Oklahoma Health Care Authority

Lead Administrator: Joel Nico Gomez (CEO)

Lead Financial Officer: Carrie Evans (CFO)

FY'15 Projected Division/Program Funding By Source						
	Appropriations	**Federal**	**Revolving**	**Local**	**Other***	**Total**
Administration/Operations 10	$22,721,635	$26,693,767	$1,702,365	$0	$0	$51,117,767
Medicaid Payments - 20	$902,948,976	$3,093,639,392	$1,269,316,521	$0	$0	$5,265,904,890
Medicaid Contracts - 30	$12,730,508	$28,283,300	$6,846,191	$0	$0	$47,860,000
Premium Assistance (IO) - 40	$0	$60,756,185	$40,267,228	$0	$0	$101,023,413
Grants Management - 50	$97,250	$2,712,789	$0	$0	$281,992	$3,092,031
ISD Information Services - 88	$14,552,145	$66,813,950	$4,770,942	$0	$0	$86,137,037
Total	**$953,050,514**	**$3,278,899,383**	**$1,322,903,247**	**$0**	**$281,992**	**$5,555,135,136**

*Source of "Other" and % of "Other" total for each.
TSET Provider Engagement Grant (82%) and TSET Health Promotions Coordinator Grant (18%)

FY'14 Carryover by Funding Source						
	Appropriations	**Federal**	**Revolving**	**Local**	**Other***	**Total**
FY'14 Carryover	$61,029,661	$0	$0	$0	$0	$61,029,661

*Source of "Other" and % of "Other" total for each.

What Changes did the Agency Make between FY'14 and FY'15

1.) Are there any services no longer provided because of budget cuts?
The Perinatal Dental Program was eliminated effective July 1, 2014.

2.) What services are provided at a higher cost to the user?
Co-pays for all services provided under the SoonerCare Program have been raised to the maximum allowed under Federal requirements.

3.) What services are still provided but with a slower response rate?
Sleep studies and back/spinal surgeries now require prior authorization which results in a delay of approximately 4-5 business days.

4.) Did the agency provide any pay raises that were not legislatively/statutorily required?
Senate Bill 2131 was passed requiring pay increases of 6.25% to certain categories of employees of various state agencies, including OHCA. The agency, in an effort to maintain fairness and consistency among its employees, decided to make the merit-based pay increase for OHCA employees who meet performance standards. These funds came from the agency's administrative payroll line, which is under budget. Executive level employees, as well as the agency's physicians, were not included in the pay increase.

FY'16 Requested Division/Program Funding By Source						
	Appropriations	**Federal**	**Revolving**	**Other**	**Total**	**% Change**
Administration/Operations 10	$22,751,699	$26,723,831	$1,702,365	$0	$51,177,894	0.12%
Medicaid Payments - 20	$1,144,903,601	$3,269,023,407	$1,246,274,865	$0	$5,660,201,873	7.49%
Medicaid Contracts - 30	$12,730,508	$28,283,300	$6,846,191	$0	$47,860,000	0.00%
Premium Assistance (IO) - 40	$0	$60,756,185	$40,267,228	$0	$101,023,413	0.00%
Grants Management - 50	$97,250	$2,712,789	$0	$281,992	$3,092,031	0.00%
ISD Information Services - 88	$14,552,145	$66,813,950	$4,770,942	$0	$86,137,036	0.00%
Total	**$1,195,035,203**	**$3,454,313,462**	**$1,299,861,591**	**$281,992**	**$5,949,492,248**	7.10%

*Source of "Other" and % of "Other" total for each.
TSET Provider Engagement Grant (82%) and TSET Health Promotions Coordinator Grant (18%)

FY'16 Top Five Appropriation Funding Requests		
		$ Amount
Request 1	Annualizations - FMAP change/ Medicare A&B Premiums (1/1/15)/State Funds to cover CHIP Population	$59,216,120
Request 2	Maintenance - Medicaid growth (4%) / Medicare A & B prem incr (1/1/16) / Physician fee schedule/FTE	$49,225,596
Request 3	One-Time Funding - FY-14 One-time Carryover & Replace	$31,029,661
Request 4	Mandate - Administrative Law Judge & Paralegal	$30,064
Request 5	Provider Rate Maintenance - Restore 3.25% reduction in FY-10 & 7.75% reduction in FY-15	$102,483,248
Total Increase above FY-15 Request		$241,984,689

How would the agency handle a 3% appropriation reduction in FY'16?

A reduction of 3% in the appropriation level amounts to a cut of $29 million. Coupled with the $140 million required to maintain the program at its current level, an additional reduction of $29 million would result in a funding shortage of approximately $169 million. Consequently, this equates to a total reduction of $436 million to the SoonerCare Program to achieve a 3% appropriation cut.

With a three month lead time to meet the required public notification process, the agency would recommend a reduction of overall provider rates by approximately 18% to accommodate a 3% reduction in the FY- 2015 appropriation base. Assuming an effective date of July 1, this provider rate cut would achieve $169 million in state dollars and reduce the matching federal dollars by $267 million. The federal statutory maintenance of effort requirement prohibits states from reducing the number of people in the program by reducing qualification standards. Federal mandates also limit the majority of benefit reductions especially as it pertains to children. Although some optional adult benefits can be reduced, savings would be minimal and would actually shift more cost to mandatory benefit categories. For example, the elimination of the adult emergency dental extractions will shift additional cost to the mandatory hospital emergency room payments and other costs of treating conditions caused by dental infection. Therefore, any significant budget reduction could only be achieved by provider rate reductions.
Each one percent reduction in provider rates equates to a reduction of $9.5 million in expenditure of state funds. Therefore, a 3% budget reduction requires a 18% provider rate cut.

How would the agency handle a 5% appropriation reduction in FY'16?

A reduction of 5% in the General Revenue appropriation level amounts to a cut of $48 million. Coupled with the $140 million required to maintain the program at its current level, an additional reduction of $48 million would result in a funding shortage of approximately $188 million. Consequently, this equates to a total reduction of $485 million to the SoonerCare Program to achieve a 5% appropriation cut.

To achieve a 5% appropriation reduction, the agency would be held to the same restrictions and utilize the same option as described above; however, the reduction in provider rates would be greater. Each one percent reduction in provider rates equates to a reduction of $9.5 million in expenditure of state funds. Therefore, a 5% budget reduction requires a 20% provider rate cut.

Is the agency seeking any fee increases for FY'16?

		$ Amount
Increase 1	No	$0
Increase 2		$0
Increase 3		$0

What are the agency's top 2-3 capital or technology (one-time) requests, if applicable?

We have no capital or technology requests at this time.

Federal Government Impact

1.) How much federal money received by the agency is tied to a mandate by the Federal Government?
None. Participation in the Medicaid Program is optional for states; however, if a state chooses to participate in Medicaid then the federal matching funds received are tied to federal requirements.

2.) Are any of those funds inadequate to pay for the federal mandate?
In relation to the response in the previous question, Medicaid is funded with federal funds matching state funds. Therefore, by definition, the federal funds are inadequate because there are not 100% federal funds tied to those mandates.

3.) What would the consequences be of ending all of the federal funded programs for your agency?
Turning back federal Medicaid funds would leave only state funds to support the program. State funds comprise about 40% of the total program expenditures that provide health care to nearly 1 million Oklahomans and has a $5.5 billion impact on the economy in SFY-2015.

4.) How will your agency be affected by federal budget cuts in the coming fiscal year?
Medicaid is included in the exempt mandatory spending. Therefore, any upcoming federal budget cuts will have no direct impact.

5.) Has the agency requested any additional federal earmarks or increases?
No

Division and Program Descriptions

Division I — **Medicaid Program**

Medicaid is a federal and state entitlement program that provides medical benefits to low income individuals who have no or inadequate heath insurance coverage. Medicaid guarantees coverage for basic health and long term care services based upon income and/or resources. Medicaid serves as the nation's primary source of health insurance for the poor. The terms on which federal Medicaid matching funds are available to states include five broad requirements related to eligibility. In order to be eligible for Medicaid, an individual must meet all of these requirements. The availability of federal matching funds does not necessarily mean that a state will cover these individuals since the state must still contribute its own matching funds toward the cost of coverage. In exchange for federal financial participation, states agree to cover groups of individuals referred to as "mandatory groups" and offer a minimum set of services referred to as "mandatory benefits." States can also receive federal matching funds to cover additional "optional" groups of individuals and benefits. A detailed summary of the categorical eligibility standards as well as mandatory and optional benefits provided in Oklahoma can be found in the OHCA Annual Report. Additional performance information is available in the annually issued Service Efforts and Accomplishments Report.

FY'16 Projected FTE

	Supervisors	Classified	Unclassified	$0 - $35 K	$35 K - $70 K	$70 K - $$$
Operations - 10	90	0	472	15	378	79
Medicaid Payments - 20	0	0	0	0	0	0
Medicaid Contracts - 30	0	0	0	0	0	0
Premium Assistance (IO) - 40	2	0	22	0	20	2
Grants Management - 50	4	0	31	3	28	0
ISD Information Services - 88	14	0	46	0	33	13
Total	**110**	**0**	**571**	**18**	**459**	**94**

FTE History

	2016 Projected	2015 Budgeted	2014		
Operations - 10	472	479	488		
Medicaid Payments - 20	0	0	0		
Medicaid Contracts - 30	0	0	0		
Premium Assistance (IO) - 40	22	22	22		
Grants Management - 50	31	31	36		
ISD Information Services - 88	46	46	37		
Total	**571**	**578**	**583**		

Performance Measure Review

		FY'14	FY'13	FY'12	FY'11	FY'10
Goal 1 - Financing & Reimbursement						
1	Total Expenditures for Physicians & Midlevel Practitioners' Services	$ 590,844,401	$ 563,294,097	$ 536,168,016		
2	Total Expenditures for Other Medical Costs	$ 483,641,315	$ 478,831,256	$ 463,506,349		
3	Reimbursement as a Percentage of Medicare Rates	96.75%	96.75%	96.75%	96.75%	99.19%
4	Total Expenditures for General Medical/Surgical Hospital Services	$817,878,530	$792,207,386	$787,399,203		
5	Total Expenditures for Psychiatric Hospitals and Psychiatric Residential Treatment Facilities (PRTF)	$103,640,348	$107,798,074	$101,475,080		
6	Reimbursement as a Percentage of Federal Upper Payment Limit	87.96%	83.33%	85.24%	64.87%	
7	Total Expenditures for Nursing Home Care	$572,855,252	$536,153,689			
8	Average % Reimbursement for Nursing Home Costs per Patient Day	99.42%	89.00%	89.00%	89.20%	94.50%
9	Total Expenditures for ICF/IDs	$95,571,570	$111,373,096			
10	Average % Reimbursement for ICF/ID Facility Costs per Patient Day	99.81%	100.00%	100.00%	100.00%	100.00%
11	Total EHR Incentive Payments to Eligible Professionals/Hospitals	$32,553,188	$38,968,791	$44,062,545	$35,271,710	
12	Total # of Unduplicated SoonerCare Members Enrolled (includes IO, SFY14)	1,033,114	1,040,332	1,007,356	968,296	885,238
13	Total # of Unduplicated Insure Oklahoma Members Enrolled (SFY14)	40,103	45,855	48,616	45,220	41,735
14	Total # of Unduplicated SoonerCare Members Enrolled (does not include IO)	993,011	994,477	958,740	923,076	843,503
15	Total SoonerCare Program Expenditures (Member Specific)	$4,397,896,751	$4,240,915,548	$4,075,519,279	$4,019,868,307	$4,327,974,101
16	Average SoonerCare Program Expenditures (Member Specific)	$4,257	$4,077	$4,046	$4,151	$4,889
17	Total Expenditures for Insure Oklahoma	$94,609,661	$113,536,514	$119,399,496	$108,806,386	$97,080,049
18	Average Cost per Insure Oklahoma Member	$2,350	$2,670	$2,677	$2,406	$2,326
19	Average monthly enrollment in Health Access Networks (HANs)	109,194	64,730	50,295	25,860	
20	Total payments made to HANs	$6,551,610	$3,885,990	$3,017,725	$1,551,595	
21	Total # of HAN member months	1,310,322	776,756	603,545	310,309	
22	# of Eligible Professionals Receiving an EHR Incentive Payment	1,022	780	718		
23	# of Eligible Hospitals Receiving an EHR Incentive Payment	55	46	44		
24	% of Eligible Professionals in compliance with meaningful use of EHR	61.0%	45.3%	3.8%		
25	% of Eligible Hospitals in compliance with meaningful use of EHR	98.2%	73.9%	4.5%		
Goal 2 - Program Development						
26	Output - HMP Total Enrollment	7,500	1,394	4,130	5,008	4,812
27	Tier 1 Engaged Members		623	888	975	940
28	Tier 2 Engaged Members		771	3,242	4,033	3,872
	HMP Per Member Per Month (First 12 month following participation in HMP)					
29	Forecast PMPM	$1,390	$1,375	$1,405	$1,381	$1,332
30	Outcome - Actual PMPM	$1,149	$1,125	$1,173	$1,192	$1,153
31	Outcome - % Below Forecast	17.3%	18.2%	16.5%	13.7%	13.4%
32	Output - HMP/Number of Providers with On-Site Practice	33	50	53	56	57
	Chronic Care Unit (Unit initiated January 1, 2013)					
33	Output - Number of Unduplicated Members Enrolled	978	206			
34	Outcome - Percent of Members with a Diagnosis of Hemophilia	10.1%	31.0%			
35	Outcome - Percent of Members with a Diagnosis of Sickle Cell Anemia	12.9%	41.3%			
36	Outcome - Percent of Members with a Combination of Chronic Conditions	77.0%	27.7%			
	Case Management					
37	Output - Number of New High-Risk OB members	2,474	1,998	1,832	1,586	
38	Output - Number of New At-Risk OB members	618	637	713	430	
39	Output - Number of New Fetal Infant Mortality Reduction Outreach to Moms	1,781	2,041	2,274	715 (partial)	
40	Output - Number of New Fetal Infant Mortality Reduction outreach to Babies	2,138	2,100	1,713 (11 mos.)	N/A	
41	Target - OHCA's Goal for Reduction in Primary Cesarean Sections Less Than 18%	N/A	less than18%	less than18%	less than18%	
42	Outcome - OHCA's Actual Rate for Primary Cesarean Sections	N/A	16.90%	16.60%	19.50%	
	Health Access Networks (HANs)					
43	Output - Number of Contracted HANS	3	3	3	1	
44	Output - Total Number of Enrollees (at June 30)	118,107	90,688	61,078	26,411	
45	Output - Number of Members Required to Receive Care Management	740	1,418	1,961		
46	Output - Number of Unduplicated Providers in HANs	584	484	309		
	SoonerCare Provider Network					
47	Output - SC Provider Network Count	39,726	38,486	40,825	30,113	28,637
48	Output - SC Choice Providers	2,309	2,170	1,933	1,598	1,531
49	Output - SC Choice PCP Total Capacity	1,177,398	1,139,130	1,202,168	1,071,965	1,037,499
50	Output - SC Choice PCP % of Capacity Used	42.26%	44.06%	37.85%	39.55%	41.30%
51	Outcome - Percent of Tier 1 Entry-Level Medical Homes	56.90%	58.60%	64.88%	67.43%	66.88%
52	Outcome - Percent of Tier 2 Advanced Medical Homes	24.00%	27.70%	26.37%	26.18%	27.34%
53	Outcome - Percent of Tier 3 Optimal Medical Homes	19.10%	13.70%	8.75%	6.39%	5.78%
54	Output - # of Tier 1 Entry-Level Medical Homes	503	502	534	559	521
55	Output - # of Tier 2 Advanced Medical Homes	212	237	217	217	213
56	Output - # of Tier 3 Optimal Medical Homes	169	117	72	53	45

		FY'14	FY'13	FY'12	FY'11	FY'10
	Patient-Centered Medical Home Enrollment/Tiers					
57	# of SC Members Enrolled in Medical Home		522,310	462,426	425,267	434,969
58	# of Native AmericanIHS/ASO enrollees		17,360	17,066	13,961	14,247
59	Output - Total # of SC Members Enrolled in Medical Home	560,887	539,670	479,492	439,228	449,216
60	Output - # of SC Traditional Members	202,934	194,294	240,920	245,159	220,283
61	Total Enrollees	763,821	733,964	720,412	684,387	669,499
62	Outcome - % of SC Members Enrolled in Medical Home	73.43%	73.53%	66.56%	64.18%	67.10%
	Member aligned with Medical Homes by Tier Level					
63	Outcome - Percent of Members Aligned with Tier 1 Entry-Level Medical Homes	41%	42%	46%		
64	Outcome - Percent of Members Aligned with Tier 2 Advanced Medical Homes	28%	31%	31%		
65	Outcome - Percent of Members Aligned with Tier 3 Optimal Medical Homes	31%	27%	23%		
66	Output - Number of Members Aligned with Tier 1 Entry-Level Medical Homes	229,964	226,661	220,566		
67	Output - Number of Members Aligned with Tier 2 Advanced Medical Homes	157,048	167,298	148,643		
68	Output - Number of Members Aligned with Tier 3 Optimal Medical Homes	173,875	145,711	110,283		
Goal 3 - Personal Responsibility						
	% of Children Accessing Well-Child Visits/EPSDT:					
69	First 15 months		97.3%	98.3%	98.3%	95.4%
70	3 to 6 years		57.6%	57.4%	59.8%	61.9%
71	Adolescents		31.6%	34.5%	33.5%	37.1%
72	Outcome - immunization rate		62.7%	61.0%	66.0%	54.4%
	Adults Health Care Use - Preventive / Ambulatory Care:					
73	20 to 44 years		82.8%	83.1%	84.2%	83.3%
74	45 to 64 years		90.8%	91.0%	91.1%	89.7%
75	Number of Medicaid Members Calling Tobacco Helpline	4,076	5,575	5,778	4,739	3,937
76	Number of Oklahomans Calling the Tobacco Helpline	22,251	35,123	38,732	37,321	37,974
77	Percent of Medicaid Members Calling the Tobacco Helpline	18.32%	15.87%	14.92%	12.70%	10.37%
78	Number Of Medicaid Members Utilizing Tobacco Cessation Benefits	21,610	22,790	25,098	25,731	NA
79	EPSDT Participation Ratio		56.0%	56.0%	55.0%	56.0%
80	Average # of Members in Pharmacy Lock-In	404	313	273	303	268
	Prenatal Care					
81	% of Members Seeking Prenatal Care	97.68%	97.32%	97.12%	97.54%	95.50%
82	# of Births	32,254	32,915	32,904	32,060	33,669
83	First Trimester	19,881	20,306	19,331	18,336	18,034
84	Second Trimester	8,088	8,289	8,890	9,175	9,911
85	Third Trimester	3,538	3,493	3,737	3,759	4,215
86	ER Visits per 1,000 Member Months (calendar year)			73.5 (half yr.)	72.9	72.6
Goal 4 - Satisfaction & Quality						
	Customer Survey Results (CAHPS) Adults:					
87	Outcome - Customer Service	82%	90%			
88	Outcome - How Well Doctors Communicate	90%	87%			
89	Outcome - Getting Care Quickly	82%	79%			
90	Outcome - Getting Needed Care	82%	80%			
91	Outcome - Shared Decision Making	50%	48%			
	Customer Survey Results (CAHPS) Children:					
92	Outcome - Customer Service	88%	77%			
93	Outcome - How Well Doctors Communicate	97%	93%			
94	Outcome - Getting Care Quickly	92%	93%			
95	Outcome - Getting Needed Care	89%	72%			
96	Outcome - Shared Decision Making	60%	52%			
	Other					
97	% of 5-Star Facilities in Focus on Excellence	17%	18%	15%		
98	% of 4-Star Facilities in Focus on Excellence	29%	29%	16%		
99	% of Members Participating in the Resident Satisfaction Survey Rating Overall Quality as Excellent or Good	93%	94%			
100	% of Employees Participating in the Employee Satisfaction Survey Who Rate Overall Satisfaction as Excellent or Good	85%	88%			
101	# of Member Calls	86,509	78,746	88,473		
102	# of Provider Calls	44,061	34,027	32,090		
103	# Involuntary Provider Contract Terminations	95	43	59	36	47
	Number of Provider Trainings:					
104	· Seminars/Workshops	29	28	43	117	185
105	· Onsite Trainings Attendees	7,211	5,242	5,200	11,672	11,739
106	· Policy Letters	43	70	104	91	
Goal 5 - Eligibility & Enrollment						
107	Output - Unduplicated Medicaid Enrollment - Total	1,033,114	1,040,332	1,007,356	968,296	885,238
108	Outcome - % of Enrollment Change (includes Insure Oklahoma)	-0.7%	3.3%	4.0%	9.4%	
109	Insure Oklahoma—Employee Sponsored Enrollment (as of June 30)	13,729	16,502	16,865	18,816	18,573
110	Insure Oklahoma—Individual Plan Enrollment (as of June 30)	4,737	13,358	13,511	13,784	13,107
111	% of SoonerCare & Insure Oklahoma Population Who Are Children	57%	57%	57%	59%	60%
112	% of SoonerCare & Insure Oklahoma Population Who Are Adults	43%	43%	43%	41%	40%
113	Estimated Count of Eligible-But-Not-Enrolled Population (EBNE)	58,699	64,965	64,860	64,783	74,563
114	% of Online Enrollment Applications That Are New	52%	55%	57%	71%	
115	% of Online Enrollment Applications That Are Recertifications	48%	45%	43%	29%	

		FY'14	FY'13	FY'12	FY'11	FY'10
	Percent of OE Applications by Media Type:					
116	Home Internet	59%	55%	48%	41%	
117	Paper	5%	5%	9%	10%	
118	Agency Internet	35%	26%	24%	24%	
119	Agency Electronic	1%	14%	20%	26%	
Goal 6 - Administration						
120	Output - Total Claims Paid	51,226,118	49,829,140	36,636,568	32,298,927	31,691,202
121	OHCA Payment Accuracy Measurement (PAM) Rate		97.64%	95.45%	97.60%	97.68%
122	OHCA Payment Error Rate Measurement (PERM) Rate	0.28%			1.24%	
123	Output - Payment Integrity Recoveries	$4,731,822	$3,404,767	$6,552,765	$9,077,565	$17,614,428
124	Output - Third Party Liability Recoveries	$37,965,691	$53,212,491	$40,258,563	$43,241,434	$41,521,418
Goal 7 - Collaboration						
125	Percentage of Enrollment Applications Received Online	91.3%	77.9%	69.0%	61.0%	
126	The Accumulated State and Federal Revenue Generated By Collaborations To Provide Services	$1,292,233,657	$1,230,314,375	$848,660,601	$963,746,651	
127	Accumulated State and Federal Revenue Generated By Collaborations to Provide Graduate Medical Education (GME)	$136,788,040	$126,057,898	$94,138,193	$103,621,161	
128	Number of Tribes Represented at Tribal Consultations	17	11			
129	The Number of Tribal Consultations Per Year	9	7			
130	Number of Individuals Who Completed Certification Through the Certified Nurse Aide (CNA) Waiver Training Program	405	881	957	711	593

Revolving Funds (200 Series Funds)			
	FY'12-14 Avg. Revenues	**FY'12-14 Avg. Expenditures**	**June '14 Balance**
Fund 200 Administrative Disbursing Fund This fund is utilized for tracking revenues (federal & state) and expenditures for OHCA's administrative cost (except administrative cost of Fund 245-HEEIA). Normally, there are no transfers from this account, only transfers in. However, in the case of a federal disallowance, we have transferred from Fund 200 to Fund 240 (Federal Deferral Account). This is a revolving fund; balances are carried forward into the next fiscal year.	$141,033,705	$153,271,912	$30,500,665
Fund 205 SHOPP Fund This fund maintains the revenues and expenditures for the Supplemental Hospital Offset Payment Program. Transfers from this account are stipulated in House Bill 1381 with payments of $7,500,000 directed to Fund 340 on a quarterly basis. Also, included is a $200,000 yearly administrative expense.	$350,626,819	$367,306,670	$4,019,099
Fund 230 Quality of Care (QOC) Revolving Fund This fund is utilized for posting of Assessment fees, penalties and interest. Expenditures for this fund were directed in HB 2019 to be for enhancements to specific Medicaid program rates of pay which included increases in the rate of pay for ICR/MR facilities, to the nursing facilities, to the nursing home rate of pay for eyeglasses and denture services, personal needs allowance increases, etc. These Medicaid program expenditures are processed through the Medicaid Management Information System which is budgeted and posted in mass to Fund 340. OHCA transfers money from Fund 230 to Fund 340 to replenish the fund for these enhanced costs.	$64,665,952	$70,831,603	$242,659
Fund 240 Federal Deferral Account Amounts are transferred in from different funds in anticipation of repayment of Federal Disallowances. Payments are not made from this account; amounts are transferred and paid from the account in which the disallowance is found.	$3,483,897	$0	$12,354,767
Fund 245 OEPIC Health Employee and Economy Improvement Act Revenue for this account includes tobacco tax collections, federal draws, interest income, and appropriations for prior year carryover. Expenditures passing through the fund are for managed program costs for employer sponsored insurance, managed care costs covered under the All Kids Act , individual plan service costs, college students managed care cost, college students service cost, All Kids service costs and administrative costs. Payments are processed through the Medicaid Management Information System which is budgeted and posted in mass to Fund 340.	$82,603,269	$74,629,288	$14,801,398
Fund 250 Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund This fund receives tobacco tax funds which may be budgeted and expended for the purpose specified and associated with the Oklahoma Breast and Cervical Act. This act established a new member group. The health services for this group are paid through the Medicaid Management Information System which is budgeted and in mass posted to Fund 340.	$922,804	$4,431,582	$0
Fund 255 OHCA Medicaid Program Fund This fund receives tobacco tax funds and those funds are transferred to Fund 340. This fund provided hospital rate increases, increase in number of physician visits allowed, increase in emergency physician rates, enhanced drug benefits dental services, etc. The health services for this fund are paid through the Medicaid Management Information System which is budgeted and in mass posted to Fund 340.	$55,297,871	$76,545,830	$0
Fund 260 Income Tax Check-off Fund	$59	$0	$0