

SUMMARY

SoonerCare Managed Care History and Performance:

1115 Waiver Evaluation

January 2009

James Verdier

Margaret Colby

Debra Lipson

Samuel Simon

Christal Stone

Thomas Bell

Vivian Byrd

Mindy Lipson

Victoria Pérez

MATHEMATICA
Policy Research, Inc.

SoonerCare, Oklahoma's Medicaid program, is managed by the Oklahoma Health Care Authority, which supported this evaluation.

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MATHEMATICA
Policy Research, Inc.

600 Maryland Avenue, SW, Suite 550
Washington, DC 20024-2512
(202) 484-9220
www.mathematica-mpr.com

As SoonerCare has grown and evolved, so has its impact on health care in Oklahoma.

SoonerCare Managed Care History and Performance: 1115 Waiver Evaluation

In 1993 the Oklahoma Health Care Authority (OHCA) was created by statute and charged with reforming Oklahoma's Medicaid program. OHCA's charter was to implement a state-wide managed care model that would control costs and improve care for Medicaid enrollees. During the subsequent 15 years, OHCA substantially modified the Medicaid program, called SoonerCare, through a Section 1115 waiver that uses managed care approaches to serve most non-elderly enrollees. Through the waiver, OHCA first implemented fully capitated services in urban areas (SoonerCare Plus) and then a partially capitated primary care case management (PCCM) program (SoonerCare Choice) in rural areas, before extending SoonerCare Choice throughout the state in 2004.¹ Over time the agency has assumed more direct responsibility for providing managed care services through SoonerCare Choice and other programs, and has begun extending coverage to groups with somewhat higher incomes who had previously not been eligible for the SoonerCare waiver programs.

As SoonerCare has grown and evolved, so has its impact on health care in Oklahoma. By October 2008, just over 610,000 individuals, representing 17 percent of the total population of Oklahoma, were enrolled in SoonerCare. About 65 percent of them were members of the SoonerCare Choice program. Moreover, OHCA programs now consume roughly 11 percent of the state's budget, an amount exceeded only by expenditures on education. State and federal Medicaid expenditures in fiscal year 2007 were estimated to have supported 111,500 direct and indirect jobs within Oklahoma's health care industry and to have provided \$3 billion in income.

Mathematica's Approach to the Evaluation

In order to broaden understanding about SoonerCare's role as a health insurance provider and economic force in Oklahoma, and to glean lessons for the future, OHCA contracted with Mathematica Policy Research, Inc. (MPR) to conduct a comprehensive evaluation of the SoonerCare 1115 waiver program. This report summarizes the results of that evaluation, which examined the waiver program from its inception in 1993 through its most recent activities in 2008. We applied a variety of analytic techniques to assess the impact of key policy and implementation decisions on enrollment trends, member access to care, provider participation, the health of enrolled members, and the financial costs to Oklahoma. The evaluation presents Oklahoma's Medicaid managed care experience within the context of national trends in Medicaid and health policy, sets out recommendations that can inform future SoonerCare managed care initiatives, and identifies lessons that other states may draw upon when developing and modifying their own Medicaid programs.

To gather qualitative information for this evaluation we interviewed nearly 60 key stakeholders, including state officials, OHCA staff, OHCA contractors, physicians and other

¹ Throughout this report the terms "SoonerCare Choice," "SoonerCare Plus," "SoonerCare waiver," and "SoonerCare managed care waiver" are used to refer to the managed care waiver that is the subject of our evaluation. When used alone, the term "SoonerCare" refers to Oklahoma Medicaid as a whole, including enrollees and programs that are not part of the managed care waiver. Section 1115 waivers exempt states from a variety of federal requirements in their Medicaid programs in order to enable states to demonstrate innovative approaches to providing and financing care. Capitated programs pay managed care organizations or health care providers a fixed amount per enrollee per month in advance to cover a range of health care services rather than paying for each service as it is provided (known as fee-for-service [FFS] payment).

The SoonerCare waiver's development was initially motivated by the state legislature's interest in controlling the Medicaid budget.

providers, managed care organizations (MCOs), enrollee advocates, and legislators during two visits to Oklahoma in May and June 2008, and in telephone interviews during August and September 2008. In addition, we conducted an extensive review of documents on Oklahoma's program history and structure, and reviewed the economic, health care market, and policy contexts in which the SoonerCare managed care waiver program developed, drawing on state budget documents and legislative records as well as nationally available data sources. To measure the effects of the SoonerCare managed care waiver, we used multiple state and national data sources to construct new measures of program performance and to examine trends over time using measures that OHCA routinely tracks.

Overview of Oklahoma's Medicaid Managed Care Experience

In the early 1990s, as Oklahoma developed the SoonerCare managed care program, many other state Medicaid programs were implementing managed care initiatives. They ranged from PCCM programs, in which the state contracts directly with physicians to provide and coordinate a limited set of primary care services, to full-risk capitated programs operated under state contract by private MCOs, which cover a full range of primary and acute care services.² These managed care programs were aimed at stabilizing and containing costs and improving access to care. Several states combined managed care initiatives with efforts to expand Medicaid eligibility, anticipating that coverage expansions could be financed with managed care savings. Oklahoma's initial managed care initiatives did not include expanded coverage, although some expansions were implemented in later years.

Origin and Early Years of the SoonerCare Waiver: 1992 to 1996

Growth in Medicaid Costs. The SoonerCare waiver's development was initially motivated by the state legislature's interest in controlling the Medicaid budget. Medicaid expenditures had grown by 72 percent from 1988 to 1992, more than twice the 31 percent increase in state general revenues during that period. Oklahoma's leaders formed two special study panels in 1992 to look at options for Medicaid and health care reform. In 1992, 26 states had some form of Medicaid managed care, so Oklahoma had several models to build upon.

Authorizing Legislation. Recommendations from the study panels provided the basis for two bills that were approved by the legislature and the governor in 1993. One required the conversion of the Medicaid program from a fee-for-service (FFS) system to a statewide comprehensive managed care system. The other established OHCA to design and implement the new program, and to administer the Medicaid program as a whole. The Medicaid program had previously been part of the large Department of Human Services, the state's welfare agency.

Oklahoma Health Care Authority. At the time OHCA was established by statute in 1993, only three other states (Arizona, Alabama, and Mississippi) had stand-alone Medicaid agencies, and there are still only seven states that take this approach rather than making Medicaid part of larger human services, welfare, or public health agencies. OHCA also has its own governing board, made up of citizens appointed by the governor and the legislature.

²The term "full-risk" capitation is used to describe the typical MCO contracting arrangement in which the state makes an upfront per-member per-month (PMPM) payment to the MCO to cover all services that enrollees are predicted to need. The MCO is responsible for paying for all needed services out of this capitation payment, even if actual service costs exceed the upfront payment. If costs for an enrollee are less than the capitated payment, the MCO can use the remaining amount to cover higher-than-expected costs for other enrollees, or add it to its profits.

For rural areas, OHCA developed a partially capitated PCCM program called SoonerCare Choice.... The partial capitation feature was unique to Oklahoma.

By 1997, there was enough evidence of savings from managed care to take steps toward expanding Medicaid eligibility.

While such appointed governing boards are common in Oklahoma, only one other state (Kansas) has an external governing board for its Medicaid agency.

SoonerCare Plus and Choice. While many in the legislature hoped Oklahoma would establish a fully capitated statewide Medicaid managed care program, OHCA ultimately determined that full capitation would not be feasible outside of the state's three urban areas (Oklahoma City, Tulsa, and Lawton). There was little experience with managed care in rural areas, and few MCOs seemed willing and able to serve the Medicaid population in those areas. OHCA therefore developed a fully capitated MCO model called SoonerCare Plus to operate just in the three urban areas, and contracted with five MCOs, each of which served one or more of the areas. This model was implemented in July 1995. For rural areas, OHCA developed a partially capitated PCCM program called SoonerCare Choice that was launched in October 1996. The partial capitation feature was unique to Oklahoma. Participating physicians were paid about 10 percent of enrollees' total predicted costs upfront and, in turn, were responsible for providing a specified package of office-based primary care services, with all other needed services paid for by the state on a FFS basis. PCCM programs in other states typically paid physicians only \$3 per member per month (PMPM) for limited care coordination, and all physician and other services were paid for on a FFS basis.

Development and Expansion of Managed Care: 1997 to 2003

SoonerCare Plus Implementation. Under federal rules, Medicaid beneficiaries must have a choice of at least two MCOs when enrollment is mandatory, as it was in Oklahoma. OHCA was initially successful in contracting with enough MCOs under the SoonerCare Plus model to meet the federal standard in the three urban areas, but three of the initial five MCOs dropped out between 1996 and 2000. Although OHCA was able to find replacements, SoonerCare Plus remained vulnerable to turnover and potential departure of MCOs.

SoonerCare Choice Implementation. The SoonerCare Choice program in rural areas was implemented smoothly, even though attracting enough physicians to provide enrollees a range of choices remained challenging because of the limited number of physicians practicing in rural areas. SoonerCare Choice members were also able to select nurse practitioners (NPs) or physician assistants (PAs) as providers.

Medicaid Eligibility Expansion. By 1997, there was enough evidence of savings from managed care to take steps toward expanding Medicaid eligibility. With the overall state budget in good condition, and with the potential for additional federal funding from the State Children's Health Insurance Program (SCHIP) then being considered in Congress, the legislature approved an increase in the maximum income limit for pregnant women and children from 150 percent to 185 percent of the federal poverty level (FPL). OHCA also took several administrative actions in 1997 and 1998 that facilitated expanded coverage.

Enrollment of the ABD Population in 1999. In 1999, OHCA began enrolling the aged, blind, and disabled (ABD) Medicaid population into SoonerCare Plus and Choice on a mandatory basis, something that fewer than 20 states were doing at that time. The original 1993 legislation required enrollment of the ABD population in managed care by 1997, but OHCA subsequently decided, with legislative approval, that the complex care needs of this population warranted additional time to lay the groundwork. Transitioning the ABD population into SoonerCare went smoothly in 1999-2000, but the costs of caring for this group were higher than expected, producing financial pressure on many MCOs, who argued that the capitated payments they were receiving from OHCA were not high enough to cover their costs.

In 2003, OHCA developed an analysis that indicated OHCA could operate the Choice program in urban areas at approximately one-quarter of the administrative costs of the Plus program.

Increasing Medicaid Budget Pressures in 2002-2003. The Medicaid budget came under increasing pressure in Oklahoma and most other states in 2002-2003, as an economic downturn led to reduced revenues and increased Medicaid enrollment. OHCA made cuts in Medicaid services and enrollment in response to these pressures. At the same time, the SoonerCare Plus MCOs continued to press for higher capitated payments to meet the growing costs of serving the ABD and other populations.

Positive Results in SoonerCare Choice. OHCA began conducting enrollee satisfaction surveys in the SoonerCare Choice and Plus programs in 1997. It also required SoonerCare Plus MCOs to report data on a variety of access and quality of care measures, and collected similar measures for the Choice program.³ In October 2003, OHCA published its first full report on performance and quality in the SoonerCare managed care program (“Minding our P’s and Q’s”). In general, the report indicated that the Choice program was performing about as well as the Plus program on most measures, and somewhat better on several of them.

End of SoonerCare Plus. One additional MCO dropped out of SoonerCare Plus in 2002-2003, leaving only two operating in each area, the minimum needed to meet federal requirements. In 2003, the MCOs sought a rate increase for 2004 of 18 percent. With the Medicaid budget still under pressure, OHCA offered a 13.6 percent hike, which two of the three remaining MCOs accepted. One MCO that operated in all three areas held out for 18 percent, believing its bargaining position was quite strong, since if it dropped out the SoonerCare Plus program would no longer meet the usual federal requirements.

During the negotiations, OHCA developed an analysis that indicated OHCA could operate the Choice program in the three urban areas at approximately one-quarter of the administrative cost of the Plus program and with one-quarter of the staff. In an emergency meeting in November 2003, the OHCA Board voted to end the Plus program as of December 31, 2003, and to replace it with the Choice program in all three urban areas. OHCA immediately began to transition all enrollees and their providers from the Plus to the Choice program and completed that effort in April 2004.

Enhancing the PCCM Model and Expanding Coverage: 2004 to 2007

Nurse Care Management. The legislature authorized a transfer of \$10 million from program to administrative funds and 99 additional staff positions for OHCA to cover the administrative and care management activities that OHCA planned to undertake in the new urban SoonerCare Choice program. With the additional resources, OHCA hired 32 nurses and 2 social services coordinators, most of whom had served as exceptional needs coordinators with the SoonerCare Plus MCOs. These nurse care managers are now performing many of the care management and coordination functions that the MCOs previously performed in the urban areas, and have also extended their reach into rural areas.

Health Management Program. Responding to a 2006 legislative directive, OHCA developed a new Health Management Program (HMP) that focuses on a limited number of high-cost, high-need enrollees. This program, launched in February 2008, is operated by an external vendor with experience operating similar programs in other states.

³The consumer satisfaction surveys were conducted using the nationally recognized Consumer Assessment of Health Plans Survey (CAHPS), and the access and quality measures were based on the national Health Plan Employer Data and Information Set (HEDIS), now called the Healthcare Effectiveness Data and Information Set.

In response to a 2004 legislative directive, OHCA, in partnership with the Oklahoma Insurance Department, established Insure Oklahoma, which helps small employers provide health insurance coverage for employees.

Oklahoma increased the Medicaid participation rate among eligible children from 55 percent on average in 2000 to 77 percent on average in 2006.

Movement Toward a “Medical Home” Model. OHCA is also developing a “medical home” model for SoonerCare Choice that moves away from the partial capitation reimbursement approach toward one that relies on FFS reimbursement for office-based services, supplemented by care coordination payments that vary with the services offered in the practice and patient characteristics, and performance-based payments for specific preventive services and quality-related activities.

Expanded Coverage for Adults Through “Insure Oklahoma.” In response to a 2004 legislative directive, OHCA, in partnership with the Oklahoma Insurance Department, established “Insure Oklahoma,” which helps small employers provide health insurance coverage for employees with incomes up to 200 percent of FPL. The employer-sponsored insurance component went into effect in late 2005, and an individual plan, focused on individuals with incomes up to 200 percent of FPL who do not have access to employer coverage, went into effect in early 2007.

All Kids Act. In early 2007, the legislature authorized coverage of children in families with incomes up to 300 percent of FPL. However, the federal government announced in August 2007 that Medicaid state plans and waiver programs that covered children in families with incomes that high would not be approved. Accordingly, Oklahoma submitted a request for approval of expansion of coverage up to 250 percent of FPL. That request has not yet been approved.

Major Findings

Our major evaluation findings are organized into three main categories: (1) SoonerCare’s impact on access to health care for lower-income Oklahomans, (2) measures of the quality of that care, and (3) the cost of the program to Oklahoma’s taxpayers. Finally, we look at how OHCA as an agency has shaped and managed the program over the last 13 years.

Access

SoonerCare has contributed to improvements in access to care for low-income Oklahomans from 1995 through 2008. Nonetheless, some aspects of access still lag behind national averages or could be significantly improved. To assess the SoonerCare program’s impact on access, we looked in particular at health insurance coverage; physician participation, emergency room visits, and preventable hospitalizations in SoonerCare managed care; and primary care utilization among lower-income Oklahomans, many of whom are enrolled in or eligible for SoonerCare.

Health Insurance Coverage

SoonerCare has improved coverage for children. From 1997 to 2007, Oklahoma experienced a doubling in SoonerCare enrollment, and 90 percent of that was attributable to children. Oklahoma increased the estimated Medicaid participation rate among eligible children (in families earning up to 185 percent of FPL) from 55 percent on average in 2000 to 77 percent on average in 2006, a boost of 38 percent. Expanded Medicaid enrollment among children has reduced the uninsured rate among those in families earning up to twice the federal poverty level from 29 percent in 1995-1996 to 13 percent in 2006-2007, below the national average of 18 percent.

SoonerCare has made coverage more affordable for some low-income uninsured adults. With the launch of Insure Oklahoma in 2005, some low-income uninsured adults can receive subsidies to help them afford insurance premiums. After a slow start, enrollment has grown from 1,394 at the end of 2006 to 15,907 as of December 2008. The maximum income level for individuals eligible to receive premium subsidies rose from 185 percent to 200 percent of FPL in November 2007. Businesses with up to 50 workers are eligible to enroll in Insure Oklahoma's employer-sponsored insurance program, up from 25 workers at the program's inception.

Gaps remain that SoonerCare must address. Despite the accomplishments, estimated Medicaid participation rates are less than two-thirds for adolescents, very poor parents with dependent children, disabled adults, and the elderly. In addition, the uninsured rate in 2006-2007 among non-elderly adults earning less than twice the federal poverty level (37 percent) has stayed about the same over the last 10 years, since Oklahoma has done little (until Insure Oklahoma) to offset the declining rate of private insurance among this group. Further progress in reducing the uninsured rate in Oklahoma depends on obtaining federal approval to implement coverage expansions enacted by the Oklahoma legislature in 2006 and 2007.

Low Medicaid income eligibility levels for parents can create large differences in coverage rates relative to their children. Oklahoma's income eligibility standards for parents with dependent children are relatively low compared to those for children, and have not been adjusted for over a dozen years. In addition, fewer parents who are eligible are enrolling. This suggests that OHCA, in concert with the Department of Human Services, could improve efforts to inform very poor parents that they, as well as their children, can qualify for Medicaid even if they do not receive public assistance. Oklahoma's effort to expand the Insure Oklahoma program to allow more individuals and businesses to receive subsidies that would enable them to afford insurance premiums would also increase coverage for adult parents.

Physician Participation

The total number of primary care provider (PCP) contracts has grown substantially since 1997, but the mix of contracts has changed, in part as a result of recent administrative changes that facilitate enrollment of practice groups as PCPs. From 1997 to 2007, the number of contracts for providers serving as SoonerCare PCPs increased from 414 to 595, a nearly 44 percent increase. The mix of PCP contracts has changed somewhat in recent years, following OHCA's decision in 2004 to allow groups to enroll as PCPs rather than requiring individual contracts with each provider within the group. In 2004, 61 percent of urban members were assigned to an individual MD, DO, NP, or PA. By 2007, about 34 percent of members were assigned to individual PCPs, and the remainder were assigned to multi-provider groups or clinics, which may result in improved access if members can seek treatment from any available group member. Similar trends were observed among rural members; about half of them were assigned to individual PCPs in 2007, down from 81 percent in 2004.

From 2004 to 2006, the total number of contracted specialists and MDs working as PCPs for SoonerCare Choice has increased by 14 percent. The number of contracted MDs grew from 4,287 in 2004 to 4,870 by 2006. Of these gains, new enrollment among PCPs accounted for one-quarter of the increase and new enrollment among specialists accounted for the remainder. By 2006 about 90 percent of all MDs in Oklahoma had contracts with the SoonerCare Choice program to deliver services to members, although not all of them serve as PCPs.

In 2006, 24 percent of general/family practitioners and 48 percent of pediatricians participated in SoonerCare Choice as PCPs.

Approximately 37 percent of physicians specializing in general/family medicine, pediatrics, and obstetrics/gynecology participate as SoonerCare Choice PCPs, with particularly high participation rates in rural areas. In 2006, 24 percent of general/family medicine practitioners and 48 percent of pediatricians statewide participated in SoonerCare Choice as PCPs. In urban areas, the participation rate for both groups was just above 30 percent, while in rural areas about 60 percent of these physicians participated, including nearly all pediatricians.

The typical SoonerCare Choice PCP in 2007 provided 84 to 90 percent more visits to assigned members than the typical SoonerCare PCP in 1997. In rural areas, the median number of annual visits (encounters) per member for adults assigned to SoonerCare Choice PCPs rose from 0.82 in 1997 to 1.56 in 2007, an increase of 90 percent. The increase in visits for children rose from 0.67 per member in 1997 to 1.23 in 2007, an increase of 84 percent. Visit trends in urban areas showed similar increases, although the data in those areas may be less reliable because so many members were enrolled in fully capitated MCOs during the Plus period.

Emergency Room Visits

SoonerCare Choice members' emergency room (ER) utilization decreased between 2004 and 2007—a time when ER use among Medicaid enrollees in the rest of the country was increasing. There were 76 ER visits for every 1,000 months in which members were enrolled in SoonerCare Choice in 2007, down from 80 in 2004. Nationally, by contrast, ER visits by Medicaid enrollees rose from 80 visits for every 100 enrollees in 2004 to 87 visits in 2006.⁴

Overall, care for SoonerCare Choice clients has shifted from emergency rooms to physician office visits. In 2003, SoonerCare Choice enrollees had 1.2 ER visits for every physician office visit. By 2007, the ratio was 0.74 ER visits for every physician office visit, a decline of 38 percent.

The SoonerCare Choice focus on high ER users appears to be effective. In 2003, the patients of the top 5 percent of providers, in terms of ER utilization relative to office visits, had 2.85 ER visits for every office visit. By 2007, the patients of the highest 5 percent of providers had 1.26 ER visits for every office visit, a reduction of more than 55 percent. In addition to actions that physicians may have taken on their own or with OHCA assistance, OHCA's efforts to provide education on appropriate ER use and self-management strategies to people who were unusually high and persistent ER users, which began in 2006, probably also had an impact.

Preventable Hospitalizations

The overall rate of preventable hospitalizations declined among SoonerCare adults from 2003 to 2006; trends for children were mixed. The overall rate of preventable hospitalizations among SoonerCare enrollees declined by 24 percent among urban adults and 15 percent among rural adults from 2003 to 2006. While most trends in preventable hospitalizations among children enrolled in SoonerCare were not statistically significant, there was a significant increase in gastroenteritis-related admissions in urban areas and a decrease in asthma-related admissions in rural areas.

⁴OHCA calculates the SoonerCare ER visit rate in a somewhat more precise way (visits per 1,000 enrollee months) than it is reported in national data (annual visits per enrollee, unadjusted for months of enrollment), but it is the relative trends that are important, not the method of calculation.

We estimate that SoonerCare Choice could save at least \$8 million a year by cutting its rate of preventable hospitalizations in half.

The SoonerCare Choice program has performed as effectively as the SoonerCare Plus MCOs in managing most types of preventable hospitalizations, but trends in urban areas for some chronic conditions indicate opportunities for improved disease management. The Choice program may have performed less effectively than the Plus program in managing diabetes-related hospitalizations among urban adults and asthma-related admissions among urban children. This pattern could also indicate that the Choice program has more aggressively implemented disease management initiatives for diabetes and asthma in rural areas than in urban areas.

Rates of preventable hospitalizations varied by age and geographic location. In 2006 roughly 3,600 preventable hospitalizations occurred among SoonerCare Choice enrollees; children accounted for 42 percent of these hospitalizations and rural enrollees accounted for 46 percent. Rates of preventable hospitalizations were generally lower among urban adults relative to rural adults, but were higher among urban children relative to rural children.

Reducing preventable hospitalizations would lower SoonerCare expenditures. We estimate that SoonerCare Choice could save at least \$8 million a year by cutting its rate of preventable hospitalizations in half. Actual savings could be much higher, given the strong link between preventable hospitalizations and emergency room utilization. About 68 percent of OHCA's preventable hospitalizations were preceded by an ER visit.

Primary Care Utilization Among Lower-Income Oklahomans

Reported access to providers declined between 1995 and 2007 for low-income adults with children, who may or may not have been covered by SoonerCare. From 2001 to 2007 the percentage of low-income adults with children reporting that they had a personal doctor or health care provider decreased from 70 percent to 56 percent. At the same time, an increasing percentage reported that during the past year they had needed to see a doctor but did not because of cost.

Low-income adults with children reported fewer checkups between 2000 and 2007. Among low-income adults residing in households with children, the percentage who had received a checkup with a doctor within the past year declined by 28 percent from 2000 to 2007. Having health care coverage and having a primary care provider were strong predictors of routine checkup utilization. In 2007 low-income adults who had some form of health care coverage but no primary care provider were about as likely as adults who had a primary care provider but no health care coverage to have received a checkup within the past two years. Encouraging new SoonerCare enrollees to access preventive care services, such as routine checkups, within the first few months of enrollment may ultimately improve member outcomes, given the low level of contact most will have had previously with the health care system.

Linking enrollees to primary care providers is likely to be an ongoing challenge for SoonerCare. About half of respondents reported in 2007 that they had a personal health care provider. While only some of these low-income adults are currently enrolled in SoonerCare, this finding underscores the importance of enrolling as many providers as possible in the program to encourage the maintenance of existing "medical home" relationships and to improve continuity of care upon enrollment in the SoonerCare program.

Among children and non-disabled adults, annual per-member costs in Oklahoma have been significantly below the national average every year between 1996 and 2005.

Quality

OHCA has made a concerted effort to measure and report quality in the SoonerCare managed care program, using a combination of HEDIS, CAHPS, and ECHO to measure utilization of key services and enrollee satisfaction.⁵ OHCA's use of these measures since 2001 in its SoonerCare Choice program is especially noteworthy, since until recently only a few states with PCCM programs have done so. Key quality-related trends in SoonerCare Choice are summarized below, with comparisons to national benchmarks when available.

Process of Care Measures: HEDIS

Quality of care trends show improvement between 2001 and 2007 for SoonerCare Choice members. Among the 19 HEDIS measures tracked by OHCA, all showed some level of improvement over time. The average percentage improvement for the 8 measures tracked between 2001 and 2007 was 18.6 percent, while the average improvement for the 10 measures tracked between 2003 and 2007 was 36.7 percent.

Quality of care is comparable to or better than national Medicaid averages for several of the measures. Of the 19 measures reported, 5 consistently met or exceeded national Medicaid benchmarks between 2001 and 2006, while the others fell below. Since the HEDIS Medicaid benchmarks include few if any PCCM programs, and since the MCOs that are included are likely to be relatively high-performing (since reporting is voluntary), the SoonerCare Choice performance on these measures is respectable.

Member Satisfaction: CAHPS and ECHO

In CAHPS surveys administered to SoonerCare Choice adults and children between 2003 and 2007, satisfaction levels were consistently high for measures most relevant to PCCM programs. Three-fourths or more of respondents gave high rankings to their overall health care and their personal health care providers, and said they were generally able to get the care they needed, and get it promptly.

SoonerCare Choice satisfaction ratings were below 2005 and 2006 CAHPS national Medicaid benchmarks, but by small margins. Since the AHRQ National CAHPS Benchmarking Database for Medicaid is made up almost entirely of MCOs that submit their results voluntarily, it is encouraging that the SoonerCare Choice ratings were reasonably close to the national benchmark on measures that a PCCM program can be expected to impact.

Satisfaction with SoonerCare behavioral health care has been consistently high in recent years. Adults were surveyed in 2004 and 2006 and approximately 7 of 10 respondents reported no problem seeing providers quickly and more than 8 out of 10 reported providers usually or always communicated well. There are no national benchmarks for the ECHO survey.

Cost

Medicaid costs per member in Oklahoma were substantially below the national average between 1996 and 2005. Among children and non-disabled adults, who account for approximately three-quarters of the enrollment in SoonerCare and in managed care programs in most

⁵ The Experience of Care and Health Outcomes (ECHO) survey is designed to collect consumers' ratings of their behavioral health treatment.

OHCA is unusual among state Medicaid agencies in several respects.

other states, annual per-member costs in Oklahoma have been significantly below the national average every year between 1996 and 2005. Oklahoma's per-member expenditures for those in the disabled eligibility category were also below the national average throughout the period, although by a smaller percentage than in the children and adult categories.

Medicaid accounted for a smaller share of total state expenditures in Oklahoma between 1996 and 2005 than the national average and 19 comparison states. Medicaid has accounted for a substantially smaller share of total state expenditures in Oklahoma than the national average from 1995 to 2006, and a smaller share than in any of the 19 comparison states we examined. Medicaid represented 6.5 percent of state expenditures in Oklahoma in 1995, rising to nearly 10 percent in 2006. During that same period, the national average remained relatively stable, with Medicaid expenditures rising from around 12.5 percent of total state expenditures in 1995 to nearly 14 percent in 2006.

OHCA Role and Performance

OHCA is unusual among state Medicaid agencies in several respects: its status as a separate, stand-alone agency; the continuity of its top leadership and key staff; its ability to maintain its own personnel and salary system; its governance by a separate appointed board; and its ability over time to obtain resources and flexibility from the legislature and governor. In combination, these factors have helped OHCA to construct a Medicaid managed care program that fits Oklahoma well and adapts as needs and circumstances change and as opportunities arise. OHCA has made modest efforts to expand health insurance coverage to children and lower-income workers, within the constraints of the state's political and fiscal circumstances. Recent coverage expansions have begun to increase the availability of employer-sponsored coverage, albeit to a limited extent.

Some of OHCA's most notable accomplishments include:

- ***SoonerCare Choice Design and Implementation.*** OHCA designed and implemented a PCCM program that increased physician participation and member access in rural areas, and that provided a solid managed care alternative in urban areas when the MCO program became too difficult to maintain in 2003.
- ***Smooth Transitions to New Programs.*** OHCA has invested substantial resources in making transitions to new programs and new forms of care as smooth as possible for beneficiaries and providers, including the initial transition to managed care in 1995-1996, the inclusion of the ABD population in managed care in 1999-2000, the transition from the MCO to the PCCM program in urban areas in 2003-2004, and implementation of the Insure Oklahoma program in 2005-2006.
- ***Managed Care Enhancements in SoonerCare Choice.*** OHCA has continued to add care coordination and disease management capabilities to the SoonerCare Choice PCCM program through an in-house team of nurse care managers, the new HMP, and plans for improved performance incentives for providers in the new "medical home" model in SoonerCare Choice.
- ***Innovation and Strategic Planning.*** OHCA's leadership has built an agency culture that values careful innovation, and that is bolstered by a systematic and broadly inclusive strategic planning process.

- **Information Technology Enhancements.** OHCA has built and continually improved information technology capabilities that facilitate provider payment and data analysis and reporting, using a well-coordinated combination of skilled and experienced in-house staff and on-site outside contractors.
- **Quality and Performance Monitoring and Reporting.** OHCA has developed a strong emphasis on quality, performance monitoring, and reporting in SoonerCare and other programs, using both in-house staff and on-site outside contractors.
- **Public Reporting and Accountability.** OHCA has undergirded all its efforts with a commitment to public reporting and accountability, with publications ranging from detailed annual reports to short “Fast Facts” summaries of key program issues.

We also found some areas where OHCA could improve:

- **Better Coordination of Care Coordination Initiatives.** OHCA does not appear to have fully worked through the ways in which SoonerCare Choice nurse care managers will relate to the new HMP. Since the potential exists for overlap in the clients served through these two efforts, and since HMP is operated by an outside contractor, coordination will likely present challenges. OHCA has begun to address some of these coordination issues. In addition, the still-developing “medical home” model for SoonerCare Choice will likely have care coordination features that will have to be integrated into what currently exists.
- **Better Coordination with Other State Agencies, Especially at the Staff Level.** While OHCA collaborates effectively with a wide range of other state agencies, and while the relationships among agency heads appear very strong, we picked up some indications in our interviews that relationships with some agencies may not be as strong below the leadership level. Responsibility for home-and-community-based services (HCBS) waiver programs is shared between OHCA and the Department of Human Services, for example, so differences in perspectives and priorities can sometimes lead to tensions between the two agencies. Since some participants in HCBS waiver programs may also be served by OHCA’s nurse care managers, greater attention to the linkages between HCBS waivers and the SoonerCare Choice program may be warranted. We also saw evidence that the Oklahoma Insurance Department perspective on the Insure Oklahoma program sometimes differs from that of OHCA, so continued efforts to improve communication and collaboration between the two agencies would likely benefit that program.
- **Even More Communication, Especially with the Legislature.** Despite OHCA’s extensive public reporting on its activities, our interviews suggested that awareness of OHCA activities and programs in the legislature and among other key constituencies is not widespread. Given the frequent turnover in Oklahoma’s term-limited legislature, ongoing education programs should remain a priority.
- **Leadership Transition Planning.** Interviews made it clear that OHCA’s success over the years can be attributed in large part to the skill, experience, and stability of the agency’s leadership and top managers. OHCA leadership has built and enhanced the agency’s institutional capabilities, so there will be strong organizational support for any new set of leaders that the future brings. Nonetheless, leadership transitions always present internal and external challenges to organizations, so any public agency should prepare for those challenges as part of its strategic planning agenda.

With sufficient resources and leadership commitment, state Medicaid agencies can manage care at lower costs than MCOs and with similar outcomes.

Lessons and Implications for Other States

We present here the key lessons that Oklahoma's experience illustrates for other states in terms of program design and management, agency management, and stakeholder relationships.

Program Design and Management

Contracting With MCOs Versus In-House Care Management

With sufficient resources and leadership commitment, state Medicaid agencies can manage care at lower costs than MCOs and with similar outcomes. Annual per-member costs in Oklahoma have been significantly below the national average for every year between 1996 and 2005, and in most cases below the average of states operating MCOs. Given the cost trajectory of Oklahoma's MCO contracts, and the limited competition that existed between companies at the time that the Plus program was terminated, it seems likely that SoonerCare would have been more costly to operate during the past four years had those contracts been maintained. Evidence from this evaluation suggests that provider participation and member outcomes have not been adversely affected as a result of the state-wide expansion of SoonerCare Choice and termination of the MCO contracts, though we did find some evidence that preventable hospitalizations for diabetes and asthma may have increased. In states such as Oklahoma, where managed care penetration is low and turnover among MCOs is relatively high, MCOs' key advantage — utilizing resources more flexibly — may have limited effectiveness in achieving better outcomes. The growing concentration of Medicaid managed care interest and capabilities in a relatively small number of multi-state private MCOs has prompted many states to look at state-managed PCCM, care management, and disease management programs as potential alternatives. Oklahoma has demonstrated that such programs have the potential to produce results that are as good as those produced by private MCOs, and perhaps better, if state Medicaid agencies have the necessary resources and a commitment to truly manage care.

General Program Design

Models from other states can be important guides, but they must be adapted to the context of individual states. Oklahoma made extensive use of outside consultants and site visits to other states when developing the initial SoonerCare program from 1992 to 1994. It then incorporated an innovative partial capitation feature in its PCCM program to encourage participation from rural physicians who had previously been reluctant to see Medicaid patients. It also set up a separate stand-alone Medicaid agency that had few counterparts in other states to help give a higher priority and greater focus to health care policy and Medicaid managed care. Other states would benefit from using an equally careful approach in borrowing and adapting successful features of other programs to their own specific context.

Wide consultation with external stakeholders on program design can pay major dividends. Oklahoma initially planned to include the ABD population in SoonerCare on a mandatory basis in 1997, a step few other states were taking at the time, but extensive consultation with disability advocacy groups, MCOs, and providers persuaded OHCA to delay implementation until 1999, when OHCA was able to phase in mandatory enrollment with little controversy or difficulty. An evaluation of the early years of SoonerCare implementation concluded that it went much more smoothly than similar managed care implementations in other states during that period, due in part to OHCA's extensive efforts to reach out to MCOs, providers, and member advocates.

OHCA has made a strong commitment to measuring program performance.

Providers offered consistently positive feedback about initiatives that OHCA has undertaken in recent years to simplify their interactions with the agency.

Ongoing Performance Measurement

Robust performance measurement capabilities, like those developed by OHCA, provide reliable data to support key management decisions. OHCA has made a strong commitment to measuring program performance. Though most states now use HEDIS and CAHPS measures to monitor MCOs' performance, and many states have begun using the measures within their PCCM programs, OHCA demonstrated an early commitment to tracking these measures. OHCA began administering CAHPS surveys in 1997, and first reported HEDIS measures in 2001. The availability of comparable quality and consumer satisfaction data, which showed strong performance in the Choice program, played a key role in supporting the difficult decision to terminate the Plus program in 2003. Since then, OHCA has continued an innovative approach to performance measurement, seeking new ways to examine data in a way that illuminates program management and implementation. Other states would benefit from Oklahoma's approach to reviewing their own performance as critically as they measure the performance of contracted MCOs.

Where data availability limits agency performance measurement capabilities, states should explore partnerships with other agencies that collect data on Medicaid populations. We built upon OHCA's existing partnership with the Oklahoma State Department of Health, combining data on inpatient hospitalizations and Medicaid enrollment in order to assess the performance of SoonerCare Plus MCOs in managing preventable hospitalizations. Data that Oklahoma received from SoonerCare Plus MCOs on patient encounters and hospitalizations were not consistently reliable, making it difficult to assess the performance of the Plus program. Many states have similar concerns about data completeness from their MCOs, and could follow the approach used in this evaluation by collaborating with the organizations in their state that collect and maintain inpatient discharge records.

States should develop measures that provide perspective on both performance improvement and performance constraints. State-specific measures that provide perspective on performance constraints may be as valuable as those that measure program performance relative to an external benchmark, but few states have focused on such measures. For example, we found that although provider participation has been an important focus in Oklahoma, OHCA's recruitment success depends in large measure on physician supply. The SoonerCare Choice program has recruited 60 percent or more of general/family practitioners and pediatricians engaged in patient care in rural areas, while in urban areas only about 30 percent of these types of physicians participate. It may be difficult for SoonerCare Choice to further boost provider participation numbers in rural areas, though there is clearly potential for urban-provider enrollment growth.

Approach to Client Service

Focusing on providers as clients can significantly improve participation rates. OHCA increased Medicaid physician reimbursement to 100 percent of Medicare rates in 2005, making Oklahoma one of only a few states that reimburse physicians at that relatively high level. Providers also offered consistently positive feedback about initiatives that OHCA has undertaken in recent years to simplify their interactions with the agency, such as online real-time claims processing and upgrades to support more fluid call center interactions. Although the role of provider reimbursement cannot be ignored, these initiatives have almost certainly contributed to OHCA's continued provider participation growth. The rollout of online enrollment for providers later this year is likely to provide an additional recruitment boost.

OHCA's transition of the SoonerCare Plus population to SoonerCare Choice is a textbook example of how to accomplish a challenging and abrupt program transition with minimal disruptions.

Medicaid eligibility expansions for children, coupled with outreach and simplified applications such as those instituted in Oklahoma, can improve participation rates and reduce uninsurance. Oklahoma's Medicaid eligibility expansions, which began in 1997, have dramatically increased enrollment among low-income pregnant women and children in the program. However, concerted outreach and simplified application processes are essential to achieve high Medicaid participation rates. Uneven progress, as is likely to be the situation in most states, indicates the importance of targeted outreach efforts to ensure the benefits of expanded coverage are shared equally. Oklahoma's success in lowering the rate of uninsured low-income children reinforces the importance of Medicaid and SCHIP to these families, in light of continuing declines in rates of private insurance coverage for low-income children.

Agency Management

Though change is always disruptive, adequate resources and leadership can ensure that even difficult transitions are accomplished smoothly. OHCA's transition of the SoonerCare Plus population to SoonerCare Choice in the first three months of 2004 is a textbook example of how to accomplish a challenging and abrupt program transition with minimal disruptions. In early November 2003, the OHCA Board decided not to renew MCO contracts and to end the Plus program on December 31, 2003. Over the next several months, OHCA staff established a clear timeline to accomplish the transition of all Plus members to SoonerCare Choice by April 2004, and worked tirelessly to ensure deadlines were met. Top leadership participated in the necessary leg-work tasks, sending a clear signal about the importance of success. Afterward, the agency evaluated its own performance during the transition process and published a report on the transition effort.

Managing managed care programs requires major investments in infrastructure, staffing, monitoring, and reporting. While OHCA had an advantage from the outset as a stand-alone agency with unusual flexibility in staffing and salary levels, it built over time very sophisticated information technology, data analysis, and reporting capabilities, using a combination of experienced in-house staff and outside contractors, most of whom work on site in close conjunction with OHCA staff.

Good management to ensure the retention of skilled in-house staff is critical to working successfully with outside contractors and to overall agency success. The experience and stability of OHCA's top leaders and managers is relatively unusual among state Medicaid agencies, but it is not just tenure that makes a difference. OHCA's leaders and managers actively work to keep morale, commitment, and productivity high. As a result, many key OHCA staff have been with the agency since the 1990s, providing guidance and continuity for key functions that are performed by outside contractors, such as claims payment and data collection and analysis.

A well-developed strategic planning process can enable an agency to be prepared to take advantage of windows of opportunity that can open and close quickly. OHCA instituted an annual strategic planning process in part to fulfill a state budget requirement; however, the process has become integral to the agency as a way to focus priorities and engage stakeholders. Top leadership make explicit choices and rank projects by relative priority, and staff throughout the agency are aware of projects that have been identified as key priorities. This type of explicit planning process, conducted with the level of specificity and commitment demonstrated by OHCA, leaves the agency well prepared to take advantage of windows of opportunity that may open only briefly. For example, with the economic

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recovery in 2005 after several years of budget challenges, OHCA was able to establish the Insure Oklahoma program.

Changing circumstances provide new opportunities; states should continue to monitor whether program design meets current needs. The original SoonerCare Choice partial capitation model was a good solution to the physician participation problem that existed in rural Oklahoma in the early 1990s, but it offered few financial incentives for providers to actually deliver the services that were capitated. OHCA added payment incentives for EPSDT screening and immunizations, and in 2005 increased Medicaid physician reimbursement to 100 percent of Medicare. Recognizing the limits of partial capitation, the opportunities presented by higher FFS reimbursement, and the growing interest in pay-for-performance reimbursement systems, OHCA has taken advantage of the current interest in “medical home” models to propose further refinement of the SoonerCare Choice reimbursement system to build in more financial incentives for physicians to provide primary care services and to improve their performance on other dimensions. As in the past, OHCA is working closely with physicians and other stakeholders to ensure that this change is fully discussed and understood before implementation.

Relationships With External Stakeholders

Effective and continuous communication is a crucial task for state Medicaid agencies. OHCA has done a thorough and skillful job of reporting on OHCA programs and accomplishments. The agency reports shortcomings and areas for improvement, thereby enhancing its credibility. The reports demonstrate a commitment to public accountability and openness that is critical in a program that serves hundreds of thousands of people, depends on thousands of providers, and uses billions of taxpayer dollars. Medicaid agencies should, as OHCA has done, seize every opportunity to provide program information to legislators, other key stakeholders, reporters, and the public as a whole, knowing that those opportunities may be fleeting. Having good information already on the shelf is the best way to be prepared to take advantage of opportunities when they arise.

Consultation with external stakeholders should be pursued in a targeted way that builds engagement and support. OHCA has created targeted opportunities for stakeholder engagement that have built its reputation as a willing and thoughtful partner. Most notably, OHCA holds its annual strategic planning meeting as an interactive forum in which the agency articulates priorities that have been identified internally, and holds a real-time dialogue with key constituents to refine those priorities, building stakeholder buy-in through the process. OHCA has also instituted a separate physicians-only advisory board to provide feedback, and annual summits with the American Indian community have resulted in productive collaborations that have enabled the agency to improve its services for this difficult-to-serve population.

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PRINCETON OFFICE

P.O. Box 2393
Princeton, NJ 08543-2393
Phone: (609) 799-3535
Fax: (609) 799-0005

WASHINGTON OFFICE

600 Maryland Avenue, SW, Suite 550
Washington, DC 20024-2512
Phone: (202) 484-9220
Fax: (202) 863-1763

CAMBRIDGE OFFICE

955 Massachusetts Avenue, Suite 801
Cambridge, MA 02139-3726
Phone: (617) 491-7900
Fax: (617) 491-8044

ANN ARBOR OFFICE

555 South Forest Avenue, Suite 3
Ann Arbor, MI 48104-2583
Phone: (734) 794-1120
Fax: (734) 794-0241

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