for persons with disabilities. This is so persons with disabilities can live and work in the community. Additionally, we coordinate with various state agencies, legislative staff, advocacy groups and CMS on the implementation, reporting and monitoring of waivers and waiver amendments by the OHCA. (2 FTE) *Manager, Trevlyn Terry (405) 522-7303.*



OHCA received a Certificate of Excellence from the Association of Government Accountants for the SFY2004 Service Efforts and Accomplishments (SEA) report.

Core Function Summary (continued)

MANAGEMENT AND AUDIT SERVICES (continued)

Special Projects develops and collects monthly-submitted Quality of Care reports from long-term care facilities statewide. We perform monthly desk and on-site audits related to verification of submitted information pertaining to staffing ratios, minimum wage for specified staff and determine penalties for non-compliance. This unit coordinates and prepares the agency-wide annual report, as well as data reports such as the monthly Fast Facts. We coordinate with various state agencies, legislative staff, advocacy groups and CMS on the development, implementation, reporting and monitoring of waivers and waiver amendments by the OHCA. Additionally, our unit is managing the State Planning Grant activities. (6.5 FTE) *Managers, Matt Lucas (405) 522-7273, Connie Steffee (405) 522-7238, Teri Dalton (405) 522-7209*.

Surveillance Utilization Review Subsystem (SURS) develops comprehensive statistical profiles and utilization patterns of health care delivery of individual providers and beneficiaries. We do this to safeguard against unnecessary or inappropriate use of Medicaid services and associated payments. We also assess the quality of those services, and identify suspected instances of fraud and abuse according to the code of federal regulations. Our unit manages the federally-outlined Medicaid beneficiary lock-in program which restricts the beneficiary to one pharmacy and/or physician during a 12 month period. (17 FTE) *Manager, Jana Webb, R.N. (405) 522-7112.*

Food and gifts were collected and distributed to several needy families during the holidays.

Staff collected more than 180 stuffed animals for the OHCA Teddy Bear Tree. Stuffed animals are distributed to various children's shelters. OHCA staff also adopted and gave toys to 100 Salvation Army Angels.

Appendix A Glossary of Terms

ABD	The **A**ged, **B**lind and **D**isabled Medicaid population.
Beneficiary	A person enrolled in Oklahoma Medicaid.
Child(ren)	Unless noted, refers to individuals under the age of 21.
CMS	**C**enters for Medicare and **M**edicaid **S**ervices, formally known as Health Care Financing Administration (HCFA), establishes and monitors Medicaid funding requirements.
EDS	**E**lectronic **D**ata **S**ystems is OHCA's fiscal agent. EDS processes claims and payments within Oklahoma's Medicaid Management Information System (MMIS).
Enrollee	For this report, an individual who has been enrolled and obtained and Oklahoma Medicaid case number and ID card. This individual has not necessarily received a service.
Fee-For-Service (FFS)	The method of payment for the Medicaid population that is not covered under ***SoonerCare***. Claims are generally paid on a per service occurrence basis.
FFY	**F**ederal **F**iscal **Y**ear—starts on October 1 and ends September 30 each year.
FMAP	**F**ederal **M**edical **A**ssistance **P**ercentage – The federal dollar match percentage.
ICF/MR	**I**ntermediate **C**are **F**acility for the **M**entally **R**etarded.
EPSDT	**E**arly and **P**eriodic **S**creening, **D**iagnosis and **T**reatment.
MMIS	**M**edical **M**anagement **I**nformation **S**ystem—the claims processing system.
Recipient	Receiver of services. See Served.
SCHIP	**S**tate **C**hildren's **H**ealth **I**nsurance **P**rogram for pregnant women regardless of age and children age 19 and under who have no creditable insurance and meet income requirements. (Title XXI)
Served	A term that accounts for persons enrolled in Medicaid that received a service.
SFY	**S**tate **F**iscal **Y**ear—starts on July 1 and ends June 30 each year.
SoonerCare	Oklahoma's partially capitated managed care program.
TANF/AFDC	**T**emporary **A**ssistance for **N**eedy **F**amilies, formerly known as **A**id to **F**amilies with **D**ependent **C**hildren.
Title XIX	Title 19—Federal Medicaid statute enacted in 1965 under the Social Security Act financed by both federal and state dollars.

Technical Notes

Throughout this report a combination of data sources were used to provide the most accurate information possible. The total number of beneficiaries are calculated on a statewide basis and various subsections. When any type of subsection is measured (i.e., aid category, county, etc.) beneficiary numbers may vary. Provider billing habits can cause claim variations as well. All report claim data is extracted with the date paid by OHCA being within the report period. Provided that a beneficiary is enrolled and eligible for a specific service at the time of service delivery, a provider has one year from the incurred date to submit a claim. Some providers hold claims and submit them all at once. For example, if a beneficiary receives a Medicaid service in May and the provider submits and is paid for the claim in July, that beneficiary will be counted as "served" or as a "recipient" and the dollar totals will be included in the July reporting period, even if the beneficiary had not been enrolled or eligible within that same reporting timeframe. If that beneficiary is not enrolled at some point within the reporting period, he or she will not be counted in the "Enrollees."

Appendix B OHCA SFY2005 Expenditures

Figure I SFY2005 Medicaid Expenditures by Payor

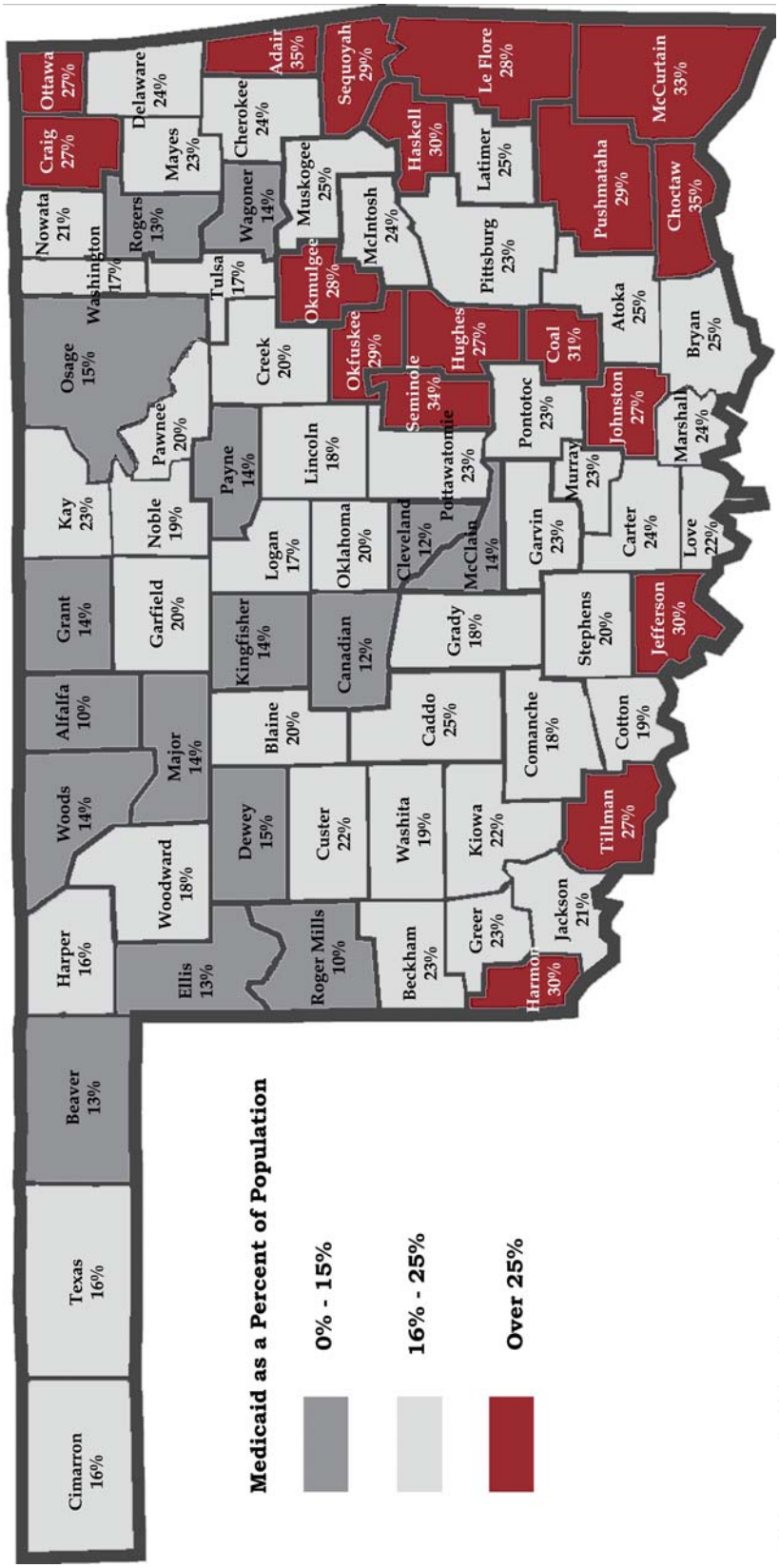
Category of Service	Total	Health Care Authority	Other State Agencies	Quality of Care
ADvantage Waiver	$89,015,303	$0	$89,015,303	$0
Ambulatory Clinics	$10,603,295	$8,991,693	$1,611,602	$0
Behavioral Health—Case Management	$829,082	$829,082	$0	$0
Behavioral Health—Clinic	$83,035,592	$57,161,373	$25,874,219	$0
Behavioral Health—Inpatient	$76,575,479	$73,606,577	$2,968,902	$0
Behavioral Health—Outpatient	$2,628,003	$2,628,003	$0	$0
Dentists	$79,575,381	$79,575,381	$0	$0
Family Planning Waiver	$2,149,569	$0	$2,149,569	$0
GME/IME/DME	$130,521,990	$3,498,283	$127,023,707	$0
Home & Community-Based Waiver	$108,812,691	$0	$108,812,691	$0
Home Health Care	$10,380,104	$10,380,104	$0	$0
Homeward Bound Waiver	$88,770,866	$0	$88,770,866	$0
ICF/MR Private	$47,765,787	$29,585,397	$0	$18,180,390
ICF/MR Public	$65,028,850	$0	$65,028,850	$0
In-Home Support Waiver	$12,636,753	$0	$12,636,753	$0
Inpatient Acute Care	$423,163,959	$371,342,664	$51,334,608	$486,687
Lab & Radiology	$10,402,142	$10,402,142	$0	$0
Medical Supplies	$39,352,295	$36,644,087	$0	$2,708,208
Medicare Buy-In	$81,269,288	$81,269,288	$0	$0
Miscellaneous Medical Payments	$9,576,685	$9,576,685	$0	$0
Nursing Facilities	$449,003,043	$291,437,506	$0	$157,565,537
Other Practitioners	$17,101,239	$16,654,875	$0	$446,364
Outpatient Acute Care	$87,742,907	$87,701,303	$0	$41,604
Personal Care Services	$17,196,110	$0	$17,196,110	$0
Physicians*	$216,198,739	$177,504,167	$33,920,806	$58,101
Prescription Drugs	$475,606,181	$462,633,189	$0	$12,972,992
Prior Year Expenditures	$3,651,232	3,651,232	$0	$0
Residential Behavioral Management	$31,950,074	$0	$31,950,074	$0
***SoonerCare* Choice**	$77,973,128	$69,527,533	$8,445,595	$0
***SoonerCare* Plus**	$1,694,974	$1,694,974	$0	$0
Targeted Case Management	$40,061,080	$0	$40,061,080	$0
Therapeutic Foster Care	$209,122	$0	$209,122	$0
Transportation	$15,118,558	$14,658,288	$0	$460,270
Total Medicaid Expenditures	**$2,805,599,501**	**$1,900,953,826**	**$707,009,857**	**$192,920,153**

Source: OHCA Financial Service Division, August 2005.

**Physicians total includes $4,715,665 in tobacco tax fund revenues.*

Appendix B OHCA SFY2005 Expenditures (continued)

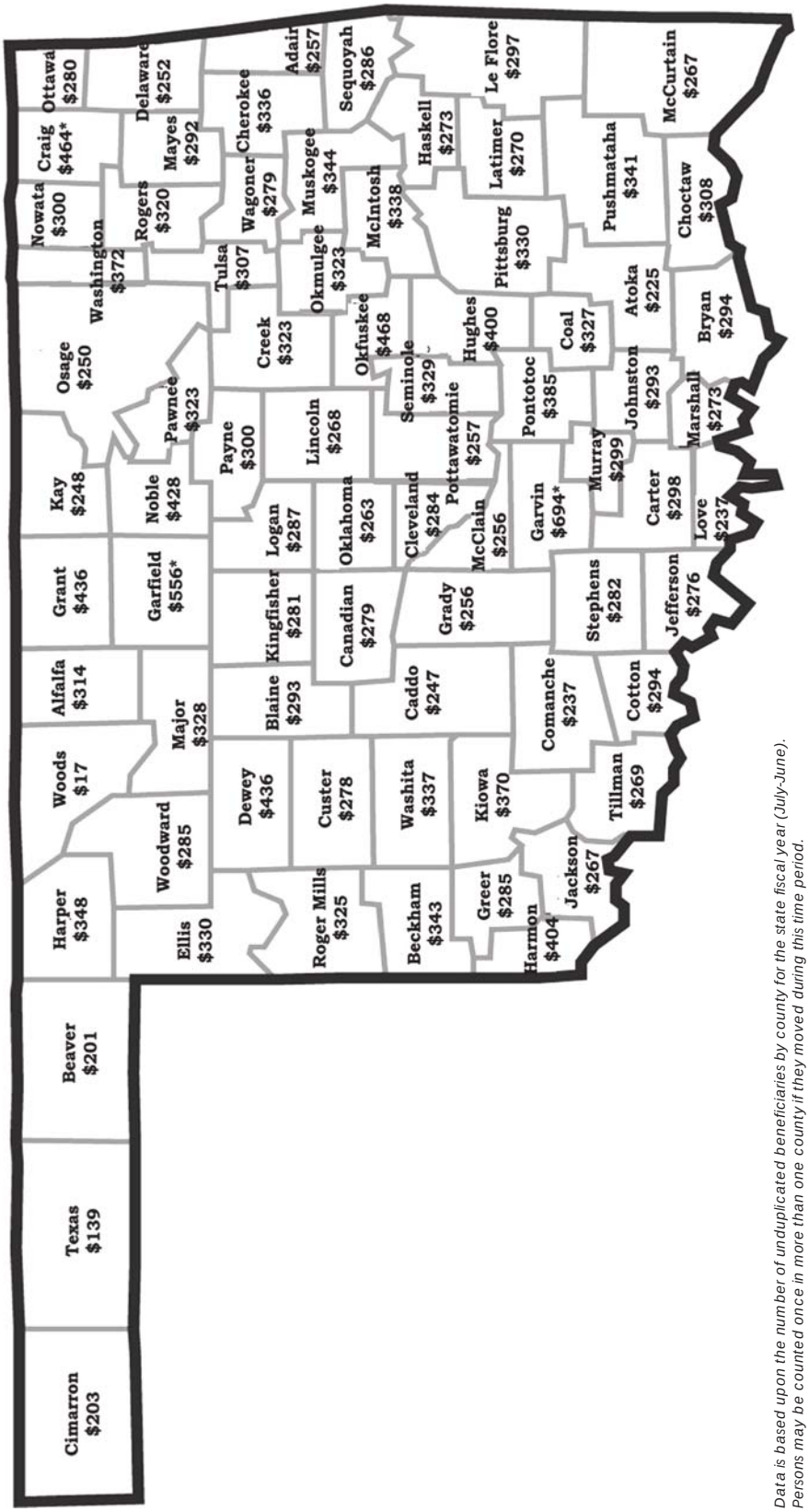
Figure II Unduplicated Persons Enrolled in Medicaid July 1, 2004 through June 30, 2005 as a Percent of the Total Oklahoma Population



Oklahoma Medicaid data is based upon the number of unduplicated beneficiaries by county for the entire state fiscal year (July-June). Persons may be counted once in more than one county if they moved during this time period. State totals based on Demographics and Population Estimates, Oklahoma Department of Commerce. http://www.okcommerce.gov.

Appendix B OHCA SFY2005 Expenditures (continued)

Figure III Average Dollars Spent per Medicaid Enrollee per Month



Data is based upon the number of unduplicated beneficiaries by county for the state fiscal year (July-June). Persons may be counted once in more than one county if they moved during this time period.
** Garfield and Garvin counties have public institutions and Craig county has 8 private institutions for the developmentally disabled (ICFs/MR) causing the average dollars per Medicaid beneficiary to be higher than the norm. Claim dollars were extracted from the claims history file for claims paid within the fiscal year.*

Appendix B OHCA SFY2005 Expenditures (continued)

Figure IV Statewide Medicaid Figures

County	Population Proj. July 2004*	Rank	Unduplicated Enrollees**	Rank	Pop. Covered by Medicaid	Rank
ADAIR	21,657	38	7,516	31	34.70%	2
ALFALFA	5,810	69	591	73	10.17%	76
ATOKA	14,255	46	3,577	44	25.09%	22
BEAVER	5,474	70	710	70	12.97%	73
BECKHAM	19,347	41	4,458	40	23.04%	34
BLAINE	11,290	55	2,303	56	20.40%	43
BRYAN	37,758	26	9,310	21	24.66%	23
CADDO	30,167	32	7,630	30	25.29%	21
CANADIAN	95,505	5	11,188	13	11.71%	75
CARTER	47,087	16	11,166	14	23.71%	28
CHEROKEE	44,106	19	10,513	17	23.84%	27
CHOCTAW	15,451	44	5,465	38	35.37%	1
CIMARRON	2,897	77	468	76	16.15%	60
CLEVELAND	222,074	3	26,561	3	11.96%	74
COAL	5,928	67	1,819	64	30.68%	5
COMANCHE	110,514	4	20,075	4	18.17%	52
COTTON	6,514	65	1,252	66	19.22%	49
CRAIG	14,873	45	4,017	42	27.01%	16
CREEK	68,666	9	13,742	8	20.01%	46
CUSTER	25,230	36	5,466	37	21.66%	40
DELAWARE	39,088	25	9,390	20	24.02%	26
DEWEY	4,667	72	687	71	14.72%	63
ELLIS	3,932	73	518	75	13.17%	72
GARFIELD	57,282	12	11,401	10	19.90%	47
GARVIN	27,229	34	6,394	33	23.48%	29
GRADY	48,176	15	8,687	24	18.03%	53
GRANT	4,824	71	680	72	14.10%	66
GREER	5,849	68	1,347	65	23.03%	35
HARMON	2,997	76	890	69	29.70%	6
HARPER	3,397	74	536	74	15.78%	61
HASKELL	12,088	51	3,569	45	29.53%	8
HUGHES	14,016	48	3,819	43	27.25%	15
JACKSON	27,182	35	5,756	36	21.18%	42
JEFFERSON	6,460	66	1,918	63	29.69%	7
JOHNSTON	10,440	59	2,819	53	27.00%	17
KAY	46,761	17	10,823	15	23.15%	31
KINGFISHER	14,176	47	1,922	62	13.56%	69
KIOWA	9,879	60	2,207	58	22.34%	38
LATIMER	10,647	58	2,700	54	25.36%	20
LEFLORE	49,161	13	13,911	7	28.30%	12

*Source: Demographics and Population Estimates, Oklahoma Department of Commerce. http://www.okcommerce.gov

**Enrollees listed above are the unduplicated count per county for the entire state fiscal year. A beneficiary may be counted twice if they had more than one county of residence within the fiscal year (July-June).

Appendix B OHCA SFY2005 Expenditures (continued)

Figure IV Statewide Medicaid Figures (continued)

County	Expenditures	Rank	Annual Per Capita	Rank	Monthly Per Enrollee	Rank
ADAIR	$23,218,904	31	$1,072	13	$257	64
ALFALFA	$2,229,717	73	$384	74	$314	31
ATOKA	$9,657,816	54	$678	50	$225	74
BEAVER	$1,716,318	75	$314	76	$201	76
BECKHAM	$18,329,237	41	$947	25	$343	15
BLAINE	$8,090,527	58	$717	46	$293	42
BRYAN	$32,847,740	22	$870	28	$294	39
CADDO	$22,647,685	32	$751	41	$247	71
CANADIAN	$37,412,854	18	$392	73	$279	53
CARTER	$39,902,572	16	$847	30	$298	37
CHEROKEE	$42,325,384	12	$960	22	$336	19
CHOCTAW	$20,220,229	36	$1,309	7	$308	32
CIMARRON	$1,137,356	77	$393	72	$203	75
CLEVELAND	$90,432,083	3	$407	71	$284	48
COAL	$7,127,483	60	$1,202	9	$327	24
COMANCHE	$57,131,290	6	$517	64	$237	73
COTTON	$4,410,059	67	$677	52	$294	40
CRAIG ‡	$22,374,543	33	$1,504	3	$464	4
CREEK	$53,185,850	8	$775	37	$323	28
CUSTER	$18,220,740	43	$722	45	$278	54
DELAWARE	$28,412,228	29	$727	44	$252	68
DEWEY	$3,594,468	70	$770	38	$436	6
ELLIS	$2,052,539	74	$522	63	$330	21
GARFIELD ‡	$76,133,880	4	$1,329	6	$556	2
GARVIN ‡	$53,231,839	7	$1,955	1	$694	1
GRADY	$26,707,757	30	$554	60	$256	66
GRANT	$3,559,690	71	$738	43	$436	5
GREER	$4,608,471	66	$788	36	$285	46
HARMON	$4,311,964	68	$1,439	4	$404	8
HARPER	$2,236,880	72	$658	53	$348	13
HASKELL	$11,703,772	47	$968	21	$273	57
HUGHES	$18,328,916	42	$1,308	8	$400	9
JACKSON	$18,437,811	40	$678	49	$267	62
JEFFERSON	$6,359,219	62	$984	19	$276	55
JOHNSTON	$9,927,935	52	$951	23	$293	41
KAY	$32,161,726	24	$688	48	$248	70
KINGFISHER	$6,481,657	61	$457	68	$281	50
KIOWA	$9,789,874	53	$991	17	$370	12
LATIMER	$8,735,199	56	$820	31	$270	58
LEFLORE	$49,590,807	9	$1,009	16	$297	38

‡Garfield and Garvin counties have public institutions and Craig county has 8 private institutions for the developmentally disabled (ICF/MRs) causing the average dollars per Medicaid enrollee to be higher than the norm. Source: OHCA Financial Service Division, October 2005.

Appendix B OHCA SFY2005 Expenditures (continued)

Figure IV Statewide Medicaid Figures (continued)

County	Population Proj. July 2004*	Rank	Unduplicated Enrollees**	Rank	Pop. Covered by Medicaid	Rank
LINCOLN	32,386	31	5,780	35	17.85%	54
LOGAN	36,301	27	6,262	34	17.25%	56
LOVE	9,133	61	2,024	61	22.16%	39
MCCLAIN	29,070	33	4,071	41	14.00%	67
MCCURTAIN	34,046	29	11,301	11	33.19%	4
MCINTOSH	19,939	40	4,816	39	24.15%	24
MAJOR	7,363	64	997	68	13.54%	70
MARSHALL	13,860	49	3,340	50	24.10%	25
MAYES	39,274	24	9,081	22	23.12%	32
MURRAY	12,682	50	2,878	52	22.69%	37
MUSKOGEE	70,626	7	18,004	5	25.49%	19
NOBLE	11,233	56	2,079	60	18.51%	51
NOWATA	10,717	57	2,280	57	21.27%	41
OKFUSKEE	11,637	53	3,395	47	29.17%	9
OKLAHOMA	680,815	1	135,220	1	19.86%	48
OKMULGEE	39,890	23	11,225	12	28.14%	13
OSAGE	45,181	18	6,802	32	15.06%	62
OTTAWA	32,737	30	8,998	23	27.49%	14
PAWNEE	16,834	43	3,422	46	20.33%	44
PAYNE	69,675	8	9,907	19	14.22%	65
PITTSBURG	43,950	20	10,144	18	23.08%	33
PONTOTOC	35,007	28	8,188	29	23.39%	30
POTTAWATOMIE	67,111	10	15,372	6	22.91%	36
PUSHMATAHA	11,715	52	3,354	48	28.63%	11
ROGER MILLS	3,259	75	314	77	9.63%	77
ROGERS	79,042	6	10,550	16	13.35%	71
SEMINOLE	24,679	37	8,312	27	33.68%	3
SEQUOYAH	40,578	22	11,693	9	28.82%	10
STEPHENS	42,826	21	8,582	26	20.04%	45
TEXAS	20,296	39	3,347	49	16.49%	59
TILLMAN	8,785	62	2,341	55	26.65%	18
TULSA	569,148	2	96,113	2	16.89%	57
WAGONER	63,054	11	8,666	25	13.74%	68
WASHINGTON	49,027	14	8,231	28	16.79%	58
WASHITA	11,512	54	2,168	59	18.83%	50
WOODS	8,570	63	1,231	67	14.36%	64
WOODWARD	18,741	42	3,289	51	17.55%	55
OTHER⁂	0		5,165			
TOTAL	**3,523,553**		**696,743**		**19.77%**	

*Source: Demographics and Population Estimates, Oklahoma Department of Commerce. http://www.okcommerce.gov

**Enrollees listed above are the unduplicated count per county for the entire state fiscal year. A beneficiary may be counted more than once if they had more than one county of residence within the fiscal year (July-June).

⁂ OTHER could include state custody children or out of state enrollees.

Appendix B OHCA SFY2005 Expenditures (continued)

Figure IV Statewide Medicaid Figures (continued)

County	Expenditures	Rank	Annual Per Capita	Rank	Monthly Per Enrollee	Rank
LINCOLN	$18,605,577	39	$574	59	$268	60
LOGAN	$21,537,853	34	$593	58	$287	44
LOVE	$5,761,328	63	$631	54	$237	72
MCCLAIN	$12,504,873	46	$430	70	$256	67
MCCURTAIN	$36,262,201	20	$1,065	14	$267	61
MCINTOSH	$19,549,614	37	$980	20	$338	17
MAJOR	$3,924,339	69	$533	62	$328	23
MARSHALL	$10,954,950	49	$790	34	$273	56
MAYES	$31,854,911	25	$811	33	$292	43
MURRAY	$10,342,445	51	$816	32	$299	36
MUSKOGEE	$74,399,193	5	$1,053	15	$344	14
NOBLE	$10,668,003	50	$950	24	$428	7
NOWATA	$8,204,528	57	$766	39	$300	35
OKFUSKEE ‡	$19,074,918	38	$1,639	2	$468	3
OKLAHOMA	$426,741,767	1	$627	55	$263	63
OKMULGEE	$43,560,833	11	$1,092	11	$323	26
OSAGE	$20,428,858	35	$452	69	$250	69
OTTAWA	$30,217,537	26	$923	26	$280	51
PAWNEE	$13,271,191	45	$788	35	$323	27
PAYNE	$35,696,447	21	$512	66	$300	34
PITTSBURG	$40,199,194	14	$915	27	$330	20
PONTOTOC	$37,842,483	17	$1,081	12	$385	10
POTTAWATOMIE	$47,441,808	10	$707	47	$257	65
PUSHMATAHA	$13,736,710	44	$1,173	10	$341	16
ROGER MILLS	$1,224,065	76	$376	75	$325	25
ROGERS	$40,537,631	13	$513	65	$320	29
SEMINOLE	$32,818,301	23	$1,330	5	$329	22
SEQUOYAH	$40,075,783	15	$988	18	$286	45
STEPHENS	$28,997,158	28	$677	51	$282	49
TEXAS	$5,589,527	64	$275	77	$139	77
TILLMAN	$7,554,048	59	$860	29	$269	59
TULSA	$353,528,573	2	$621	56	$307	33
WAGONER	$29,025,789	27	$460	67	$279	52
WASHINGTON	$36,727,992	19	$749	42	$372	11
WASHITA	$8,779,796	55	$763	40	$337	18
WOODS	$4,685,938	65	$547	61	$317	30
WOODWARD	$11,235,715	48	$600	57	$285	47
OTHER⁂	$323,052,602					
TOTAL	**$2,805,599,500**		**$796**		**$336**	

‡ *Okfuskee County has 12 private institutions for the developmentally disabled (ICFs/MR) causing the average dollars per Medicaid beneficiary to be higher than the norm.*
⁂ *OTHER could include state custody children, out of state enrollees or providers and any non-provider or non-beneficiary specific payments.*
Source: OHCA Financial Service Division, October 2005. Claim dollars were extracted from the claims history file for claims paid within the fiscal year .

Appendix B OHCA SFY2005 Expenditures (continued)

Figure V Dollars Paid to Providers and Beneficiaries by County in SFY2005

County	Total Dollars Paid by Provider County	Total Dollars Paid by Beneficiary County	% of Dollars Staying in County
ADAIR	$10,948,999	$23,218,904	47.2%
ALFALFA	$1,369,237	$2,229,717	61.4%
ATOKA	$6,383,704	$9,657,816	66.1%
BEAVER	$1,281,561	$1,716,318	74.7%
BECKHAM	$14,640,836	$18,329,237	79.9%
BLAINE	$4,491,929	$8,090,527	55.5%
BRYAN	$36,930,288	$32,847,740	112.4%
CADDO	$18,079,856	$22,647,685	79.8%
CANADIAN	$25,775,994	$37,412,854	68.9%
CARTER	$34,130,957	$39,902,572	85.5%
CHEROKEE	$42,371,724	$42,325,384	100.1%
CHOCTAW	$13,565,025	$20,220,229	67.1%
CIMARRON	$745,670	$1,137,356	65.6%
CLEVELAND	$79,266,378	$90,432,083	87.7%
COAL	$3,651,406	$7,127,483	51.2%
COMANCHE	$57,429,016	$57,131,290	100.5%
COTTON	$2,155,567	$4,410,059	48.9%
CRAIG	$19,935,400	$22,374,543	89.1%
CREEK	$42,689,968	$53,185,850	80.3%
CUSTER	$17,065,828	$18,220,740	93.7%
DELAWARE	$16,315,590	$28,412,228	57.4%
DEWEY	$2,871,119	$3,594,468	79.9%
ELLIS	$1,983,580	$2,052,539	96.6%
GARFIELD	$71,899,223	$76,133,880	94.4%
GARVIN	$49,159,417	$53,231,839	92.3%
GRADY	$18,456,983	$26,707,757	69.1%
GRANT	$2,333,694	$3,559,690	65.6%
GREER	$3,146,595	$4,608,471	68.3%
HARMON	$3,586,828	$4,311,964	83.2%
HARPER	$2,068,780	$2,236,880	92.5%
HASKELL	$14,526,578	$11,703,772	124.1%
HUGHES	$9,351,401	$18,328,916	51.0%
JACKSON	$16,304,592	$18,437,811	88.4%
JEFFERSON	$3,981,162	$6,359,219	62.6%
JOHNSTON	$6,526,404	$9,927,935	65.7%
KAY	$23,765,470	$32,161,726	73.9%
KINGFISHER	$8,201,417	$6,481,657	126.5%
KIOWA	$10,054,593	$9,789,874	102.7%
LATIMER	$4,908,599	$8,735,199	56.2%
LEFLORE	$36,153,415	$49,590,807	72.9%

Appendix B OHCA SFY2005 Expenditures (continued)

Figure V Dollars Paid to Providers and Beneficiaries by County in SFY2005 (continued)

County	Total Dollars Paid by Provider County	Total Dollars Paid by Beneficiary County	% of Dollars Staying in County
LINCOLN	$10,562,278	$18,605,577	56.8%
LOGAN	$13,683,161	$21,537,853	63.5%
LOVE	$3,110,677	$5,761,328	54.0%
MCCLAIN	$9,842,387	$12,504,873	78.7%
MCCURTAIN	$24,624,777	$36,262,201	67.9%
MCINTOSH	$18,523,725	$19,549,614	94.8%
MAJOR	$2,860,815	$3,924,339	72.9%
MARSHALL	$8,471,117	$10,954,950	77.3%
MAYES	$16,646,266	$31,854,911	52.3%
MURRAY	$6,179,634	$10,342,445	59.8%
MUSKOGEE	$73,900,703	$74,399,193	99.3%
NOBLE	$7,638,080	$10,668,003	71.6%
NOWATA	$5,590,872	$8,204,528	68.1%
OKFUSKEE	$14,325,700	$19,074,918	75.1%
OKLAHOMA	$704,901,632	$426,741,767	165.2%
OKMULGEE	$30,038,092	$43,560,833	69.0%
OSAGE	$5,989,223	$20,428,858	29.3%
OTTAWA	$29,590,730	$30,217,537	97.9%
PAWNEE	$9,368,620	$13,271,191	70.6%
PAYNE	$32,106,851	$35,696,447	89.9%
PITTSBURG	$36,602,638	$40,199,194	91.1%
PONTOTOC	$40,203,825	$37,842,483	106.2%
POTTAWATOMIE	$31,806,128	$47,441,808	67.0%
PUSHMATAHA	$12,891,572	$13,736,710	93.8%
ROGER MILLS	$692,802	$1,224,065	56.6%
ROGERS	$32,776,364	$40,537,631	80.9%
SEMINOLE	$25,288,523	$32,818,301	77.1%
SEQUOYAH	$35,568,327	$40,075,783	88.8%
STEPHENS	$23,085,275	$28,997,158	79.6%
TEXAS	$5,552,476	$5,589,527	99.3%
TILLMAN	$4,858,195	$7,554,048	64.3%
TULSA	$513,860,749	$353,528,573	145.4%
WAGONER	$10,484,733	$29,025,789	36.1%
WASHINGTON	$26,034,274	$36,727,992	70.9%
WASHITA	$4,756,756	$8,779,796	54.2%
WOODS	$3,677,880	$4,685,938	78.5%
WOODWARD	$11,068,206	$11,235,715	98.5%
OTHER⁂	$219,930,652	$323,052,602	
TOTAL	**$2,805,599,500**	**$2,805,599,500**	**Average: 78.46%**

⁂ *OTHER could include state custody children, out of state enrollees or providers and any non-provider or non-beneficiary specific payments. Non-provider specific payments includes $81,269,288 in Medicare Buy-In payments and $51,211,981 in GME payments to medical schools.*

Source: OHCA Financial Service Division, November 2005. Claim dollars were extracted from the claims history file for claims paid within the fiscal year.

Appendix B OHCA SFY2005 Expenditures (continued)

Figure VI Expenditures by Service Type and by Aid Category

Service Type	Total	Aged	Blind / Disabled	TANF / Poverty Related	Breast & Cervical Cancer	Family Planning Waiver	Other
Adult Day Care	$993,621	$765,598	$228,022	$0	$0	$0	$0
Adv Comp Health	$33,991,060	$22,096,193	$11,894,868	$0	$0	$0	$0
Advanced Practice Nurse (APN)	$1,952,840	$36,134	$245,325	$1,669,512	$1,869	$0	$0
ADvantage Home Delivered Meals	$3,408,482	$2,225,956	$1,182,525	$0	$0	$0	$0
Ambulatory Surgical Services	$2,600,138	$302,429	$598,950	$1,692,347	$5,530	$881	$0
Architectural Modifications	$527,104	$46,096	$481,008	$0	$0	$0	$0
Audiology	$96,463	$379	$17,963	$78,120	$0	$0	$0
Behavioral Health	$60,642,248	$1,443,487	$23,609,410	$35,586,288	$1,516	$0	$1,548
Capitated (CAP) Services	$84,745,647	$22,098	$12,070,642	$72,446,519	$26,478	$0	$179,910
Capitated (CAP) Services - GME to Medical Schools	$51,211,981	$0	$0	$51,211,981	$0	$0	$0
Chiropractic	$6,812	$4,155	$2,653	$4	$0	$0	$0
Clinic	$7,404,118	$905,432	$1,870,094	$4,604,802	$18,073	$5,074	$644
Clinics - OSA	$3,491,931	$282	$475,115	$2,946,974	$4,253	$65,272	$34
Community Mental Health Services	$25,222,328	$847,134	$17,960,048	$6,406,705	$8,440	$0	$0
Dental	$79,306,999	$347,569	$3,727,747	$75,220,194	$10,169	$0	$1,320
Direct Support	$154,719,659	$1,494,176	$153,225,483	$0	$0	$0	$0
Employee Training Specialist	$20,530,857	$199,548	$20,331,309	$0	$0	$0	$0
End Stage Renal Disease (ESRD)	$8,913,735	$1,551,716	$7,202,677	$159,343	$0	$0	$0
Eye Care and Exams	$4,404,218	$124,554	$422,986	$3,855,047	$1,319	$0	$312
Eyewear	$6,049,544	$10,878	$350,459	$5,687,403	$366	$0	$438
Free Standing Birthing Center	$60,253	$125	$0	$60,128	$0	$0	$0
Group Home	$12,405,244	$301,086	$12,104,158	$0	$0	$0	$0
Home Health (HH)	$10,627,992	$131,968	$8,043,642	$2,447,796	$4,586	$0	$0
Homemaker	$804,092	$1,321	$802,771	$0	$0	$0	$0
Hospice	$276,729	$0	$276,729	$0	$0	$0	$0
HSP - Indirect Medical Education (IME)	$24,136,084	$22,929,280	$0	$1,206,804	$0	$0	$0
HSP - Graduate Medical Education (GME)	$55,559,445	$52,781,473	$0	$2,777,972	$0	$0	$0
HSP - Acute DSH	$31,175,374	$29,616,605	$0	$1,558,769	$0	$0	$0
HSP - Upper Payment Limit	$36,815,335	$34,974,568	$0	$1,840,767	$0	$0	$0
ICF-MR	$113,131,475	$5,265,883	$107,667,563	$198,029	$0	$0	$0
Inpatient	$354,086,919	$20,195,268	$106,101,984	$227,502,246	$286,732	$0	$689
Laboratory	$11,000,083	$148,018	$1,807,497	$9,021,496	$21,625	$813	$633

Appendix B OHCA SFY2005 Expenditures (continued)

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

Service Type	Total	Aged	Blind / Disabled	TANF / Poverty Related	Breast & Cervical Cancer	Family Planning Waiver	Other
Medicare Buy-In Payments	$81,269,288	$81,269,288	$0	$0	$0	$0	$0
Mid Level Practitioner (MLP)	$360,841	$3,350	$71,255	$285,559	$484	$0	$192
Medical Supplies/ Durable goods	$47,695,144	$11,161,559	$27,427,884	$9,097,199	$7,769	$0	$734
Non-Emergency Transportation	$15,060,916	$1,431,016	$2,297,277	$11,324,127	$7,986	$0	$510
Nursing Home	$448,627,507	$356,478,770	$91,523,501	$625,213	$0	$0	$23
Nursing	$16,416,188	$7,814,627	$8,601,561	$0	$0	$0	$0
Nutritionist	$280,601	$5,061	$273,829	$1,711	$0	$0	$0
Outpatient	$89,755,318	$845,789	$19,531,330	$68,772,960	$601,578	$880	$ 2,781
Personal Care	$47,632,058	$28,191,042	$19,402,238	$38,779	$0	$0	$0
Physician	$224,367,166	$10,441,739	$57,293,349	$155,348,695	$1,273,125	$3,147	$7,112
Podiatry	$434,317	$61,377	$191,189	$181,651	$100	$0	$0
Prescribed Drugs	$466,786,778	$124,560,229	$223,148,768	$118,764,727	$305,521	$3,321	$4,212
Prosthetic/Orthotic	$880,667	$96,821	$570,720	$213,127	$0	$0	$0
Psychiatric	$62,566,762	$759,843	$10,749,479	$51,057,440	$0	$0	$0
Residential Behavior Management	$32,172,073	$28,347	$524,432	$31,613,477	$0	$0	$5,816
Respite Care	$232,071	$106,089	$125,983	$0	$0	$0	$0
Room and Board	$157,893	$800	$20,710	$136,383	$0	$0	$0
School Based Services	$5,551,664	$35	$2,643,295	$2,908,334	$0	$0	$0
Specialized Foster Care/MR Services	$3,251,094	$0	$3,251,094	$0	$0	$0	$0
State Program (SP) Services	$29,474	$3	$0	$29,471	$0	$0	$0
Targeted Case Manager (TCM)	$40,273,538	$4,602,639	$17,124,376	$18,545,053	$219	$199	$1,053
Therapy	$1,822,952	$9,080	$1,458,930	$354,943	$0	$0	$0
Transportation	$16,415,404	$1,166,745	$10,089,289	$5,151,499	$1,894	$0	$5,976
X-Ray	$1,329,602	$79,346	$393,772	$844,963	$11,521	$0	$0
Unknown Services	$1,931,371	$60,435	$226,677	$998,240	$20,242	$0	$625,777
Grand Total	**$2,805,599,500**	**$827,943,438**	**$989,642,568**	**$984,472,797**	**$2,621,396**	**$79,587**	**$839,713**

Appendix B OHCA SFY2005 Expenditures (continued)

Figure VII Expenditures by Service Type

SFY2005 Service Type	Expenditures	Recipients*	Avg. per Recipient
Adult Day Care Services	$993,621	378	$2,629
Adv Comp Health Services	$33,991,060	10,231	$3,322
Advanced Practice Nurse (APN)	$1,952,840	13,926	$140
ADvantage Home Delivered Meals	$3,408,482	6,235	$547
Ambulatory Surgical Services	$2,600,138	9,044	$287
Architectural Modification	$527,104	250	$2,108
Audiology Services	$96,463	698	$138
Behavioral Health Services	$60,642,249	49,343	$1,229
Capitated (CAP) Services	$84,745,648	478,945	$177
Capitated (CAP) Services - GME to Medical Schools	$51,211,981	-	
Chiropractic Services	$6,812	190	$36
Clinic Services	$7,404,118	28,511	$260
Clinics - OSA Services	$3,491,931	37,476	$93
Community Mental Health	$25,222,328	17,933	$1,406
Dental Services	$79,307,000	194,667	$407
Direct Support Services	$154,719,659	3,821	$40,492
Employee Training Specialist	$20,530,857	2,357	$8,711
End Stage Renal Disease (ESRD)	$8,913,735	1,696	$5,256
Eye Care and Exam Services	$4,404,218	73,155	$60
Eyewear Services	$6,049,544	55,611	$109
Free Standing Birthing Center	$60,253	48	$1,255
Group Home Services	$12,405,244	531	$23,362
Home Health (HH) Services	$10,627,992	3,473	$3,060
Homemaker Services	$804,092	310	$2,594
Hospice Services	$276,729	32	$8,648
Hospital - Indirect Medical Education (IME)	$24,136,084	-	
Hospital - Graduate Medical Education (GME)	$55,559,445	-	
Hospital - Acute DSH	$31,175,374	-	
Hospital - Upper Payment Limit	$36,815,335	-	
ICF/MR Services	$113,131,475	1,969	$57,456
Inpatient Services	$354,086,919	83,747	$4,228
Laboratory Services	$11,000,084	103,162	$107
Medicare Buy-In Payments	$81,269,288	-	
Mid Level Practitioner (MLP)	$360,841	5,412	$67

Appendix B OHCA SFY2005 Expenditures (continued)

Figure VII Expenditures by Service Type (continued)

SFY2005 Service Type	Expenditures	Recipients*	Avg. per Recipient
Medical Supply/Durable Goods	$47,695,145	55,360	$862
Non-Emergency Transportation (NET) Services	$15,060,916	594,523	$25
Nursing Home Services	$448,627,507	22,709	$19,755
Nursing Services	$16,416,188	6,461	$2,541
Nutritionist Services	$280,601	717	$391
Outpatient Services	$89,755,319	304,185	$295
Personal Care Services	$47,632,058	18,434	$2,584
Physician Services	$224,367,166	352,595	$636
Podiatry Services	$434,317	3,931	$110
Prescribed Drugs Services	$466,786,777	418,165	$1,116
Prosthetic/Orthotic Services	$880,667	1,080	$815
Psychiatric Services	$62,566,762	4,469	$14,000
Residential Behavior Mgmt (RBMS) Services	$32,172,073	3,008	$10,696
Respite Care Services	$232,071	109	$2,129
Room and Board Services	$157,893	371	$426
School Based Services	$5,551,664	12,996	$427
Specialized Foster Care/MR Services	$3,251,094	269	$12,086
State Program (SP) Services	$29,474	16	$1,842
Targeted Case Manager (TCM)	$40,273,538	30,769	$1,309
Therapy Services	$1,822,952	1,514	$1,204
Transportation Services	$16,415,404	35,283	$465
X-Ray Services	$1,329,602	32,071	$41
Unknown Services by Claim Type	$1,931,371	14,881	$130
TOTALS	**$2,805,599,500**	**629,703**	**$4,455**

Source: OHCA Financial Service Division, October 2005. Claim dollars were extracted from the claims history file for claims paid within the fiscal year.
** Recipient figures are the unduplicated counts of beneficiaries that received a service. If a beneficiary received services from multiple service type providers, they would be counted once for each service type category.*

Appendix B OHCA SFY2005 Expenditures (continued)

Figure VIII Adult and Children Expenditures by Service Type

SFY2005	Adult Totals			Children Totals		
Service Type	Expenditures	Recipients*	Avg. per Adult	Expenditures	Recipients*	Avg. per Child
Adult Day Care Services	$993,621	378	$2,629	$0	-	$0
Adv Comp Health Services	$33,980,304	10,226	$3,323	$10,756	5	$2,151
Advanced Practice Nurse (APN)	$846,487	6,314	$134	$1,106,354	7,612	$145
ADvantage Home Delivered Meals	$3,408,201	6,234	$547	$281	1	$281
Ambulatory Surgical Services	$1,170,808	5,580	$210	$1,429,330	3,464	$413
Architectural Modification	$435,896	215	$2,027	$91,208	35	$2,606
Audiology Services	$3,691	80	$46	$92,772	618	$150
Behavioral Health Services	$23,987,521	18,871	$1,271	$36,654,728	30,472	$1,203
Capitated (CAP) Services	$18,582,996	101,676	$183	$66,162,651	377,269	$175
Capitated (CAP) Services - GME to Medical Schools	$0	-	$0	$51,211,981	-	$0
Chiropractic Services	$6,812	190	$36	$0	-	$0
Clinic Services	$3,758,885	13,812	$272	$3,645,234	14,699	$248
Clinics - OSA Services	$167,369	2,215	$76	$3,324,562	35,261	$94
Community Mental Health	$19,179,746	9,695	$1,978	$6,042,582	8,238	$734
Dental Services	$5,785,620	15,406	$376	$73,521,380	179,261	$410
Direct Support Services	$138,294,709	2,832	$48,833	$16,424,950	989	$16,608
Employee Training Specialist	$19,450,860	2,180	$8,922	$1,079,996	177	$6,102
End Stage Renal Disease (ESRD)	$8,837,003	1,681	$5,257	$76,732	15	$5,115
Eye Care and Exam Services	$401,771	8,074	$50	$4,002,447	65,081	$61
Eyewear Services	$24,274	304	$80	$6,025,270	55,307	$109
Free Standing Birthing Center	$40,349	34	$1,187	$19,904	14	$1,422
Group Home Services	$11,168,111	485	$23,027	$1,237,132	46	$26,894
Home Health (HH) Services	$1,484,950	2,643	$562	$9,143,042	830	$11,016
Homemaker Services	$410,853	158	$2,600	$393,239	152	$2,587
Hospice Services	$276,729	32	$8,648	$0	-	$0
Hospital - Indirect Medical Education (IME)	$15,776,254	-	$0	$8,359,830	-	$0
Hospital - Graduate Medical Education (GME)	$36,315,746	-	$0	$19,243,699	-	$0
Hospital - Acute DSH	$20,377,399	-	$0	$10,797,975	-	$0
Hospital - Upper Payment Limit	$24,063,890	-	$0	$12,751,445	-	$0
ICF/MR Services	$109,237,960	1,880	$58,105	$3,893,515	89	$43,747
Inpatient Services	$159,445,098	62,223	$2,562	$194,641,821	21,524	$9,043
Laboratory Services	$5,309,292	47,922	$111	$5,690,792	55,240	$103
Medicare Buy-In Payments	$81,269,288	-	$0	$0	-	$0
Mid Level Practitioner (MLP)	$114,692	1,706	$67	$246,148	3,706	$66

Appendix B OHCA SFY2005 Expenditures (continued)

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

SFY2005	Adult Totals			Children Totals		
Service Type	Expenditures	Recipients*	Avg. per Adult	Expenditures	Recipients*	Avg. per Child
Medical Supply/Durable Goods	$30,673,772	42,462	$722	$17,021,373	12,898	$1,320
Non-Emergency Transportation (NET) Services	$4,747,836	189,291	$25	$10,313,080	405,232	$25
Nursing Home Services	$447,705,513	22,664	$19,754	$921,994	45	$20,489
Nursing Services	$16,307,407	6,454	$2,527	$108,781	7	$15,540
Nutritionist Services	$268,832	656	$410	$11,769	61	$193
Outpatient Services	$33,533,004	117,504	$285	$56,222,315	186,681	$301
Personal Care Services	$47,175,173	18,311	$2,576	$456,886	123	$3,715
Physician Services	$105,093,928	155,050	$678	$119,273,238	197,545	$604
Podiatry Services	$273,438	3,282	$83	$160,879	649	$248
Prescribed Drugs Services	$338,085,546	164,826	$2,051	$128,701,231	253,339	$508
Prosthetic/Orthotic Services	$301,273	672	$448	$579,394	408	$1,420
Psychiatric Services	$780,539	725	$1,077	$61,786,223	3,744	$16,503
Residential Behavior Mgmt (RBMS) Services	$39,413	2	$19,706	$32,132,660	3,006	$10,690
Respite Care Services	$188,034	88	$2,137	$44,038	21	$2,097
Room and Board Services	$30,043	130	$231	$127,850	241	$530
School Based Services	$7,023	4	$1,756	$5,544,641	12,992	$427
Specialized Foster Care/MR Services	$1,537,488	117	$13,141	$1,713,606	152	$11,274
State Program (SP) Services	$24,523	13	$1,886	$4,951	3	$1,650
Targeted Case Manager (TCM)	$19,199,471	10,056	$1,909	$21,074,067	20,713	$1,017
Therapy Services	$843,313	967	$872	$979,640	547	$1,791
Transportation Services	$11,573,181	28,557	$405	$4,842,223	6,726	$720
X-Ray Services	$803,274	14,410	$56	$526,328	17,661	$30
Unknown Services by Claim Type	$601,358	4,640	$130	$1,330,013	10,241	$130
TOTALS	$1,804,400,566	212,209	$8,503	$1,001,198,935	417,494	$2,398

Source: OHCA Financial Service Division, October 2005. Claim dollars were extracted from the claims history file for claims paid within the fiscal year.
** Recipient figures are the unduplicated counts of beneficiaries that received a service. If a beneficiary received services from multiple service type providers, they would be counted once for each service type category.*

Appendix B OHCA SFY2005 Expenditures (continued)

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

Home and Community-Based Waiver Service Type	ADvantage	Community	Homeward Bound	In Home Support
Adult Day Care Services	$978,562	$14,604	$0	$455
Adv Comp Health Services	$33,991,060	$0	$0	$0
ADvantage Home Delivered Meals	$3,408,482	$0	$0	$0
Architectural Modification Services	$74,772	$190,702	$190,059	$71,571
Audiology Services	$0	$475	$361	$105
Behavioral Health Services	$0	$761,742	$390,881	$39,003
Clinic Services	$0	$304	$0	$0
Dental Services	$0	$30,542	$34,859	$2,090
Direct Support Services	$0	$69,671,748	$75,262,622	$9,785,289
Employee Training Specialist	$0	$13,747,347	$5,068,658	$1,714,851
Group Home Services	$0	$12,297,394	$107,850	$0
Home Health Services	$0	$1,075	$0	$0
Homemaker Services	$0	$621,459	$14,969	$167,664
Hospice Services	$276,729	$0	$0	$0
MSDG Services	$6,938,841	$2,055,022	$968,937	$472,447
Nursing Services	$12,809,788	$1,190,546	$2,415,854	$0
Nutritionist Services	$0	$127,718	$151,505	$1,378
Personal Care Services	$27,401,786	$0	$0	$0
Physician Services	$0	$1,932,010	$1,083,584	$89,243
Prescribed Drugs Services	$5,623,705	$509,789	$1,106,078	$38,691
Prosthetic/Orthotic Services	$62	$0	$0	$0
Respite Care Services	$180,589	$38,440	$0	$13,042
Specialized Foster Care/MR	$0	$3,191,479	$59,280	$335
Targeted Case Manager (TCM)	$7,460,936	$0	$0	$0
Therapy Services	$0	$469,284	$301,796	$49,064
Transportation Services	$193	$2,891,551	$2,611,816	$280,919
Unknown Services by Claim Type	$0	$28	$0	$0
Total	**$99,145,503**	**$109,743,259**	**$89,769,111**	**$12,726,145**
Unique Beneficiaries Served	16,518	2,679	824	1,232
Cost per Served Beneficiary	$6,002	$40,964	$108,943	$10,330

Source: OHCA Financial Service Division, October 2005. Claim dollars were extracted from the claims history file for claims paid within the fiscal year.

Appendix B OHCA SFY2005 Expenditures (continued)

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

Service Type	Expenditures	Recipients*	Average per Recipient
Behavioral Health Services for Children			
Inpatient (Acute)	$5,095,022	1,277	$3,990
Inpatient (Freestanding Hospital and RTCs)	$61,823,614	,745	$16,508
Outpatient Behavioral Health (Private)	$31,964,512	22,093	$1,447
Outpatient Community Mental Health Services (Public / Contracted)	$8,458,849	9,288	$911
Psychologist	$2,211,643	4,957	$446
Psychiatrist	$1,481,140	4,654	$318
Other Outpatient Behavioral Health Services	$125,913	269	$468
Residential Behavior Mgmt Services (RBMS)	$32,172,073	3,008	$10,696
Targeted Case Management (TCM)	$134,921	1,333	$101
Children Total	**$143,467,687**	**35,592**	**$4,031**
Behavioral Health Services for Adults			
Inpatient (Acute)	$8,743,465	2,238	$3,907
Inpatient (Freestanding Hospital)	$743,149	725	$1,025
Outpatient Behavioral Health (Private)	$14,635,863	7,049	$2,076
Outpatient Community Mental Health Services	$26,839,865	12,059	$2,226
Psychologist	$869,109	1,561	$557
Psychiatrist	$1,314,612	5,745	$229
Other Behavioral Health Services	$325,318	469	$694
Residential Behavior Mgmt Services (RBMS)	-	-	-
Targeted Case Management (TCM)	659,190	3,231	$204
Adult Total	**$54,130,571**	**19,548**	**$2,769**
Total All Behavioral Health Services	**$197,598,258**	**55,021**	**$3,591**

Source: OHCA Financial Service Division, October 2005. Claim dollars were extracted from the claims history file for claims paid within the fiscal year.
** Recipient figures are the unduplicated counts of beneficiaries that received a service. If a beneficiary received services from multiple service type providers, they would be counted once for each service type category.*

Appendix C Contracted Medicaid Providers

Provider Type	Percent Change 1995 to 2005	SFY1995	SFY2005
Adult Day Care	2,450%	2	51
Advance Practice Nurse	1,266%	38	519
Advantage Comprehensive Health Care	414%	7	36
Advantage Home Delivered Meal	2,100%	-	21
Ambulatory Surgical Center (ASC)	39%	41	57
Audiologist	28%	68	87
Capitation Provider - IHS Case Manager	2,300%	-	23
Case Manager (Targeted)	18%	67	79
Certified Registered Nurse Anesthetist (CRNA)	70%	359	609
Chiropractor	-51%	92	45
Clinic - Family Planning Clinic	-13%	8	7
Clinic - Federally Qualified Health Clinic (FQHC)	13%	8	9
Clinic - Group	29%	1,577	2,034
Clinic - Rural Health	-1%	76	75
Clinic - Speech/Hearing Clinic	0%	4	4
DDSD - Architectural Modification	-3%	72	70
DDSD - Employee Training Specialist	33%	73	97
DDSD - Homemaker Services	23%	204	251
DDSD - Non-Federal Medical	-38%	1,233	770
DDSD - Supportive Living Arrangements	26%	34	43
DDSD - Volunteer Transportation Provider	52%	191	291
Dentist	-13%	632	550
Direct Support Services	44%	194	279
DME/Medical Supply Dealer	250%	1,193	4,176
End-Stage Renal Disease (RSD) Clinic	55%	22	34
Extended Care Facility - Facility Based Respite Care	9,100%	-	91
Extended Care Facility - ICF/MR	113%	30	64
Extended Care Nursing/Skilled Nursing Facilities	-8%	389	356
Free Standing Birthing Center	100%	1	2
Home Health Agency	-17%	203	168
Hospital - Acute Care	-30%	693	482
Hospital - Critical Access	3,500%	-	35
Hospital - Psychiatric	-60%	53	21
Hospital - Residential Treatment Center	59%	27	43
Laboratory	119%	74	162
Long Term Care Authority Hospice	800%	-	8
Mental Health Provider - Counselor	226%	19	62
Mental Health Provider - Psychologist	-13%	356	310
Mental Health Provider - Social Worker	-54%	332	152
Mid-Level Practitioner	18,100%	3	546

Appendix C Contracted Medicaid Providers (continued)

Provider Type	Percent Change 1995 to 2005	SFY1995	SFY2005
Nutritionist	142%	53	128
Optometrist	5%	437	458
Outpatient Mental Health Clinic	95%	76	148
Personal Care Services	413%	15	77
Pharmacy	14%	873	996
Physician - Allergist	41%	29	41
Physician - Anesthesiologist	10%	746	819
Physician - Cardiologist	10%	513	563
Physician - General Pediatrician	97%	720	1,419
Physician - General Practitioner	10%	2,216	2,445
Physician - General Surgeon	2%	572	581
Physician - Internist	20%	1,315	1,580
Physician - Obstetrician/Gynecologist	37%	417	573
Physician - Other Specialist	21%	2,493	3,008
Physician - Radiologist	14%	719	823
Residential Behavior Management Services (RBMS)	-17%	24	20
Respite Care	48%	153	226
School Corporation	445%	38	207
Specialized Foster Care/MR	4%	210	219
Therapist - Physical	39%	260	362
Therapist - Occupational	81%	108	196
Therapist - Speech/Hearing	80%	226	407
Transportation Provider	121%	235	520
X-Ray Clinic	1,433%	3	46
TOTAL	**37%**	**20,826**	**28,581**

The term "contracted" is defined as a provider that was enrolled with Oklahoma Medicaid within SFY2005 and SFY1995, it does not necessarily indicate participation or that a provider has provided services. Some of the above provider counts are grouped by the subcategory of provider specialty; therefore, a provider may be counted multiple times if they have multiple provider types and/or specialties.

Appendix D OHCA Board Approved Rules

August 19, 2004

- Emergency to revise Outpatient Behavioral Health Services rules to: (1) better describe appropriate Alcohol and Other Drug (AOD) treatment services; (2) allow AOD providers a window to contract to be a provider (if certified by the state to perform services on July 1, 2004, and meet other specifications) without having national accreditation but they would be required to be accredited by January 1, 2006; (3) add Behavioral Health Aide services for seriously emotionally disturbed children; (4) add Mental Health Clubhouse services as a new service; (5) require Mental Health Professionals and Behavioral Health Rehabilitation Specialists who perform services in contracted Outpatient Behavioral Health agencies to obtain individual provider numbers and use them when billing for services; and (6) add additional detail regarding the prior authorization process. **(Reference APA WF # 04-06)**
  Budget neutral
  Effective: October 6, 2004
- Emergency rule to establish reimbursement for Independent Diagnostic Testing Facility and Mobile X-Ray entities. **(Reference APA WF # 04-09)**
  Budget neutral
  Effective: October 6, 2004
- Emergency rules to allow for the use of extrapolation when calculating provider overpayments. **(Reference APA WF # 04-11)**
  Budget neutral
  Effective: October 6, 2004

September 9, 2004

- Emergency rule for Long Term Care Facilities to allow payment for nurse aide training in nursing facility settings and private training courses. **(Reference APA WF # 04-10)**
  Budget neutral
  Effective: November 1, 2004

October 14, 2004

- Emergency rule to implement the Breast and Cervical Cancer Prevention and Treatment Act of 2000 program. **(Reference APA WF # 04-13)**
  Total annual cost: $15,013,140; State share: $3,427,500
  Effective: January 1, 2005
- Emergency rule to amend the reimbursement methodology for state-owned Residential Psychiatric Treatment Centers. **(Reference APA WF # 04-12)**
  Total annual cost: $710,000; State share: $212,000
  Effective: December 1, 2004

December 9, 2004

- Emergency rule for Developmental Disabilities Services rules to (1) establish criteria for a new adult day service; and (2) bring rules in line with other sections of rules by adding the existing Intensive Personal Supports service to these sections of rules. **(Reference APA WF # 04-16)**
  Budget neutral to this agency. However, the Developmental Disabilities Services Division of OKDHS, who is responsible for paying the state share for Adult Day Services, is estimating an annual savings of $139,400.
  Effective: February 1, 2005
- Emergency rule to (1) establish a process for determining the value of annuities; and (2) clarify procedures to determine the status of loans. **(Reference APA WF # 04-19)**
  he agency anticipates state dollar savings. However, because it is impossible to determine how many individuals will purchase annuities and predict who will eventually apply for Medicaid, it is difficult to establish a dollar savings amount at this time
  Effective: February 1, 2005

Appendix D OHCA Board Approved Rules (continued)

February 10, 2005

- Emergency rule to establish program guidelines for a new federally approved Family Planning Waiver program. **(APA WF # 04-14)**
  Budget neutral to this agency as the Oklahoma State Department of Health has agreed to be responsible for the state share
  Effective: April 1, 2005

March 10, 2005

- Emergency rule to establish criteria for a Consumer-Directed Personal Assistance Services and Supports (CD-PASS) program for ADvantage Program clients in certain geographic areas of Oklahoma. **(APA WF # 05-01)**
  Budget neutral for both OHCA and the Oklahoma Department of Human Services
  Effective: May 4, 2005

May 12, 2005

- Emergency rule for ADvantage Waiver Services to restructure Institution Transition Services to coincide with CD-PASS requirements at the request of the Centers for Medicare and Medicaid Services. **(Reference APA WF # 05-02)**
  Budget neutral
  Effective: July 1, 2005
- Emergency rule to comply with provisions of Senate Bill 1622 of the 2nd Session of the 49th Legislature related to the methodology for establishing nursing home reimbursement rates. **(Reference APA WF # 05-03)**
  Budget neutral
  Effective: July 1, 2005

June 9, 2005

- Emergency rule to add coverage for hospice services for children. **(Reference APA WF # 05-04)**
  Budget neutral as hospice services will replace services in place at this time, such as inpatient hospital care, private duty nursing, and durable medical equipment expenses
  Effective: August 1, 2005
- Emergency rule to allow payment for allergy injections administered under the supervision of the contracted provider. **(Reference APA WF # 05-05)**
  Budget neutral
  Effective: August 1, 2005
- Emergency rule to add coverage for private duty nursing care for children. **(Reference APA WF # 05-06)**
  Budget neutral
  Effective: August 1, 2005

Reader Notes

Important Telephone Numbers

OHCA Main Number 405-522-7300

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

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

Customer Service — Provider	405-522-6205	1-800-522-0114
1 — Claim Status	6 — Claims Adjustments	
2 — Check Eligibility/EVS	7 — Third Party Liability	
3 — Care Management	8 — PIN Resets/EDI/Medicaid on the Web Assistance	
4 — Pharmacy Help Desk	9 — Prior Authorizations	
5 — Provider Contracts	* Repeat Options	

OHCA Internet Resources

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

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

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

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

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

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