Oklahoma Health Care Authority # 807

Lead Administrator: Becky Pasternik-Ikard | **Lead Financial Officer: Carrie Evans (CFO)**

FY'18 Projected Division/Program Funding By Source						
	Appropriations	**Federal**	**Revolving**	**Local**	**Other***	**Total**
Administration/Operations 10	$24,610,512	$27,016,075	$515,703			$52,142,290
Medicaid Payments - 20	$950,817,391	$3,000,629,761	$1,320,459,238		$4,650,843	$5,276,557,234
Non-Title XIX Medical Services- 21 thru 25	$0	$0	$83,650,000			$83,650,000
Medicaid Contracts - 30	$8,854,076	$17,825,262	$4,400,087			$31,079,425
Premium Assistance (IO) - 40	$0	$55,229,435	$41,231,844			$96,461,279
Grants Management - 50	$50,400	$4,675,164	$31,492		$678,566	$5,435,623
ISD Information Services - 88	$11,761,775	$56,717,774	$5,499,885			$73,979,434
Total	**$996,094,155**	**$3,162,093,470**	**$1,455,788,249**	**$0**	**$5,329,409**	**$5,619,305,284**

*Source of "Other" and % of "Other" total for each.
*Medicaid Payments: FY17 GR Return
*Grants Management: TSET (62%) and Tulsa Community Foundation Women's Health Fund (38%)

FY'17 Carryover and Refund by Funding Source						
	Appropriations	**Federal**	**Revolving**	**Local**	**Other***	**Total**
FY'17 Carryover	$35,249,968					$35,249,968
FY'17 GR Refund	$4,650,843					$4,650,843
Other One-Time Funding **	$79,212,766					$79,212,766

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

**To Restore SFY-2018 Appropriation base ($31.5M) and FY-2018 Unfunded Liability from 2.5 Delayed Provider Payment Cycles from June 2018 to July 2019 ($47.7M)

Note:

What Changes did the Agency Make between FY'17 and FY'18?

1) Are there any services no longer provided because of budget cuts?
No

2) What services are provided at a higher cost to the user?
There were no changes between FY'17 and FY'18

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'19 Requested Division/Program Funding By Source						
	Appropriations	**Federal**	**Revolving**	**Other**	**Total**	**% Change**
Administration/Operations 10	$24,610,512	$27,016,075	$515,703	$0	$52,142,290	0.00%
Medicaid Payments - 20	$1,064,168,091	$3,163,659,540	$1,289,333,510	$4,650,843	$5,521,811,984	4.65%
Non-Title XIX Medical Services- 21 thru 25	$0	$0	$83,650,000	$0	$83,650,000	0.00%
Medicaid Contracts - 30	$8,854,076	$17,825,262	$4,400,087	$0	$31,079,425	0.00%
Premium Assistance (IO) - 40	$0	$55,229,435	$41,231,844	$0	$96,461,279	0.00%
Grants Management - 50	$50,400	$4,675,164	$31,492	$678,566	$5,435,623	0.00%
ISD Information Services - 88	$11,761,775	$56,717,774	$5,499,885	$0	$73,979,434	0.00%
Total	**$1,109,444,855**	**$3,325,123,249**	**$1,424,662,520**	**$5,329,409**	**$5,864,560,034**	4.36%

*Source of "Other" and % of "Other" total for each.
TSET Provider Engagement Grant (42%), Tulsa Community Foundation Women's Health Fund (31%), and TSET Health Promotions Coordinator Grant (27%)

FY'19 Top Five Appropriation Funding Requests		
		$ Amount
Request 1:	Annualizations - FMAP change/Medicare A&B Premiums (1/1/2018), CHIP to Title 19 Regular FMAP	(18,993,266)
Request 2:	Maintenance - Medicaid Program growth (1.6%), Medicare A&B Premiums (1/1/2019), Medicare Part D	13,230,389
Request 3:	One-Time Funding - FY'17 Carryover & replace, FY'17 GR return, Restore FY-2018 Appropriation base and Unfunded Payment Cycles	119,113,577
Total Increase above FY-19 Request		**$113,350,700**

How would the agency handle a 2% appropriation reduction in FY'19?

A reduction of 2% in the appropriation level amounts to a cut of $20 million state dollars. Coupled with the $113 million required to maintain the program at its current level, an additional reduction of $20 million would result in a funding shortage of approximately $133 million. Consequently, this equates to a total reduction of $345.5 million to the SoonerCare Program to achieve a 2% appropriation reduction.

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 15.6% to accommodate a 2% reduction in the FY-2018 appropriation base. Assuming an effective date of July 1, this provider rate cut would achieve savings of $133 million in state dollars and reduce the matching federal dollars by $212 million. Except for a limited number of individuals receiving services in long term care acilities, 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 $8.5 million in expenditure of state funds. Therefore, a 2% appropriation reduction requires a 15.6% provider rate cut.

How would the agency handle a 4% appropriation reduction in FY'19?

A reduction of 4% in the appropriation level amounts to a cut of $40 million state dollars. Coupled with the $113 million required to maintain the program at its current level, an additional reduction of $40 million would result in a funding shortage of approximately $153 million. Consequently, this equates to a total reduction of $397 million to the SoonerCare Program to achieve a 4% appropriation reduction.

To achieve a 4% 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 $8.5 million in expenditure of state funds. Therefore, a 4% reduction requires a 17.9% provider rate cut.

How would the agency handle a 6% appropriation reduction in FY'19?

A reduction of 6% in the appropriation level amounts to a cut of $60 million state dollars. Coupled with the $113 million required to maintain the program at its current level, an additional reduction of $60 million would result in a funding shortage of approximately $173 million. Consequently, this equates to a total reduction of $449 million to the SoonerCare Program to achieve a 6% appropriation reduction.

To achieve a 6% 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 $8.5 million in expenditure of state funds. Therefore, a 6% reduction requires an 20.3% provider rate cut.

Is the agency seeking any fee increases for FY'19?

		$ 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 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. In FY-2018, State funds comprise about 43% 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-2018.

4.) How will your agency be affected by federal budget cuts in the coming fiscal year?

Under current law, 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'19 Budgeted FTE

	Supervisors	Classified	Unclassified	$0 - $35 K	$35 K - $70 K	$70 K - $$$
Operations - 10	107	0	497	18	401	78
Medicaid Payments - 20	0	0	0	0	0	0
Medicaid Contracts - 30	0	0	0	0	0	0
Premium Assistance (IO) - 40	5	0	36	4	29	3
Grants Management - 50	6	0	27	0	22	5
ISD Information Services - 88	14	0	41	1	33	7
Total	**132**	**0**	**601**	**23**	**485**	**93**

FTE History

	2018 Budgeted	2017	2014	2011	2007
Operations - 10	497.0	494.0	488.0	440.5	418.75
Medicaid Payments - 20	0.0	0	0	0	0
Medicaid Contracts - 30	0.0	0	0	0	0
Premium Assistance (IO) - 40	36.0	37.0	22.0	28.0	3.00
Grants Management - 50	27.0	31.0	36.0	16.0	0
ISD Information Services - 88	41.0	43.0	37.0	0.0	0
Total	**601.0**	**605.0**	**583.0**	**484.5**	**421.8**

Performance Measure Review

		FY'17	FY'16	FY'15	FY'14	FY'13
Goal 1 - Financing & Reimbursement						
1	Reimbursement as a Percentage of Medicare Rates	86.57%	86.57%	89.25%	96.75%	96.75%
2	Reimbursement to Hospitals as a % of Federal Upper Pymt Limit	97.21%	94.19%	90.21%	87.96%	83.33%
3	Average % Reimbursement for Nursing Home Costs per Patient Day	91.79%	90.67%	92.66%	94.42%	89.00%
4	Average % Reimbursement for ICF/ID Facility Costs per Patient Day	96.90%	98.21%	98.85%	99.81%	100.00%
5	# of Eligible Professionals Receiving an EHR Incentive Pymt	808	569	1,003	1,022	780
6	# of Eligible Hospitals Receiving an EHR Incentive Payment	24	16	70	55	46
7	Total EHR Incentive Pymts to Eligible Professionals/Hospitals	$17,204,062	$10,640,175	$32,050,254	$32,553,188	$38,968,791
8	% of Eligible Professionals in Compliance with Meaningful Use of EHR	70.0%	64.7%	70.3%	61.0%	45.3%
9	% of Eligible Hospitals in Compliance with Meaningful Use of EHR	75.0%	100.0%	97.1%	98.2%	73.9%
10	Avg SoonerCare Program Expenditure per Member Enrolled	$4,370	$4,103	$4,260	$4,257	$4,077
11	Total # of Unduplicated SoonerCare Members Enrolled	1,014,983	1,052,826	1,021,359	1,033,114	1,040,332
12	Average Expenditure per Insure Oklahoma Member Enrolled	$2,648	$2,056	$2,365	$2,350	$2,670
13	Total # of Unduplicated Insure Oklahoma Members Enrolled	32,356	32,574	28,397	40,261	45,855
14	Avg Monthly Enrollment in Health Access Networks (HANs)	131,859	116,553	121,891	109,194	64,730
15	Total # of HAN Member Months	1,582,311	1,412,479	1,462,695	1,310,322	776,756
16	Total Payments Made to HANs	$7,665,365	$6,359,145	$7,063,475	$6,551,610	$3,885,990
Goal 2 - Program Development						
	Health Management Program					
17	HMP Total Enrollment	2,721	4,544	4,297	5,355	1,394
	HMP Per Member Per Month					
18	Forecast PMPM	$1,136	$1,127	$1,097	$1,075	$1,375
19	Actual PMPM	$854	$899	$979	$960	$1,125
20	% Below Forecast	25.00%	21.0%	11.0%	11.0%	18.2%
21	HMP/Number of Providers with On-Site Practice Facilitation	38	44	41	33	50
	Chronic Care Unit					
22	Number of Unduplicated Members Enrolled	1,772	1,500	1,147	978	206
23	Percent of Members with a Diagnosis of Hemophilia	4.1%	7.4%	4.7%	10.1%	0.31
24	Percent of Members with a Diagnosis of Sickle Cell Anemia	1.70%	1.4%	5.4%	12.9%	0.413
25	Percent of Members with a Combination of Chronic Conditions	94.2%	91.2%	89.9%	77.0%	0.277
	Case Management					
26	Number of New High-Risk OB members	1,790	3,840	2,192	2,474	1,998
27	Number of New At-Risk OB members	1,192	1,278	459	618	637
28	Number of New Fetal Infant Mortality Reduction Outreach to Moms	48	1,795	1,694	1,781	2,041
29	Number of New Fetal Infant Mortality Reduction Outreach to Babies	1,999	2,245	2,059	2,138	2,100

Performance Measure Review		FY'17	FY'16	FY'15	FY'14	FY'13
Goal 2 - Program Development (Continued)						
	Health Access Networks (HANs)					
30	Number of Contracted HANS	3	3	3	3	3
31	Total Number of Enrollees (at June 30)	147,559	117,750	133,471	118,107	90,688
32	Number of Members Required to Receive Care Management	11,787	13,200	8,405	740	1,418
33	Number of Unduplicated Providers in HANs	957	767	698	584	484
	SoonerCare Provider Network					
34	SC Choice Providers	2,844	2,719	2,558	2,309	2,170
35	SC Choice PCP Total Capacity	1,233,680	1,166,074	1,151,757	1,177,398	1,139,130
36	SC Choice PCP % of Capacity Used	40.16%	41.96%	42.92%	42.26%	44.06%
37	Percent of Tier 1 Entry-Level Medical Homes	53.30%	52.91%	53.76%	56.90%	58.64%
38	Percent of Tier 2 Advanced Medical Homes	25.05%	24.88%	25.55%	23.98%	27.69%
39	Percent of Tier 3 Optimal Medical Homes	21.64%	22.19%	20.69%	19.12%	13.67%
40	# of Tier 1 Advanced Medical Homes	468	472	486	503	502
41	# of Tier 2 Advanced Medical Homes	220	222	231	212	237
42	# of Tier 3 Optimal Medical Homes	190	184	184	169	117
	Patient-Centered Medical Home Enrollment/Tiers					
43	Total # of SC Members Enrolled in Medical Home	545,858	529,917	548,162	560,887	539,670
44	% of SC Members Enrolled in Medical Home	67.00%	67.23%	66.00%	70.00%	69.00%
	Member aligned with Medical Homes by Tier Level					
45	Percent of Members Aligned with Tier 1 Entry-Level Medical Homes	39%	39%	40%	41%	42%
46	Percent of Members Aligned with Tier 2 Advanced Medical Homes	28%	28%	27%	28%	31%
47	Percent of Members Aligned with Tier 3 Optimal Medical Homes	33%	32%	34%	31%	27%
48	Number of Members Aligned with Tier 1 Entry-Level Medical Homes	223,066	234,880	205,814	229,964	226,661
49	Number of Members Aligned with Tier 2 Advanced Medical Homes	156,997	169,374	144,334	157,048	167,298
50	Number of Members Aligned with Tier 3 Optimal Medical Homes	186,497	193,424	175,071	173,875	145,711
Goal 3 - Personal Responsibility						
	% of Children Accessing Well-Child Visits/EPSDT:					
51	First 15 months	N/A	96.40%	94.3%	96.3%	97.3%
52	3 to 6 years	N/A	56.10%	57.1%	58.5%	57.6%
53	Adolescents	N/A	22.40%	22.1%	21.8%	22.5%
	Adults Health Care Use - Preventive Care:					
54	20 to 44 years	NA	80.30%	81.0%	82.4%	83.4%
55	45 to 64 years	NA	90.00%	90.1%	89.9%	89.8%
56	Number of Medicaid Members Calling Tobacco Helpline	5,127	5,710	4,102	4,076	5,575
57	Number of Oklahomans Calling the Tobacco Helpline	35,079	34,339	24,879	22,251	35,123
58	Percent of Medicaid Members Calling the Tobacco Helpline	14.60%	16.60%	16.49%	18.32%	15.87%
59	Number Of Medicaid Members Utilizing Tobacco Cessation Benefits	43,535	28,464	26,783	21,610	23,581
60	EPSDT Participation Ratio	NA	63.0%	60.0%	60.0%	56.0%
61	Average # of Members in Pharmacy Lock-In	283	390	406	404	313
62	% of Members Seeking Prenatal Care	95.89%	96.46%	97.74%	97.68%	97.32%
63	# of Births	29,644	30,594	31,237	32,254	32,915
64	First Trimester	17,195	18,192	18,824	19,881	20,306
65	Second Trimester	8,055	8,091	8,077	8,088	8,289
66	Third Trimester	3,175	3,227	3,630	3,538	3,493
67	ER Visits per 1,000 Member Months (calendar year)	NA	NA	NA	NA	N/A
Goal 4 - Satisfaction & Quality						
	Customer Survey Results (CAHPS) Adults:					
68	Customer Service	N/A	87%	92%	82%	90%
69	How Well Doctors Communicate	N/A	91%	90%	90%	87%
70	Getting Care Quickly	N/A	84%	86%	82%	79%
71	Getting Needed Care	N/A	85%	85%	82%	80%
72	Shared Decision Making	N/A	77%	77%	50%	48%
	Customer Survey Results (CAHPS) Children:					
73	Customer Service	91%	86%	86%	88%	77%
74	How Well Doctors Communicate	96%	97%	96%	97%	93%
75	Getting Care Quickly	92%	93%	92%	92%	93%
76	Getting Needed Care	81%	89%	85%	89%	72%
77	Shared Decision Making	80%	78%	78%	60%	52%
	Other					
78	% of 5-Star Facilities in Focus on Excellence	17%	18%	20%	17%	18%
79	% of 4-Star Facilities in Focus on Excellence	30%	29%	19%	29%	29%
80	% of Members Participating in the Resident Satisfaction Survey Rating Overall Quality as Excellent or Good	92%	92%	93%	93%	0.94
81	% of Employees Participating in the Employee Satisfaction Survey Who Rate Overall Satisfaction as Excellent or Good	87%	85%	87%	85%	0.88
82	% of Member calls answered	95.30%	93%	90%	88%	1
83	% of Provider calls answered	96.00%	97%	95%	92%	1
84	# Involuntary Provider Contract Terminations	171	62	100	95	43

	Performance Measure Review					
		FY'17	FY'16	FY'15	FY'14	FY'13
Goal 5 - Eligibility & Enrollment						
85	Number of Online Enrollment Applications Received	429,993	383,914	210,571	291,323	437,668
86	% of Online Enrollment Applications That Are New	63%	59%	60%	52%	55%
87	% of Online Enrollment Applications That Are Recertifications	37%	41%	40%	48%	45%
88	Number of Online Applications Approved	348,871	331,918	179,782	253,723	320105
89	Number of Online Applications Denied	81,122	51,916	30,789	37,830	11756300%
90	Estimated Count of Eligible-But-Not-Enrolled Population (EBNE)	NA	NA	54,255	58,699	64,965
91	Home Internet	48%	70%	59%	59%	55%
92	Paper	21%	1%	5%	5%	5%
93	Agency Internet	5%	29%	35%	35%	26%
94	Agency Electronic	26%	0%	1%	1%	14%
95	Telephone	0%	0%	0	Unavailable	Unavailable
Goal 6 - Administration						
96	Percent of Administration Budgeted Dollars Used	70.14%	69.00%	64.00%	73.00%	0.6579
97	Per Capita OHCA Administrative Cost	$115.70	$116.65	$122.24	$138.96	119.92
98	Total Claims Paid	51,200,808	49,362,595	51,039,537	51,226,118	49,829,140
99	Payment Accuracy Measurement Rate (PAM)	97.87%	94.78%	95.38%	97.64%	0.955
100	OHCA Payment Error Measurement Rate (PERM)	3.82%		0.28%	0.28%	0.28%
101	Number of Prior Authorizations Generated for Prescriptions	173,914	161,387	91,786	115,206	155644
102	Percentage of Manual Prior Authorizations for Prescriptions	58.91%	62.74%	57.56%	77.90%	0.754
103	Payment Integrity Recoveries	$5,806,096	$5,995,190	$4,524,690	$4,731,822	$3,404,767
104	Number of Provider Audits	725	1159	611	285	133
105	Number of Providers Referred to Medicaid Fraud Control Unit	NA	1	0	0	1
106	Third Party Liability Recoveries	$27,362,860	$43,537,686	$39,050,461	$37,965,691	$53,212,491
107	Number of SoonerCare Members with Third Party Insurance	166,418	158,337	162,886	160,271	163006
108	Percent of SoonerCare Members with Third Party Insurance	20.50%	15.04%	15.95%	20.30%	0.206
Goal 7 - Collaboration						
109	Percent of Applications Submitted as Agency Internet and Agency Electronic Media Type	21%	29%	37%	41%	0.397091184
110	State and Federal Revenue Generated by Collaborations to Provide Services	$1,452,181,746	$1,441,259,300	$1,429,947,269	$1,292,233,657	$1,230,314,375
111	State and Federal Revenue Generated by Collaborations to Provide Medical Education	$141,002,176	$113,526,078	$140,931,567	$136,788,040	$126,057,898
112	Number of Tribes Represented at Tribal Consultations	19	19	17	17	14
113	Number of Tribal Partners Represented at Tribal Consultations (I/T/U and I.H.S.)	4	4	4	4	4

Revolving Funds (200 Series Funds)			
	FY'15-17 Avg. Revenues	FY'15-17 Avg. Expenditures or Transfers	June '17 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.	$130,483,178	$130,667,598	$25,547,406
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. As of 1/1/14 SHOPP expenditures are processed through the agency's Fund	$206,973,872	$206,534,605	$4,407,228
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.	$76,875,028	$76,937,417	$55,492
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.	$5,238,274	$5,906,547	$15,349,947
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.	$72,103,374	$74,013,461	$9,073,137
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.	$806,511	$806,511	$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.	$48,340,245	$48,340,245	$0
Fund 260 Income Tax Check-Off Fund	$0	$0	$0