Oklahoma Health Care Authority # 807

Lead Administrator: Joel Nico Gomez (CEO) **Lead Financial Officer: Carrie Evans (CFO)**

FY'16 Projected Division/Program Funding By Source

	Appropriations	Federal	Revolving	Local	Other*	Total
Administration/Operations 10	$24,317,669	$26,730,800	$499,691			$51,548,159
Medicaid Payments - 20	$922,948,975	$3,159,043,580	$1,309,816,221			$5,391,808,776
Medicaid Contracts - 30	$11,271,700	$25,523,127	$6,499,826			$43,294,653
Premium Assistance (IO) - 40	$0	$53,224,533	$36,346,464			$89,570,997
Grants Management - 50	$97,250	$2,604,777			$429,417	$3,131,444
ISD Information Services - 88	$12,414,919	$56,316,530	$5,621,401			$74,352,850
Total	**$971,050,513**	**$3,323,443,347**	**$1,358,783,603**	**$0**	**$429,417**	**$5,653,706,879**

*Source of "Other" and % of "Other" total for each.
TSET Provider Engagement Grant (57%) and TSET Health Promotions Coordinator Grant (43%)

FY'15 Carryover by Funding Source

	Appropriations	Federal	Revolving	Local	Other*	Total
FY'15 Carryover	$47,016,727					$47,016,727

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

What Changes did the Agency Make between FY'15 and FY'16?

1) Are there any services no longer provided because of budget cuts?
Removal of benign skin lesions, sleep studies, and continuous positive airway pressure (CPAP) equipment for adults have been eliminated.

2) What services are provided at a higher cost to the user?
There were no changes between FY'15 and FY'16.

3) What services are still provided but with a slower response rate?
N/A

4) Did the agency provide any pay raises that were not legislatively/statutorily required? If so, please provide a detailed description in a separate document.
No

FY'17 Requested Division/Program Funding By Source

	Appropriations	Federal	Revolving	Other	Total	% Change
Administration/Operations 10	$24,317,669	$26,730,800	$499,691		$51,548,159	0.00%
Medicaid Payments - 20	$960,613,539	$3,176,710,643	$1,318,861,077		$5,456,185,260	1.19%
Medicaid Contracts - 30	$11,271,700	$25,523,127	$6,499,826		$43,294,653	0.00%
Premium Assistance (IO) - 40	$0	$53,224,533	$36,346,464		$89,570,997	0.00%
Grants Management - 50	$97,250	$2,604,777	$0	$429,417	$3,131,444	0.00%
ISD Information Services - 88	$12,414,919	$56,316,530	$5,621,401		$74,352,850	0.00%
Total	**$1,008,715,077**	**$3,341,110,410**	**$1,367,828,459**	**$429,417**	**$5,718,083,363**	1.14%

*Source of "Other" and % of "Other" total for each.
TSET Provider Engagement Grant (57%) and TSET Health Promotions Coordinator Grant (43%)
NOTE: The agency anticipates a 3% provider rate reduction effective January 1, 2016 which will reduce the % change to zero.

FY'17 Top Five Appropriation Funding Requests

		$ Amount
Request 1:	Annualizations - FMAP change/ Medicare A&B Premiums (1/1/2016)	$30,463,374
Request 2:	Maintenance - Medicaid growth (1%) / Medicare Part D- Clawback / Physician fee schedule	$22,184,463
Request 3:	One-Time Funding - FY-15 One-time Carryover & Replace	$12,016,727
Request 4:	One-Time Savings - FY-16 Onetime Savings	(27,000,000)
Total Increase above FY-17 Request		
NOTE: The agency anticipates a 3% provider rate reduction effective Jan. 1, 2016 which will negate the need for additional State funding.		**37,664,564**

How would the agency handle a 5% appropriation reduction in FY'17?

A reduction of 5% in the appropriation level amounts to a cut of $49 million state dollars. This reduction in state dollars, combined with the matching federal funds, equates to a total reduction of $122 million to the SoonerCare Program to achieve a 5% 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 6% to accommodate a 5% reduction in the FY-2016 appropriation base. Assuming an effective date of July 1, this provider rate cut would achieve savings of $49 million in state dollars and reduce the matching federal dollars by $73 million. Except for a limited number of individuals receiving services in long term care facilities, eligibility for adults has been lowered to the minimum allowed by Federal requirements. The federal statutory maintenance of effort requirement prohibits states from reducing the number of children in the program by reducing qualification standards and also limits the reduction of benefits for this group. Although some optional adult benefits can be reduced, this action would shift costs to mandatory benefit categories. For example, the elimination of the adult emergency dental extractions will shift additional costs 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 $8.2 million in expenditure of state funds. Therefore, a 5% appropriation reduction requires a 6% provider rate cut.

How would the agency handle a 7.5% appropriation reduction in FY'17?

A reduction of 7.5% in the appropriation level amounts to a cut of $73 million state dollars. This reduction in state dollars, combined with the matching federal funds, equates to a total reduction of $183 million to the SoonerCare Program to achieve a 7.5% appropriation cut.

To achieve a 7.5% 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 $8.2 million in expenditure of state funds. Therefore, a 7.5% reduction requires a 9% provider rate cut.

How would the agency handle a 10% appropriation reduction in FY'17?

A reduction of 10% in the appropriation level amounts to a cut of $97 million state dollars. This reduction in state dollars, combined with the matching federal funds, equates to a total reduction of $244 million to the SoonerCare Program to achieve a 10% appropriation cut.

To achieve a 10% 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 $8.2 million in expenditure of state funds. Therefore, a 10% reduction requires an 12% provider rate cut.

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

		$ Amount
Increase 1	N/A	$0
Increase 2	N/A	$0
Increase 3	N/A	$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 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 $5.6 billion impact on the economy in SFY-2016.

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 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 health 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 matchings 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'17 Budgeted FTE

	Supervisors	Classified	Unclassified	$0 - $35 K	$35 K - $70 K	$70 K - $$$
Operations - 10	103		492	19	396	77
Medicaid Payments - 20	0		0	0	0	0
Medicaid Contracts - 30	0		0	0	0	0
Premium Assistance (IO) - 40	4		37	4	31	2
Grants Management - 50	1		25	0	24	1
ISD Information Services - 88	14		45	0	36	9
Total	**122**	**0**	**599**	**23**	**487**	**89**

FTE History

	2016 Budgeted	2015	2012	2009	2005
Operations - 10	492.0	479.0	448.5	425.0	389.5
Medicaid Payments - 20		0	0	0	0
Medicaid Contracts - 30		0	0	0	0
Premium Assistance (IO) - 40	37.0	22.0	24.0	9.0	0
Grants Management - 50	32.0	31.0	24.0	0	0
ISD Information Services - 88	45.0	46.0	0	0	0
Total	**606.0**	**578.0**	**496.5**	**434.0**	**389.5**

Performance Measure Review

		FY'15	FY'14	FY'13	FY'12	FY'11
Goal 1 - Financing & Reimbursement						
1	Reimbursement as a Percentage of Medicare Rates	89.25%	96.75%	96.75%	96.75%	96.75%
2	Reimbursement to Hospitals as a % of Federal Upper Pymt Limit	90.21%	87.96%	83.33%	85.24%	64.87%
3	Average % Reimbursement for Nursing Home Costs per Patient Day	92.66%	94.42%	89.00%	89.00%	89.20%
4	Average % Reimbursement for ICF/ID Facility Costs per Patient Day	98.85%	99.81%	100.00%	100.00%	100.00%
5	# of Eligible Professionals Receiving an EHR Incentive Pymt	1,003	1,022	780	718	
6	# of Eligible Hospitals Receiving an EHR Incentive Payment	70	55	46	44	
7	Total EHR Incentive Pymts to Eligible Professionals/Hospitals	$32,050,254	$32,553,188	$38,968,791	$44,062,545	$35,271,710
8	% of Eligible Professionals in Compliance with Meaningful Use of EHR	70.3%	61.0%	45.3%	3.8%	
9	% of Eligible Hospitals in Compliance with Meaningful Use of EHR	97.1%	98.2%	73.9%	4.5%	
10	Avg SoonerCare Program Expenditure per Member Enrolled	$4,260	$4,257	$4,077	$4,046	$4,151
11	Total # of Unduplicated SoonerCare Members Enrolled	1,021,359	1,033,114	1,040,332	1,007,356	968,296
12	Average Expenditure per Insure Oklahoma Member Enrolled	$2,365	$2,350	$2,670	$2,677	$2,406
13	Total # of Unduplicated Insure Oklahoma Members Enrolled	28,397	40,261	45,855	48,616	45,220
14	Avg Monthly Enrollment in Health Access Networks (HANs)	121,891	109,194	64,730	50,295	25,860
15	Total # of HAN Member Months	1,462,695	1,310,322	776,756	603,545	310,309
16	Total Payments Made to HANs	$7,063,475	$6,551,610	$3,885,990	$3,017,725	$1,551,595
Goal 2 - Program Development						
	Health Management Program					
17	HMP Total Enrollment	4,297	5,355	1,394	4,130	5,008
	HMP Per Member Per Month					
18	Forecast PMPM	$1,097	$1,075	$1,375	$1,405	$1,381
19	Actual PMPM	$979	$960	$1,125	$1,173	$1,192
20	% Below Forecast	11.0%	11.0%	18.2%	16.5%	13.7%
21	HMP/Number of Providers with On-Site Practice Facilitation	41	33	50	53	56
	Chronic Care Unit					
22	Number of Unduplicated Members Enrolled	1,147	978	206		
23	Percent of Members with a Diagnosis of Hemophilia	4.7%	10.1%	31.0%		
24	Percent of Members with a Diagnosis of Sickle Cell Anemia	5.4%	12.9%	41.3%		
25	Percent of Members with a Combination of Chronic Conditions	89.9%	77.0%	27.7%		
	Case Management					
26	Number of New High-Risk OB members	2,192	2,474	1,998	1,832	1,586
27	Number of New At-Risk OB members	459	618	637	713	430
28	Number of New Fetal Infant Mortality Reduction Outreach to Moms	1,694	1,781	2,041	2,274	715 (partial)
29	Number of New Fetal Infant Mortality Reduction Outreach to Babies	2,059	2,138	2,100	1,713 (11 mos)	N/A

Performance Measure Review						
		FY'15	FY'14	FY'13	FY'12	FY'11
Goal 2 - Program Development (Continued)						
	Health Access Networks (HANs)					
30	Number of Contracted HANS	3	3	3	3	1
31	Total Number of Enrollees (at June 30)	133,471	118,107	90,688	61,078 (10 mos)	26,411
32	Number of Members Required to Receive Care Management	8,405	740	1,418	1,961	
33	Number of Unduplicated Providers in HANs	698	584	484	309	
	SoonerCare Provider Network					
34	SC Choice Providers	2,558	2,309	2,170	1,933	1,598
35	SC Choice PCP Total Capacity	1,151,757	1,177,398	1,139,130	1,202,168	1,071,965
36	SC Choice PCP % of Capacity Used	42.92%	42.26%	44.06%	37.85%	39.55%
37	Percent of Tier 1 Entry-Level Medical Homes	53.76%	56.90%	58.64%	64.88%	67.43%
38	Percent of Tier 2 Advanced Medical Homes	25.55%	23.98%	27.69%	26.37%	26.18%
39	Percent of Tier 3 Optimal Medical Homes	20.69%	19.12%	13.67%	8.75%	6.39%
40	# of Tier 1 Advanced Medical Homes	486	503	502	534	559
41	# of Tier 2 Advanced Medical Homes	231	212	237	217	217
42	# of Tier 3 Optimal Medical Homes	184	169	117	72	53
	Patient-Centered Medical Home Enrollment/Tiers					
43	Total # of SC Members Enrolled in Medical Home	548,162	560,887	539,670	479,492	439,228
44	% of SC Members Enrolled in Medical Home	66.00%	70.00%	69.00%	63.00%	64.18%
	Member aligned with Medical Homes by Tier Level					
45	Percent of Members Aligned with Tier 1 Entry-Level Medical Homes	40%	41%	42%	46%	
46	Percent of Members Aligned with Tier 2 Advanced Medical Homes	27%	28%	31%	31%	
47	Percent of Members Aligned with Tier 3 Optimal Medical Homes	34%	31%	27%	23%	
48	Number of Members Aligned with Tier 1 Entry-Level Medical Homes	205,814	229,964	226,661	220,566	
49	Number of Members Aligned with Tier 2 Advanced Medical Homes	144,334	157,048	167,298	148,643	
50	Number of Members Aligned with Tier 3 Optimal Medical Homes	175,071	173,875	145,711	110,283	
Goal 3 - Personal Responsibility						
	% of Children Accessing Well-Child Visits/EPSDT:					
51	First 15 months	N/A	96.3%	97.3%	98.3%	98.3%
52	3 to 6 years	N/A	58.5%	57.6%	57.4%	59.8%
53	Adolescents	N/A	21.8%	22.5%	34.5%	33.5%
	Adults Health Care Use - Preventive Care:					
54	20 to 44 years	NA	82.4%	83.4%	83.1%	84.2%
55	45 to 64 years	NA	89.9%	89.8%	91.0%	91.1%
56	Number of Medicaid Members Calling Tobacco Helpline	4,102	4,076	5,575	5,778	4,739
57	Number of Oklahomans Calling the Tobacco Helpline	24,879	22,251	35,123	38,732	37,321
58	Percent of Medicaid Members Calling the Tobacco Helpline	16.49%	18.32%	15.87%	14.92%	12.70%
59	Number Of Medicaid Members Utilizing Tobacco Cessation Benefits	26,783	21,610	23,581	25,098	25,731
60	EPSDT Participation Ratio	NA	60.0%	56.0%	56.0%	55.0%
61	Average # of Members in Pharmacy Lock-In	406	404	313	273	303
62	% of Members Seeking Prenatal Care	97.74%	97.68%	97.32%	97.12%	97.54%
63	# of Births	31,237	32,254	32,915	32,904	32,060
64	First Trimester	18,824	19,881	20,306	19,331	18,336
65	Second Trimester	8,077	8,088	8,289	8,890	9,175
66	Third Trimester	3,630	3,538	3,493	3,737	3,759
67	ER Visits per 1,000 Member Months (calendar year)	NA	NA	N/A	73.5 (half yr)	72.9
Goal 4 - Satisfaction & Quality						
	Customer Survey Results (CAHPS) Adults:					
68	Customer Service	92%	82%	90%		
69	How Well Doctors Communicate	90%	90%	87%		
70	Getting Care Quickly	86%	82%	79%		
71	Getting Needed Care	85%	82%	80%		
72	Shared Decision Making	77%	50%	48%		
	Customer Survey Results (CAHPS) Children:					
73	Customer Service	86%	88%	77%		
74	How Well Doctors Communicate	96%	97%	93%		
75	Getting Care Quickly	92%	92%	93%		
76	Getting Needed Care	85%	89%	72%		
77	Shared Decision Making	78%	60%	52%		
	Other					
78	% of 5-Star Facilities in Focus on Excellence	20%	17%	18%	15%	
79	% of 4-Star Facilities in Focus on Excellence	19%	29%	29%	16%	
80	% of Members Participating in the Resident Satisfaction Survey Rating Overall Quality as Excellent or Good	93%	93%	94%		
81	% of Employees Participating in the Employee Satisfaction Survey Who Rate Overall Satisfaction as Excellent or Good	87%	85%	88%		
82	% of Member calls answered	90%	88%	86%		
83	% of Provider calls answered	95%	92%	92%		
84	# Involuntary Provider Contract Terminations	100	95	43	59	36

Performance Measure Review

		FY'15	FY'14	FY'13	FY'12	FY'11
Goal 5 - Eligibility & Enrollment						
85	Number of Online Enrollment Applications Received	210,571	291,323	437,668	440,091	384,487
86	% of Online Enrollment Applications That Are New	60%	52%	55%	57%	71%
87	% of Online Enrollment Applications That Are Recertifications	40%	48%	45%	43%	29%
88	Number of Online Applications Approved	179,782	253,723	320,105	Unavailable	Unavailable
89	Number of Online Applications Denied	30,789	37,830	117,563	Unavailable	Unavailable
90	Estimated Count of Eligible-But-Not-Enrolled Population (EBNE)	54,255	58,699	64,965	64,860	64,783
91	Home Internet	59%	59%	55%	48%	41%
92	Paper	5%	5%	5%	9%	10%
93	Agency Internet	35%	35%	26%	24%	24%
94	Agency Electronic	1%	1%	14%	20%	26%
95	Telephone	0%	Unavailable	Unavailable	Unavailable	Unavailable
Goal 6 - Administration						
96	Percent of Administration Budgeted Dollars Used	64.00%	73.00%	65.79%		
97	Per Capita OHCA Administrative Cost	$122.24	$138.96	$119.92		
98	Total Claims Paid	51,039,537	51,226,118	49,829,140	36,636,568	32,298,927
99	Payment Accuracy Measurement Rate (PAM)	95.38%	97.64%	95.50%		
100	OHCA Payment Error Measurement Rate (PERM)	0.28%	0.28%	0.28%	0.28%	2.32%
101	Number of Prior Authorizations Generated for Prescriptions	91,786	115,206	155,644		
102	Percentage of Manual Prior Authorizations for Prescriptions	57.56%	77.90%	75.40%		
103	Payment Integrity Recoveries	$4,524,690	$4,731,822	$3,404,767	$6,552,765	$9,077,565
104	Number of Provider Audits	611	285	133		
105	Number of Providers Referred to Medicaid Fraud Control Unit	0	0	1		
106	Third Party Liability Recoveries	$39,050,461	$37,965,691	$53,212,491	$40,258,563	$43,241,434
107	Number of SoonerCare Members with Third Party Insurance	162,886	160,271	163,006		
108	Percent of SoonerCare Members with Third Party Insurance	15.95%	20.30%	20.60%		
Goal 7 - Collaboration						
109	Percent of Applications Submitted as Agency Internet and Agency Electronic Media Type	37%	41%	40%	NA	NA
110	State and Federal Revenue Generated by Collaborations to Provide Services	$1,429,947,269	$1,292,233,657	$1,230,314,375	$848,660,601	$963,746,651
111	State and Federal Revenue Generated by Collaborations to Provide Medical Education	$140,931,567	$136,788,040	$126,057,898	$94,138,193	$103,621,161
112	Number of Tribes Represented at Tribal Consultations	17	17	14	NA	NA
113	Number of Tribal Partners Represented at Tribal Consultations (I/T/U and I.H.S.)	4	4	4	NA	NA

Revolving Funds (200 Series Funds)			
	FY'13-15 Avg. Revenues	FY'13-15 Avg. Expenditures or Transfers	June '15 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.	$149,053,882	$146,594,995	$17,722,478
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.	$292,220,134	$403,136,390	$4,007,647
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.	$73,021,975	$80,586,945	$450,263
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.	$2,405,660	$0	$17,625,963
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 and administrative costs. Payments are processed through the Medicaid Management Information System which is budgeted and posted in mass to Fund 340.	$74,740,619	$65,696,000	$27,746,236
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.	$858,047	$3,979,338	$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 physicians 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.	$51,421,933	$79,514,812	$0
Fund 260 Income Tax Check-Off Fund	$0	$0	$0