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Comparison of Kansas & Oklahoma Medicaid Managed Care Market Conditions

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Date Submitted:
January 4, 2010

Introduction

Oklahoma implemented a state-wide “enhanced fee-for-service” or Primary Care Case Management (PCCM) program in 2004 to serve their Medicaid/SCHIP population. In doing so, they eliminated the managed care program they had operated in three urban areas since 1997. The following explores some of the important differences between the Oklahoma and Kansas Medicaid managed care programs for KHPA’s consideration.

Summary

Oklahoma made the move from managed care to the enhanced fee-for-service or PCCM model of health care delivery by default, not design. They were forced to implement an alternative to managed care because the specific conditions in the state called for such an alternative. Those conditions included:

- an unstable managed care private market
- an Aged, Blind, and Disabled (ABD) population that had been moved to managed care without sufficient funding to support the provision of services
- access to significant state resources (including hiring FTEs) to set up an internal program
- low provider participation in the Medicaid program
- high provider turnover in the Medicaid program
- high provider payment rates (100% - 140% of Medicare)

Simply put, **none of the conditions that led to the elimination of Medicaid managed care in Oklahoma exist in Kansas.**

The Managed Care Private Marketplace

- Oklahoma was unable to expand managed care to rural areas.¹ Kansas has had state-wide managed care for Medicaid for many years.
- Oklahoma encountered difficulty in attracting and maintaining sufficient MCOs to maintain its managed care program.² Kansas has not had any difficulty attracting and maintaining sufficient MCO participation. In fact, beginning January 1, 2007, Kansas dramatically increased its use of managed care companies when it moved approximately 50,000 additional enrollees from the fee-for-service (FFS) program known as HealthConnect Kansas (HCK)³ into the two newly contracted MCOs.
- Oklahoma had low penetration of managed care and high turnover of MCOs serving the Medicaid population.⁴ Kansas has a stable MCO environment.

¹ SoonerCare 1115 Waiver Evaluation: Final Report; Mathematica Policy Research, Inc.; January 2009; Page xv.

² Id. at page 15.

³ KHPA 2008 Medicaid Transformation Plan – Chapter 12: HealthConnect Kansas Program Review, January 2009; Page 171.

⁴ SoonerCare 1115 Waiver Evaluation: Final Report at pages 15-17.

- Most of the MCOs serving the Oklahoma enrollees were not Medicaid-focused thus yielding higher administrative cost ratios among the MCOs.⁵ Of the seven MCOs that operated in the SoonerPlus Program, only two had predominately Medicaid lines of business and/or were not owned by larger, for-profit insurers.⁶ In Kansas two thirds of the managed care enrollees are enrolled with a not-for-profit safety net health plan (CMFHP) that is focused solely on Medicaid and CHIP. One third of the enrollees are enrolled with a Medicaid-focused subsidiary of a national health insurer (Unicare Health Plan of Kansas).⁷

Medicaid Managed Care Enrolled Populations

- Oklahoma put their ABD population into capitated managed care in 1999 while also expanding benefits.⁸ They did so without sufficient historic cost data to be able to accurately predict the future cost. This caused significant losses among the contracted MCOs for the ABD population. Kansas does not have its ABD population in managed care.

Availability of Ongoing Resources

- Oklahoma had the availability of resources appropriated by the state to build the IT infrastructure and staffing to support the provision of administrative and medical management functions. This included the hiring of 99 FTEs, about one third of which were nurses.⁹ The budget environment in Kansas would suggest there is no similar availability of resources.

Quality Measurement

- Oklahoma had HEDIS data available for their existing FFS/PCCM population. Kansas does not have any comparative HEDIS data for its FFS population. HEDIS data is available only for the MCOs serving Kansas Medicaid.
- In HEDIS quality measures, Oklahoma rated at or above the national average in 3 of 14 measures presented. For the same 14 measures, CMFHP rated above OK in 12 and above the national average in 9. See the following table.

⁵ Id.

⁶ SoonerCare 1115 Waiver Evaluation: Final Report, Table II.4. Oklahoma SoonerCare Plus MCO Characteristics; Mathematica Policy Research, Inc.; January 2009; Page 16.

⁷ KHPA Enrollment Report, December 25, 2009.

⁸ Id. at pages 14, 19-20.

⁹ Id. at page 25.

HEDIS Measurement	2007 National Avg¹⁰	2007 SoonerCare Choice - Admin¹¹	2008 CMFHP KS19 - Admin
Adolescent Well Care	43.6	28.6	49.3
Cervical Cancer Screening	65.7	43.9	62.1
CDC - Eye Exam	51.4	26.3	39.5
CDC - HbA1c Testing	78.0	63.3	67.8
CDC - LDL-C Screen	71.1	55.2	50.0
CDC - Nephropathy Screen	74.6	78.1	51.5
Use of Appropriate Asthma Meds	87.1	85.4	89.0
Well Child Visits 3 - 6 years	66.8	57.1	69.6
Children's Access to PCP			
12-24 months	94.1	94.1	97.5
25 mths - 6 yrs	84.9	81.4	91.0
7-11 years	85.9	80.8	92.9
12-19 years	83.2	80.1	93.7
Adult Access to Primary Care			
20-44 years	78.2	75.6	89.8
45-64 years	83.1	85.2	86.6

- In CAHPS member satisfaction scores, Oklahoma rated below the national benchmark in all 8 categories. CMFHP rated above the national benchmark in 6 of 8 categories. See the following table.

Survey Category	2008 National Avg¹²	2008 SoonerCare Choice¹³	2008 CMFHP - KS19
Rating of Health Plan	72%	62%	76%
Getting Needed Care	76%	73%	81%
Customer Service	80%	78%	82%
Rating of Health Care	67%	61%	69%
Getting Care Quickly	80%	77%	86%
How Well Doctors Communicate	87%	80%	90%
Rating of Personal Doctor	76%	65%	76%
Rating of Specialist	76%	69%	72%

- In the State Scorecard on Health System Performance prepared by The Commonwealth Fund¹⁴, the State of Kansas was ranked higher than Oklahoma in all 6 categories.

¹⁰ National Average Source: Quality Compass (NCQA).

¹¹ SoonerCare data posted at www.ohca.state.ok.us; report dated 10/21/08, posted 1/8/09; 2007 data is most current data available for Oklahoma on OHCA's website

¹² National Average Source: Quality Compass (NCQA)

¹³ SoonerCare data posted at www.ohca.state.ok.us; CMFHP and Oklahoma use The Myers Group to collect CAHPS data.

¹⁴ See www.commonwealthfund.org; report dated 10-8-09

Provider Payment, Participation and Satisfaction

- Oklahoma was unable to sufficiently increase the participation of providers in the urban areas served by the MCOs. Oklahoma's urban area participation rate was only 30% and its rural participation rate only 60%. MCOs in Kansas have achieved much higher rates of participation. For example, CMFHP's participation rate is 55% in urban areas and 99% in rural areas, or 72% in aggregate within our service area.
- Oklahoma had (has) high provider turnover (16%) within the Medicaid program. CMFHP's turnover rate is only 6%.
- Oklahoma increased physician payment rates in 2005 to 100% of Medicare for private practice providers and 140% of Medicare for physicians employed by the Oklahoma University and Oklahoma State University Colleges of Medicine.¹⁵ Kansas' Medicaid physician payment rates are approximately 83% of Medicare (prior to the announced 10% decrease in provider payments planned for January 1, 2010). In spite of significantly lower payment rates Kansas has achieved greater levels of participation.
- Kansas has conducted provider satisfaction surveys that compare the provider's satisfaction with the MCOs and the FFS program. MCOs in general and CMFHP in particular consistently rank higher than FFS in provider satisfaction. Oklahoma has not published provider satisfaction survey results.

Cost Savings?

Prior to the decision to eliminate the managed care contracts the Oklahoma Legislature commissioned a task force to review potential options for the Medicaid program. When considering the issue of the potential elimination of managed care the Task Force concluded the "elimination of managed care would not be a cost effective solution."¹⁶ The decision to eliminate managed care appears to have been based more on necessity (i.e. an unstable MCO marketplace) than anything else. Further, as a subsequent study has pointed out, Oklahoma has not completed any ROI analysis of the work of its PCCM program since its conversion from capitated MCOs.¹⁷

Conclusion

- The decision to eliminate managed care in Oklahoma seems to have been made based primarily on that state's market conditions
- None of the market conditions that led to the elimination of Medicaid managed care in Oklahoma exist in Kansas.

¹⁵ SoonerCare 1115 Waiver Evaluation: Final Report; Mathematica Policy Research, Inc.; January 2009; Pages 26-27.

¹⁶ Oklahoma Health Care Authority Study Task Force; May 3, 2002, page 26, VII. A.

¹⁷ Verdier, James, et al.; Enhanced Primary Care Case Management Programs in Medicaid: Issues and Options for States; Center for Health Care Strategies, Inc.; September 2009; page 26.

- No information was presented that would have led to the conclusion that the overall cost of the program would have decreased. To the contrary, the Task Force assembled by Oklahoma concluded it would not be a cost effective decision. There have been no studies completed subsequently to demonstrate any savings relative to the transition from Oklahoma's use of fully capitated MCOs to a PCCM model.